



CONSISTENT FAILURE OF HARM REDUCTION

Australian drug policy locked into a failed ideology

Suggest the following print box is enlarged a little

1. **Attitudes to Drug Use:** Australian drug policy positions should uniformly address the fact that surveys show almost all Australians do not approve of illicit drug use. Australians want less drugs, not more, and Australia should discard policies that increase use/ **and/or** do not work
2. **Decriminalisation:** characteristically creates increased drug use, not less. Portugal's decriminalisation experiment has seen increasing illicit drug use
3. **Methadone Maintenance:** The most recent Cochrane Collaboration review on methadone found it does not reduce overdose mortality or criminality, the very things it was employed to reduce
4. **Needle and Syringe Programs:** The world's most authoritative review of needle programs by the US IOM, which has historically been sympathetic to these programs, shows no protective effect
5. **Injecting Rooms:** The science on injecting rooms shows no success across a broad range of outcomes
6. **Pill Testing:** The only studies on ecstasy deaths in Australia indicate that ecstasy itself causes almost every pill death, while pill testing does in fact promote ecstasy use – the very substance causing almost all deaths. **More people are likely to take Ecstasy after pill testing.**
7. **Australia knows what works.** It already has a track-record establishing what works in this country. Tough on Drugs, between 1998 and 2007 reduced drug use by 39%, but since its prevention policies were discarded, drug use has risen 22%

Central Issues
&
Compiled Evidence

DRUG FREE AUSTRALIA

EVIDENCE CONTRADICTING AUSTRALIAN POLICY POSITIONS

Executive Summary

1. **Drug Use Attitudes:** All Australian drug policy positions should uniformly address the fact that surveys show almost all Australians do not approve of illicit drug use. Australians want less drugs, not more, and Australia should discard policies that increase use/do not work

Almost all Australians, according to the 2019 National Drug Strategy Household Survey of around 25,000 Australians, do not approve of illicit drug use. 99% do not give approval to the regular use of heroin or speed/ice, cocaine (97%), ecstasy (96%) or cannabis (80%).

Australian drug policy positions should be designed for the MAJORITY of Australians, not the minority 1.0% that use heroin, or the 1.3% that use speed and ice, or the 4.2% that use cocaine, or the 3% that use ecstasy, or the 11.6% using cannabis. Policies assuming user rights must be scrapped for policies that prioritise prevention

2. **Decriminalisation:** characteristically creates increased drug use, not less, something Australians clearly do not want. Portugal's decriminalisation experiment has seen increasing illicit drug use in contrast to Australia's 1998-2007 Tough on Drugs policy which saw Australian drug use decrease by 42% across comparable drugs types as those measured in Portugal

Decriminalisation has always been associated with increases in drug use. This is true for the Netherlands, various states in the USA that decriminalised cannabis in the 1970s, Australian States that decriminalised cannabis in the 1980s and 1990s, as well as for Portugal which decriminalised all illicit drugs in 2001

Australia needs a policy of spent 'convictions' where a user bears criminal penalties and is coerced into rehab in line with drug court coercions. If a convicted user can demonstrate they have been drug-free for a designated period, their conviction is spent, and any record of that conviction deleted

Decriminalisation has been specifically used as an incremental step towards drug legalisation, which in the US has markedly increased cannabis use and associated social problems

According to the US SAMHSA household survey, those reporting they had used cannabis in the last month before survey increased by 245,000 between 2010 (when medical cannabis was commercialised) and 2015. This 43% increase in regular cannabis users creates a vast new population susceptible to the multitude of harms presented by cannabis - psychosis, depression, suicide, driving and work accidents, amotivational syndrome, immunosuppression, permanent harms to the unborn, as well as cardio and pulmonary conditions.

Colorado and Washington were the first states to legalise recreational use, having previously legalised medical cannabis. Within a year of legalisation in 2013 cannabis use by those aged 12-17 had risen 20% against decreases of 4% for all other states, rising 17% for college age young people against 2% for other states – all despite cannabis being illegal for all under age 21. Adult use rose 63% against 21% nationally.

When comparing three year averages before and after legalisation, cannabis-related traffic deaths rose 62%. Hospitalisations related to cannabis went from 6,715 in 2012 to 11,439 in 2014. Notably, black market criminals found new sanctuary in Colorado, attracted by lower risks of enforcement. In 2018, Governor Hickenlooper introduced House Bill 1221 to address the 380% rise in arrests for black market grows between 2014 and 2016.

3. **Methadone Maintenance:** The most recent Cochrane Collaboration review on methadone found it does not reduce overdose mortality OR criminality, the very things it was employed to reduce
4. **Needle and Syringe Programs:** The world's most authoritative review of needle programs by the US IOM, which has historically been sympathetic to these programs, shows no protective effect.

Most of the rigorous studies on the effectiveness of needle exchanges in preventing blood-borne diseases were done between 1995 and 2005. The most authoritative 2006 review by the prestigious US Institute of Medicine found no success in preventing HIV and Hepatitis C for stand-alone needle and syringe programs

5. **Injecting Rooms:** The science on injecting rooms shows no success across a broad range of outcomes

The most rigorous review on injecting rooms to date found reductions in overdoses, ambulance callouts and in crime. However, Drug Free Australia has irrefutably demonstrated that the Vancouver study conclusions cited for overdose reductions is contradicted by official statistics as well as the then Police Commander. The study on reduced ambulance callouts failed to note that there were superior reductions at night when the injecting facility was closed, thus discrediting its conclusions. The study finding reduced crime in Vancouver falls to the same criticisms levelled at the study on reduced overdoses. No positive outcomes have been demonstrated for injecting rooms in rigorous scientific studies

The recent June 2020 review of the Melbourne MSIR shows that the facility failed against all legislated outcomes, while simultaneously increasing crime in the North Richmond area.

6. **Pill Testing:** The only studies on ecstasy deaths in Australia indicate that ecstasy itself caused almost every pill death, while pill testing does in fact promote ecstasy use – the very substance causing almost all deaths

Pill testing doesn't address the causes of ecstasy deaths:

1. It cannot identify individual vulnerabilities to ecstasy that cause deaths
2. It doesn't identify other co-used drugs such as alcohol or amphetamines which cause the majority of deaths
3. It can't identify which ecstasy user will have an ecstasy-fuelled accident (mostly car accidents)

7. **Australia knows what works.** There is already a track-record establishing what works in this country. Tough on Drugs, between 1998 and 2007 reduced drug use by 39%, but since its prevention policies were discarded, drug use has risen 22%. The Federal Government needs to trust Australians, who know what is right, and reimplement prevention priorities. **Australia's Long Term National**



Health Plan and the upcoming National Preventive Health Strategy is an ideal vehicle to ensure these changes occur.

<https://www.health.gov.au/resources/publications/australia-as-long-term-national-health-plan>

The evidence supporting each of the seven central issues nominated here is found in the following pages

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EVIDENCE INDICATING FAILURE OF HARM REDUCTION POLICIES - 1

All Australian drug policy positions should uniformly address the fact that surveys show almost all Australians do not approve of illicit drug use. Australians want less drugs, not more, and Australia should discard policies that increase use/do not work

Almost all Australians, according to the 2019 National Drug Strategy Household Survey of around 25,000 Australians, do not approve of illicit drug use. 99% do not give approval to the regular use of heroin or speed/ice, cocaine (97%), ecstasy (96%) or cannabis (80%).

Australian drug policy positions should be designed for the MAJORITY of Australians, not the minority 1.0% that use heroin, or the 1.3% that use speed and ice, or the 4.2% that use cocaine, or the 3% that use ecstasy, or the 11.6% using cannabis. Policies assuming user rights must be scrapped for policies that prioritise prevention

Almost all Australians do not approve of illicit drug use

The Australian Government's Australian Institute of Health and Welfare (AIHW) conducts the National Drug Strategy Household Survey every 3 years, surveying close to 25,000 Australians each time. The very large sample gives this survey a great deal of validity.

The last survey was in 2019, and Table 9.17 from its statistical data <https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/data> indicates Australian approval or disapproval of the regular use of various illicit drugs.

Drug	Persons				
	2007	2010	2013	2016	2019
Alcohol	45.2	45.1	45.1	46.0	45.4
Tobacco	14.3	15.3	14.7	15.7	15.4
Illicit drugs (excluding pharmaceuticals)					
Marijuana/cannabis	6.6	8.1	9.8	14.5	19.6#
Ecstasy	2.0	2.3	2.4	2.9	3.8#
Meth/amphetamine ^(b)	1.2	1.2	1.4	1.2	1.2

Cocaine/crack	1.4	1.7	1.6	1.7	2.3#
Hallucinogens	1.7	2.4	3.1	3.7	5.6#
Inhalants	0.8	1.0	0.9	1.0	1.0
Heroin	1.0	1.2	1.2	1.1	1.1
Pharmaceuticals					
Over-the-counter pain-killers/pain-relievers ^(b)	n.a.	14.3	14.5	19.1	n.a.
Prescription pain-killers/pain-relievers ^(b)	n.a.	13.0	12.6	12.7	12.4
Tranquilisers, sleeping pills ^(b)	4.1	6.4	8.2	9.3	9.3
Steroids ^(b)	1.6	2.2	2.2	2.4	2.4
Methadone or buprenorphine ^(b)	1.0	1.2	1.3	1.3	1.5

Australians want less drugs, not more

With 96-99% of all Australians not giving their approval to the use of heroin, cocaine, speed/ice and ecstasy, and 80% not giving their approval to the regular use of cannabis, it is clear that Australians do not want these drugs being used in their society.

Drug policy should not pander to tiny user minorities

The percentages of Australians using the main illicit drugs are very, very small. Heroin, speed and ice is used by 1% or less of Australians, while ecstasy (3%), cocaine (4%) and cannabis (12%) are used by only tiny to small minorities. As such there is no reason for government to pander to user rights ideologies – and most importantly, there is no United Nations right to use illicit drugs. In fact UN policy is precisely the opposite, with the 1961 Single Convention on Narcotic Drugs finding international agreement against illicit drug use since that date, confirming other Conventions in place since 1912.

Below is Table 4.6 from the same 2019 Australian survey, this time for drug use in the past 12 months before survey.

Table 4.6: Recent^(a) illicit use of drugs, people aged 14 and over, 2001 to 2019 (per cent)

Drug/behaviour	Proportion						
	2001	2004	2007	2010	2013	2016	2019
Illicit drugs (excluding pharmaceuticals)							
Marijuana/cannabis ^(b)	12.9	11.3	9.1	10.3	10.2	10.4	11.6#
Ecstasy ^(c)	2.9	3.4	3.5	3.0	2.5	2.2	3.0#
Meth/amphetamine ^(d)	3.4	3.2	2.3	2.1	2.1	1.4	1.3
Cocaine	1.3	1.0	1.6	2.1	2.1	2.5	4.2#
Hallucinogens	1.1	0.7	0.6	1.4	1.3	1.0	1.6#
Inhalants	0.4	0.4	0.4	0.6	0.8	1.0	1.4#
Heroin	0.2	0.2	0.2	0.2	0.1	0.2	*<0.1
Ketamine	n.a.	0.3	0.2	0.2	0.3	0.4	0.9#
GHB	n.a.	0.1	*0.1	0.1	*<0.1	*0.1	*0.1
Synthetic Cannabinoids	n.a.	n.a.	n.a.	n.a.	1.2	0.3	0.2
New and Emerging Psychoactive Substances	n.a.	n.a.	n.a.	n.a.	0.4	0.3	*0.1#
Injected drugs	0.6	0.4	0.5	0.4	0.3	0.3	0.3
Any illicit ^(e) excluding pharmaceuticals	14.2	12.6	10.8	12.0	12.0	12.6	14.1#
Non-medical use of pharmaceuticals							
Pain-killers/pain-relievers and opioids ^(d,f)	n.a.	n.a.	n.a.	n.a.	n.a.	3.6	2.7#
Tranquilisers/sleeping pills ^(d)	1.1	1.0	1.4	1.5	1.6	1.6	1.8
Steroids ^(d)	0.2	*<0.1	*0.1	0.1	*0.1	*0.1	0.2
Methadone or Buprenorphine ^(d,g)	0.1	*<0.1	*<0.1	0.2	0.2	0.1	0.1
Non-medical use of pharmaceuticals ^(h,i)	n.a.	n.a.	n.a.	n.a.	n.a.	4.8	4.2#
Illicit use of any drug							
Any opioid ^(j)	n.a.	n.a.	n.a.	n.a.	n.a.	3.7	2.8#
Any illicit ^(k)	16.7	15.3	13.4	14.7	15.0	15.6	16.4



Harm reduction's premises contradict Australian attitudes

As [defined](#) by the International Harm Reduction Association harm reduction aims “primarily to reduce the adverse health, social and economic consequences of psychoactive drugs without necessarily reducing drug consumption.’ So contrary to Australian attitudes, harm reduction does not aim for less drug use.

If harm reduction is failing in its every iteration, and it is failing to reduce drug use, then it is clear that drug policy funding must all be directed to that which works – prevention and rehabilitation.

EVIDENCE INDICATING FAILURE OF HARM REDUCTION POLICIES - 2

Decriminalisation characteristically creates increased drug use, not less, something Australians clearly do not want. Portugal's decriminalisation experiment has seen increasing illicit drug use in contrast to Australia's 1998-2007 Tough on Drugs policy which saw Australian drug use decrease by 42% across comparable drugs types as those measured in Portugal

Decriminalisation has always been associated with increases in drug use. This is true for the Netherlands, various states in the USA that decriminalised cannabis in the 1970s, Australian States that decriminalised cannabis in the 1980s and 1990s, as well as for Portugal which decriminalised all illicit drugs in 2001

Australia needs a policy of spent 'convictions' where a user bears criminal penalties and is coerced into rehab in line with drug court coercions. If a convicted user can demonstrate they have been drug-free for a designated period, their conviction is spent, and any record of that conviction deleted

Soft policies in the Netherlands increased use

In 1976 the Netherlands took a liberal approach to what they called the 'soft' drug cannabis but by the late 1990s **the Netherlands had the highest levels of hard' drug use in Europe**, outside of the drug-liberal United Kingdom/Ireland.

The Table (below) from the EMCDDA 2000 Annual Report Annex, <http://www.emcdda.europa.eu/html.cfm/index37279EN.html> shows **student drug use higher than all but the drug-liberal UK/Ireland** (all European countries where English was a second language arguably had a lesser level of penetration by US and UK musicians and artists who promoted illicit drug use). Over the last decade the country has become more politically conservative, bringing a tightening of drug policy with a greater majority of cannabis cafes closed and recently made unavailable to foreigners. Since 2004 the government has concentrated on anti-cannabis campaigns highlighting its harms, with some success.

Lifetime prevalence of use of different illegal drugs among 15- to 16-year-

	Year	Sample	SCHOOL Surveys Lifetime prev	
			All illegal drugs	Cannabis
Austria	1994	2250	9.9%	9.5%
Belgium (Fla.) (1)	1996	2391	-	19.6%
Belgium (Fla.) (2)	1998	9211	-	23.7%
Denmark (1)	1995	2571	-	18.0%
Denmark (2)	1999	1557	-	24.4%
Finland (1)	1995	2300	5.5%	5.2%
Finland (2)	1999	Preliminar	-	(10%)
France (1)	1993	12391	15.3%	11.9%
France (2)	1997	9919	27.5%	23.0%
Greece (1)	1993	10543	4.5%	3.0%
Greece (2)	1998	8557	11.4%	10.2%
Ireland	1995	1849	37.0%	37.0%
Italy (1)	1995	1641	21.0%	19.0%
Italy (2)	1999	20000	-	19.0%
Luxembourg	1998	660	-	18.5%
Netherlands	1996	10455	31.7%	31.1%
Portugal	1995	4767	4.7%	3.8%
Spain (1)	1996	19191	29.6%	24.3%
Spain (2)	1998	18348	33.9%	28.0%
Sweden (1)	1997	5683	7.6%	6.8%
Sweden (2)	1998	5455	7.7%	7.2%
United Kingdom (1)	1995	7722	42.0%	41.0%
United Kingdom (2)	1997	28756	39.8%	37.5%

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.¹ They recriminalised shortly thereafter.

California decriminalised cannabis on January 1, 1975. 10 months after cannabis use by 18 - 29 year olds was up **15%**.²

Oregon decriminalised cannabis in 1973. 12 months after cannabis use by 18 - 29 year olds was up **12%**.³

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 (below) found in <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1508375/pdf/amjph00013-0029.pdf>. WE note that the reducing use from the US 1980s 'Just Say No' campaign is also evident, something drug law reformers try to deny.

Table 2.1. Trends in Prevalence of Lifetime and Last Year Marijuana Use by Age¹ (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

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1508375/pdf/amjph00013-0029.pdf>

¹ Olsson O, Liberalization of drug policies – an overview of research and studies concerning a restrictive drug policy. Swedish National Institute of Public Health, Stockholm 1996 pp 33-4

² Ibid pp 32,3

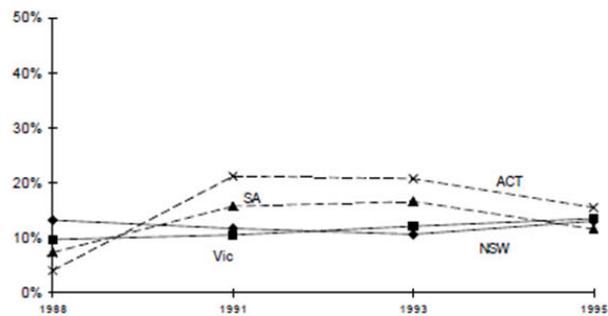
³ Ibid, pp 31,2

Decriminalisation in Australia increased use

South Australia decriminalised cannabis in 1987, followed by the **ACT** in 1993. The graphs below from NDS Household Surveys show sharp rises in cannabis use for both jurisdictions before equalling the use of NSW and Victoria, States with previously entrenched cannabis problems.

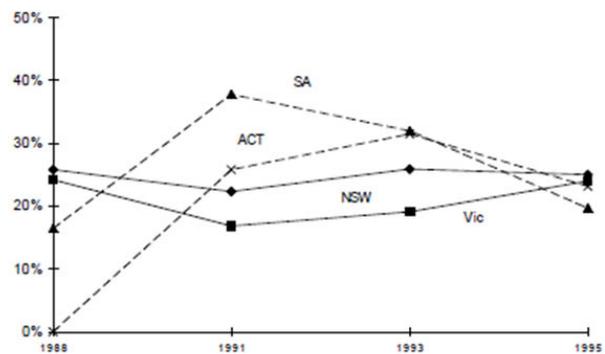
SA offences went from 6,231 in '87/'88 to 17,425 in '93/'94 and when researchers asked users about the increases, many said "We thought cannabis was now legal."

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

<http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-drugs-mono31-cnt.htm>

Portugal's decriminalisation – the truth is in the data

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 which are 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.

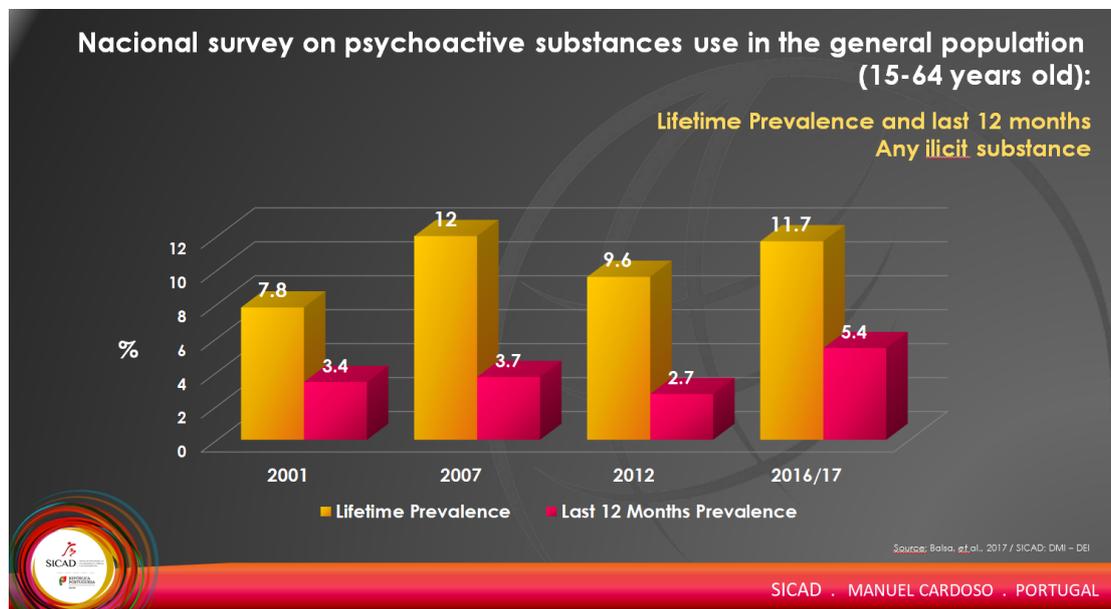
By 2017 drug use was 59% higher than in 2001

While Portugal has not yet reproduced the results of its 2016-17 survey in the usual REITOX National Report which would give a breakdown of use for each drug type, the figures for overall illicit drug use are available from a presentation by Manuel Cardoso, the Deputy General-Director of SICAD, Portugal's agency responsible for monitoring the country's drug use. This presentation can be accessed at <https://drugfree.org.au/index.php/resources/library/9-drug-information/182-portugal.html> using the link [Integrated Drug Policy Manuel Cardoso SICAD \(zip file\)](#).

Copied below from Cardoso's Powerpoint presentation at the June 2018 Sydney conference run by the Network of Alcohol and other Drug Agencies (NADA) are both the lifetime prevalence and last 12 month figures for Portugal for 2016/17. The figures for use in the last 12 months before survey are as follows:

Use in the last 12 months

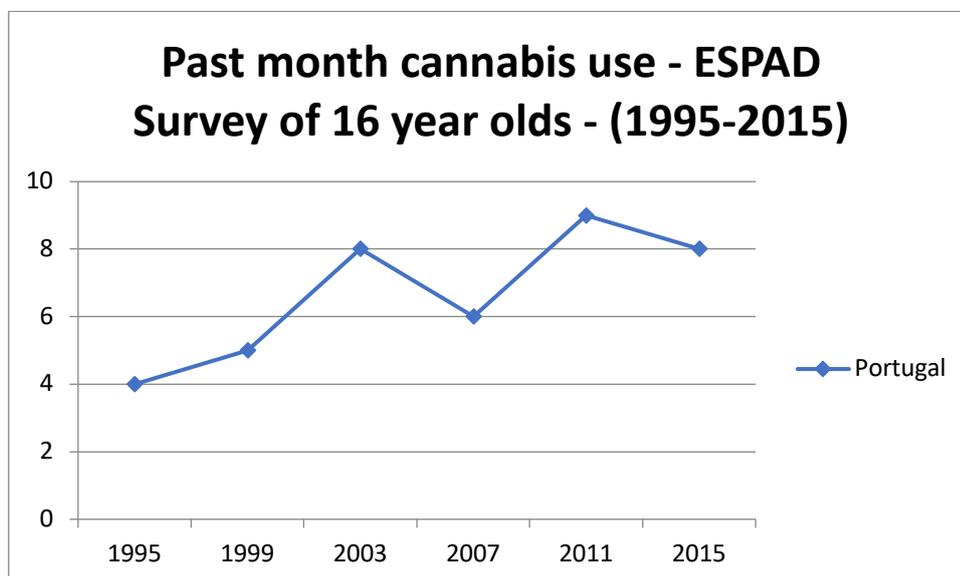
2001	3.4
2007	3.7
2012	2.7
2017	5.4



Note that Portugal's drug use in 2017 for those aged 15-64 was 59% higher than in 2001. This would be an alarming outcome for any country, demonstrating that Portugal's drug policy fails to deter rising drug use.

High School cannabis use 60% higher in 2015 than in 2001

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 2015. The increases are substantial - 60% higher than in 1999. See Appendix C for the actual ESPAD statistics.



Drug deaths in Portugal increased

Claims that there were significant decreases in drug-related deaths in Portugal immediately following 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 2018 EMCDDA Statistical Bulletin are copied below. Notice that there is no such figure recorded for 2001.

Overdose deaths > Trends > EMCDDA 'Selection B'

[Download as Excel file \(.xlsx\)](#)

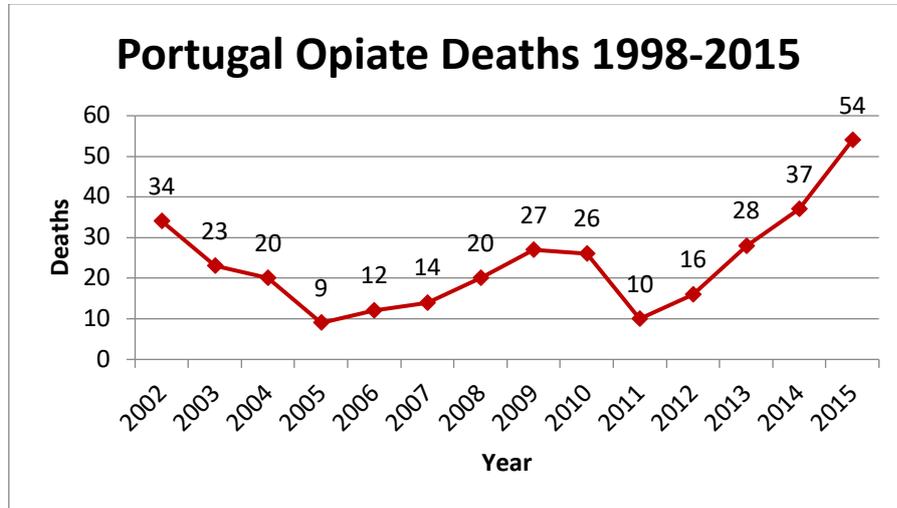
Search:

Country	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000
Poland	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Portugal	:	54	37	28	16	10	26	27	20	14	12	9	20	23	34	:	:
Romania *	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

http://www.emcdda.europa.eu/data/stats2018/drd_en

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 between 2002 and 2005 are part of the same decreasing trend in opiate use, as noted previously, which **predated** decriminalisation with reductions from 0.9% in 1998, to 0.7% in 2000. 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 2015, the latest year for which data is currently available.

Portugal's graph should be compared with Australia's Tough on Drugs results recorded 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.

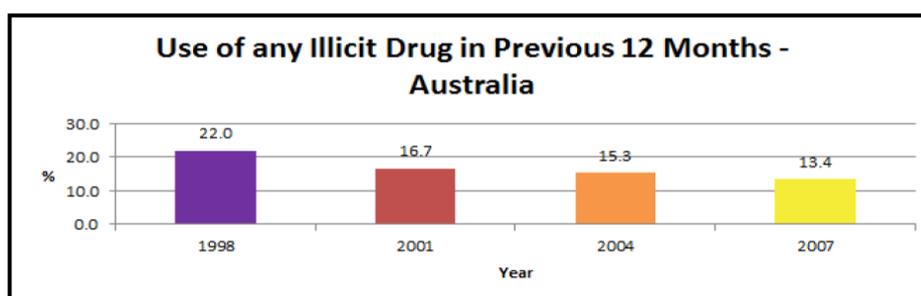
Portugal's increasing trend in deaths since 2011 undoubtedly reflects rising drug use, in light of drug overdose deaths usually closely correlated to levels of rising opiate use. This is because there is a reasonably inelastic relationship between opiate use and opiate deaths, where typically 1% of opiate users fatally overdose each year. Portugal's increasing trend in overdose deaths should be indicate similar increases in opiate use.

Now compare Australia's Tough on Drugs results

Compare the results of Australia's 'Tough on Drugs' between 1998 and 2007. This approach was with use of most illicit still a criminal offence. Use of all illicit drugs declined by 39%. Portugal's decriminalisation has never approached the success of Tough on Drugs.

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^{(d)(e)}	14.0	16.7	22.0	16.7	15.3	13.4	14.7



It is important to recognize that Australia's drug use statistics, graphed from the final line of Table 2.1 above, include a wide variety of drugs, whereas Portugal's statistics are based on only a handful of drugs. When Australian drug use decreases are compared with Portugal on a drug by drug comparison, Australian decreased its drug use by 42% in comparison to Portugal's increases.

Decriminalisation increases use – something Australians don't want

Australians surveyed on their attitudes to decriminalisation are largely in favour, but Drug Free Australia contends that the Australian media's dereliction of its duty to inform the public of these statistics above is wholly responsible. Drug Free Australia has sent all the above information to a wide variety of Australian media, which shows no interest in publicising them.

Given Australians high disapproval ratings of illicit drug use, there can be no question that their attitudes to decriminalisation would change dramatically if they were given the truth about decriminalisation.

The implementation of spent convictions

Drug Free Australia advocates the UK concept of 'spent' convictions where drug use remains a criminal offence. Once a user has lived drug-free for a

period of 3-5 years, as can be decided by legislators, the conviction is wiped from their record, providing no impediment to employment or travel. Such an approach upholds the required meaningful consequences that encourage rehabilitation, seeing as rehabilitation will facilitate less drugs as Australians want. Decriminalisation fails because it gives no incentive for a drug user to do anything but continue using drugs, given that fines and cautions have little deterrent value with little price to pay. Alternately, criminalisation deters 31% of Australians from using drugs, lowering use. The Table below is from the National Drug Strategy Household Survey for 2019 (Table 4.27), which asks reasons for not taking drugs. 31% of Australians do not take drugs specifically because they are illegal and they do not want to suffer the legal consequences.

Proportion

Factor	All Persons				
	2007	2010	2013	2016	2019
For reasons related to health or addiction	45.7	47.0	42.8	43.2	44.0
For reasons related to the law	24.8	28.6	29.1	31.1	31.6
Didn't want anyone to find out	4.5	5.2	3.8	3.8	3.8
Didn't like to feel out of control	18.0	22.4	24.2	24.5	25.5
Pressure from family or friends	10.2	10.8	9.5	10.5	9.7
Didn't think it would be enjoyable	14.4	17.8	17.8	19.3	19.6
Just not interested	69.6	73.3	76.1	73.4	72.8
Financial reasons	5.6	6.7	5.2	6.4	6.5
No opportunity or illicit drugs available	6.1	5.4	4.8	5.0	5.6
Religious/moral reasons	17.0	19.1	22.4	22.9	21.8
Fear of death	13.6	17.6	18.1	18.2	19.2
Other	7.4	2.9	2.1	2.7	2.3

Decriminalisation an incremental pathway to drug legalisation

The same drug policy advisors who have pushed for drug decriminalisation in this country have likewise been working towards drug legalisation. This has been true of organisations such as the [Australian Drug Law Reform Foundation](#) and [Family Drug Support Australia](#).

Australia allows these drug policy advisors to lead at its own peril. Because various States in the USA have legalised cannabis use, we can now make well-informed judgments regarding the failure of such legalisation experiments.

Australians do not want drugs legalised

The last National Drug Strategy Household Survey of 25,000+ Australians which asked attitudes to the legalisation of any illicit drug gave the results facsimiled below. While 2 in every 3 Australians do not want cannabis legalised, only 5-10% of Australians support the legalisation of heroin, ice, speed, cocaine and ecstasy.

Table 9.25: Support^(a) for the legalisation of selected illicit drugs, people aged 14 and over, by drug use, 2010 to 2019 (per cent)

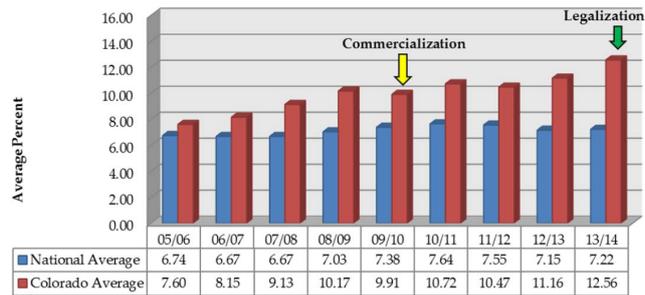
Drug	Proportion															
	Never used				Ex-user ^(b)				Recent user ^(c)				Persons			
	2010	2013	2016	2019	2010	2013	2016	2019	2010	2013	2016	2019	2010	2013	2016	2019
Cannabis	13.6	14.1	21.3	24.8#	32.5	33.5	47.8	56.6#	69.5	76.8	85.7	88.2	24.8	26.0	35.4	41.1#
Heroin ^(d)	5.7	5.3	5.4	5.3	26.6	27.8	26.3	25.2	49.3	48.0	57.9	59.2	6.0	5.7	5.8	5.6
Meth/amphetamines	4.6	4.2	4.2	3.9	7.1	7.7	8.7	9.7	17.4	22.5	26.9	33.3	5.0	4.8	4.8	4.6
Cocaine	5.3	4.8	5.3	5.3	14.3	15.0	19.7	19.6	27.2	31.7	30.0	42.0#	6.3	6.2	7.0	8.0#
Ecstasy	5.3	5.3	5.5	5.8	14.0	14.6	22.2	24.5	30.4	40.3	52.1	60.1	6.8	7.3	8.2	9.5#

We must recognise that decriminalisation is an incremental step in an endgame that Australians simply do not want.

Colorado - use of cannabis by those aged 12-17 rose 20% in first year

The legalisation of recreational use of cannabis in Colorado and Washington in 2013 has led to increasing drug use in those states. It is illegal for any under the age of 21 to use cannabis, especially given the effect of cannabis on the developing adolescent brain. But use in Colorado by those aged 12-17 rose substantially against decreases of 4% in other states, despite use already being elevated by the legalisation of medical cannabis.

Past Month Marijuana Use
Youth Ages 12 to 17 Years Old

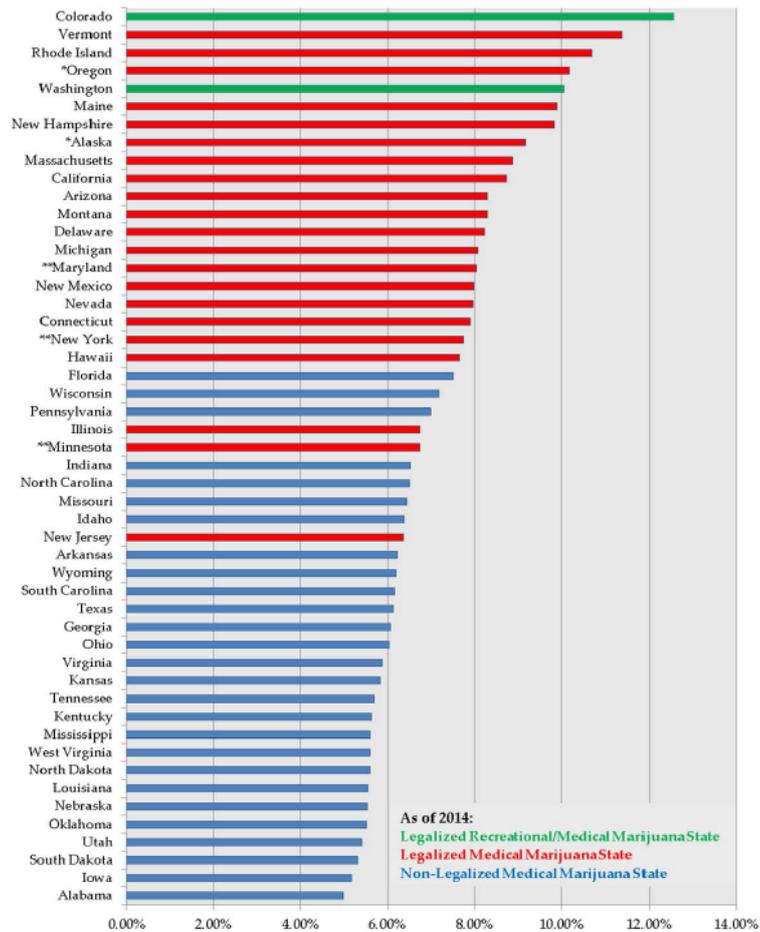


Annual Averages of Data Collection

SOURCE: SAMHSA.gov, National Survey on Drug Use and Health 2013 and 2014

In 2013/14 Colorado youth ranked #1 for cannabis use in the United States, up from #4 in 2011/12 and from #14 in 2005/6. In the graph below states with legalised medical cannabis are marked red, and green for recreational use.

Past Month Usage, 12 to 17 Years Old, 2013/2014



SOURCE: SAMHSA.gov, National Survey on Drug Use and Health 2013 and 2014

NOTE: *Oregon and Alaska voted to legalize recreational marijuana in November 2014
 **States that had legislation for medical marijuana signed into effect during 2014

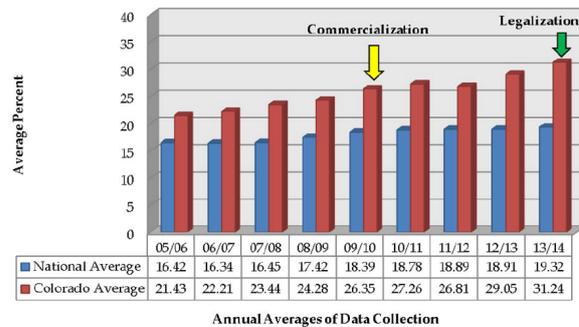
In the following 2 year period, drug use fell such that Colorado recent use for this age group fell to 7th in the nation. This was because other states had legalised cannabis in the intervening years, and Colorado was passed by states most of which had legalised cannabis use or were in the process of doing so. Below is the graph for all states with those states that had legalised cannabis by 2016 in red, or where legalisation legislation was already in process.

The most likely explanation for the marked decreases for this age-group is that they are under the institutional control of schools, whereas older age-groups are not subject to those institutional controls.

College-age use rose by 17%

Against increases of 2% nationally, use of cannabis by those of college age rose by 17% within the first year of legalised cannabis use.

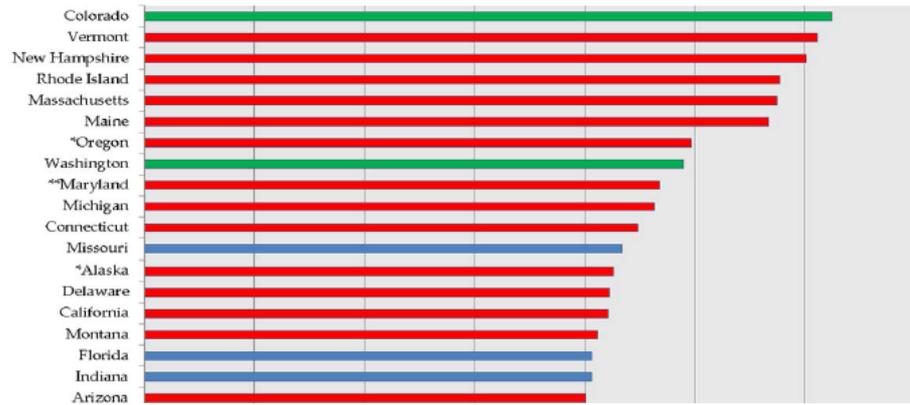
**Past Month Marijuana Use
College Age 18 to 25 Years Old**



SOURCE: SAMHSA.gov, National Survey on Drug Use and Health 2013 and 2014

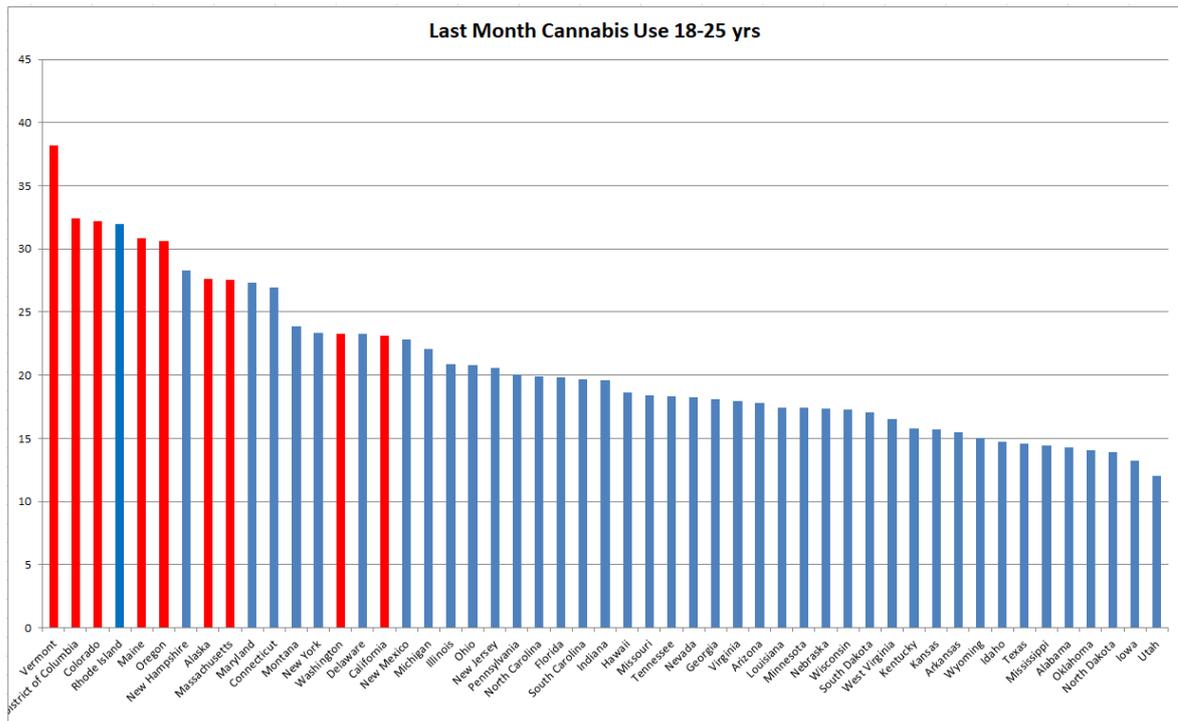
In 2013/14 Colorado college-age students ranked #1 for cannabis use in the United States, up from #3 in 2011/12 and from #8 in 2005/6.

Past Month Usage, 18 to 25 Years Old, 2013/2014



In 2015/16 against increases of 6% nationally, use of cannabis by those of college age rose by 3% (from 31.24% to 32.20%) between 2013/2014 and 2015/2016. In 2015/2016 Colorado college-age students ranked #3 for cannabis use in the United States. States ranking #1 (Vermont) and #2 (District of Columbia) were states that had legalised cannabis or were in the process of legalising (denoted by red below).

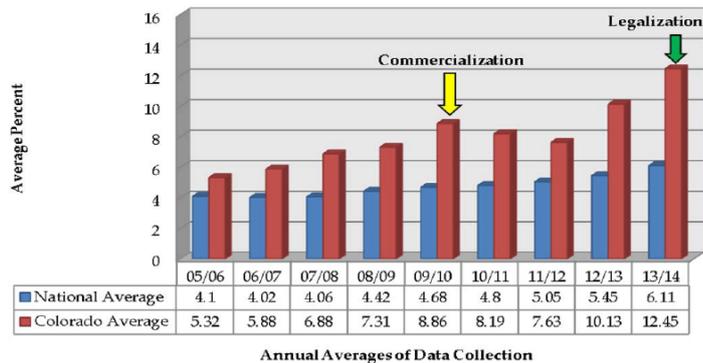
Last Month Cannabis Use 18-25 yrs



Adult use rose by 63%

Adult use increased by 63% in the first year after legalisation against increases of 21% nationally.

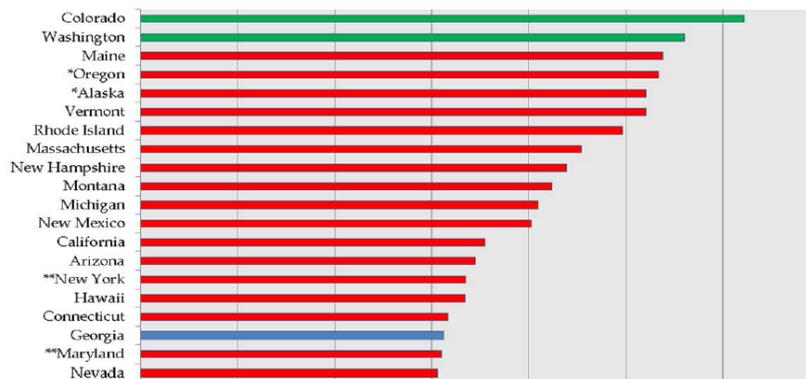
Past Month Marijuana Use Adults Age 26+ Years Old



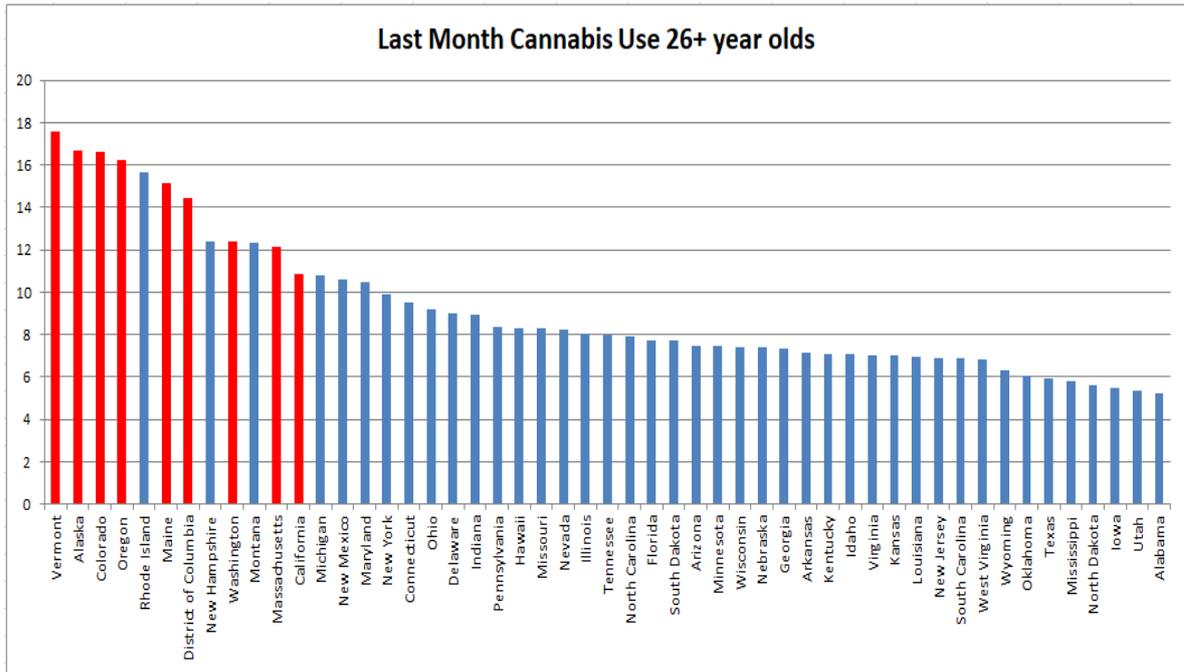
SOURCE: SAMHSA.gov, National Survey on Drug Use and Health 2013 and 2014.

In 2013/14 Colorado adults ranked #1 for cannabis use in the United States, up from #7 in 2011/12 and from #8 in 2005/6. States marked red are those states that had legalised cannabis for medical use.

Past Month Usage, 26+ Years Old, 2013/2014



In 2015/16 adult use increased by 33% (from 12.45% - 16.62%) against increases of 49% nationally. In 2015/2016 Colorado adults ranked #3 in the United States. The impact of various states legalising cannabis can be seen on the United States skyrocketing consumption. States ranking #1 (Vermont) and #2 (Alaska) ahead of Colorado were states which had legalised cannabis or were in the process of legalising (denoted by red below).



Cannabis legalisation, as has been graphically shown, creates considerably more use, not less use as Australians want.

Cannabis-related road fatalities rose by 62%

Road fatalities related to cannabis use rose by 62%, from 71 to 115 persons since 2013 when recreational cannabis use was legalised.

Traffic Deaths Related to Marijuana*			
Crash Year	Total Statewide Fatalities	Fatalities with Operators Testing Positive for Marijuana	Percentage Total Fatalities (Marijuana)
2006	535	37	6.92%
2007	554	39	7.04%
2008	548	43	7.85%
2009	465	47	10.10%
2010	450	49	10.89%
2011	447	63	14.09%
2012	472	78	16.53%
2013	481	71	14.76%
2014	488	94	19.26%
2015	547	115	21.02%

*Fatalities Involving Operators Testing Positive for Marijuana

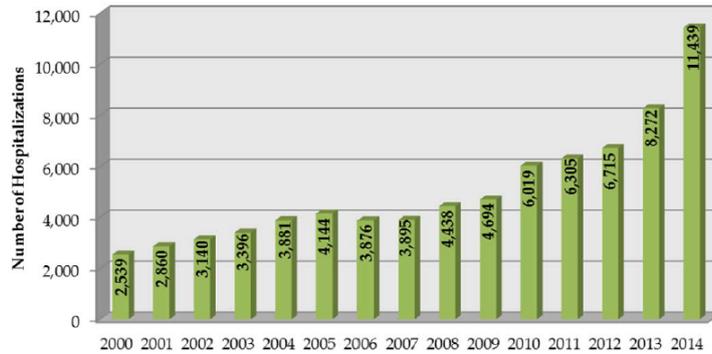
SOURCE: National Highway Traffic Safety Administration, Fatality Analysis Reporting System (FARS)

Hospitalisations related to cannabis use rose markedly

The number of hospitalisations likely related to cannabis increased 32% in the two year average (2013-14) since Colorado legalised recreational marijuana compared to the two-year average prior to legalisation (2011-2012).

Hospitalisations moved from 6,715 to 11,439 since 2013.

Hospitalizations Related to Marijuana



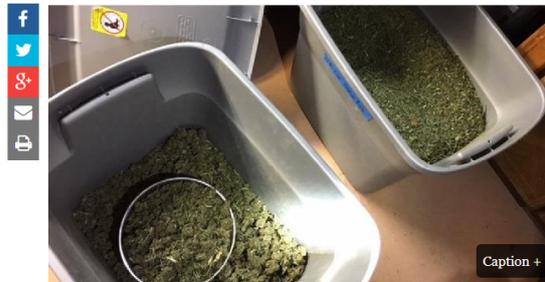
SOURCE: Colorado Hospital Association, Hospital Discharge Dataset. Statistics prepared by the Health Statist and Evaluation Branch, Colorado Department of Public Health and Environment

Legislation introduced to cut black market criminality

Governor Hickenlooper last year introduced House Bill 1221 to address the 380% rise in arrests for black market grows between 2014 and 2016.

Collateral Impact: The Unintended Consequences of the Legalization of Pot

By: David Olinger, Special to The Gazette · February 17, 2018 · Updated: February 22, 2018 at 2:34 pm



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Four years after legal recreational marijuana went on sale in Colorado, Gov. John Hickenlooper says the black market for marijuana in the state is shrinking and predicted that it "will be largely gone" in a few years.

But new statistics show that arrests for the production of black market pot increased by 380 percent in the 2014-16 time frame, and Colorado law enforcement agencies say they are battling a boom in illegal marijuana cultivation by sometimes violent groups of criminals who rake in millions of dollars by exporting what they grow.



Related:

- Collateral Impact: Study finds Colorado marijuana dispensaries are giving bad advice to pregnant women
- One Colorado Springs school district among top 10 in state for most marijuana incidents reported
- Collateral Impact: Colorado schools on front line as debate swirls over legalization's effect on teens' pot use
- CSU-Pueblo researchers study links between marijuana and community problems

<http://gazette.com/collateral-impact-the-unintended-consequences-of-the-legalisation-of-pot/article/1621232>

House Bill 1220 would aid law enforcement in detecting black market operations and might eliminate Colorado's dubious distinction as the best place in North America to produce pot for widespread distribution. It would limit grows on residential property to 12 plants, with an exception for medical marijuana patients or primary caregivers in compliance with local laws that allow exceptions.

House Bill 1221 would establish an annual \$6 million grant program to reimburse local governments for training, education and enforcement related to black market grows. These bills may not go far enough, and the \$6 million in HB 1221 does not approach what local authorities need. But the two bills are a good start in what should be an urgent effort to stop the unseemly and dangerous proliferation of black market pot.

<http://gazette.com/editorial-pass-bills-to-curb-black-market-marijuana-in-colorado/article/1598339>

Colorado added 245,000 extra cannabis users in 5 years

From 2010, when Colorado introduced the commercialisation of medical cannabis (with an explosion of medical cannabis user numbers) to 2015, the state added 245,000 extra frequent cannabis users. This is a 43% increase in cannabis use during those years for all surveyed age-groups.

Year	Population	Frequent Users
2010	5,029,196	573,919
2015	5,448,055	819,179
Change		245,260

245,000 extra users became susceptible to these cannabis harms

While the harms of cannabis have not been studied for as many years as the harms of tobacco and alcohol, it is already well-established that cannabis combines the harms of intoxication from alcohol with the particulate damage of tobacco. Cannabis presents a wide variety of additional harms.

- Cannabis is an established gateway to other dangerous drugs, adding an additional gateway beyond the two existing legal drugs
- Cannabis users are 50% more likely to develop alcohol use disorder
- Cannabis use is associated with a doubling the chance of psychosis
- Cannabis use is associated with a 4 times greater chance of depression
- Cannabis is associated with Amotivational Syndrome
- Cannabis use is associated with a 3 fold risk of suicidal ideation
- The immune system of cannabis users is adversely affected

- VIOLENCE AND AGGRESSION are a documented part of its withdrawal syndrome
- Brain Function
 - Verbal learning is adversely affected
 - Organisational skills are adversely affected
 - Cannabis causes loss of coordination
 - Associated memory loss can become permanent
 - Cannabis is associated with attention problems
- Drivers are 16 times more likely to hit obstacles
- Miscarriage is elevated with cannabis use
- Fertility is adversely affected
- Newborns are adversely affected with appearance, weight, size, hormonal function, cognition and motor function adversely affected through to adulthood
- Cannabis use causes COPD & bronchitis
- Cannabis is also associated with cardiovascular stroke and heart attack, with chance of myocardial infarction 5 times higher after one joint

EVIDENCE INDICATING FAILURE OF HARM REDUCTION POLICIES - 3

The most recent Cochrane Collaboration review on methadone found it does not reduce overdose mortality OR criminality, the very things it was employed to reduce

Gold standard review - methadone does not reduce overdose or criminality

The most important outcome for methadone maintenance is its ability to save lives from opiate overdose, as well as reducing the need for users to commit criminal acts to buy heroin.

Yet the most authoritative review of well-designed journal studies by the Cochrane Collaboration (full study at Appendix A) found no such effectiveness for methadone maintenance. It is notable that the lead researcher for this review is Richard Mattick, former head of the Australian National Drug and Alcohol Research Centre (NDARC) at NSW University, who is an ardent harm reductionist.

From the Abstract of the Cochrane review itself:

Main results

Eleven studies met the criteria for inclusion in this review, all were randomised clinical trials, two were double-blind. There were a total number of 1969 participants. The sequence generation was inadequate in one study, adequate in five studies and unclear in the remaining studies. The allocation of concealment was adequate in three studies and unclear in the remaining studies. Methadone appeared statistically significantly more effective than non-pharmacological approaches in retaining patients in treatment and in the suppression of heroin use as measured by self report and urine/hair analysis (6 RCTs, RR = 0.66 95% CI 0.56-0.78), but not statistically different in criminal activity (3 RCTs, RR=0.39; 95%CI: 0.12-1.25) or mortality (4 RCTs, RR=0.48; 95%CI: 0.10-2.39).

Authors' conclusions

Methadone is an effective maintenance therapy intervention for the treatment of heroin dependence as it retains patients in treatment and decreases heroin use better than treatments that do not utilise opioid replacement therapy. It does not show a statistically significant superior effect on criminal activity or mortality.

Methadone maintenance therapy versus no opioid replacement therapy

Published: 8 July 2009

Authors: Mattick RP, Breen C, Kimber J, Davoli M

Primary Review Group: Drugs and Alcohol Group

See the full Review on the Cochrane Library

- Print
- PDF
- Citation

Methadone maintenance treatment can keep people who are dependent on heroin in treatment programs and reduce their use of heroin. Methadone is the most widely used replacement for heroin in medically-supported maintenance or detoxification programs. Several non-drug detoxification and rehabilitation methods are also used to try and help people withdraw from heroin. However the review found that people have withdrawn from trials when they are assigned to a drug-free program. Consequently, there are no trials comparing methadone maintenance treatment with drug-free methods other than methadone placebo trials, or comparing methadone maintenance with methadone for detoxification only. These trials show that methadone can reduce the use of heroin in dependent people, and keep them in treatment programs.

Authors' conclusions:

Methadone is an effective maintenance therapy intervention for the treatment of heroin dependence as it retains patients in treatment and decreases heroin use better than treatments that do not utilise opioid replacement therapy. It does not show a statistically significant superior effect on criminal activity or mortality.

Read the full abstract...

Altmetric score 159 Who is talking about this article?



A substantial percentage of methadone users still use heroin

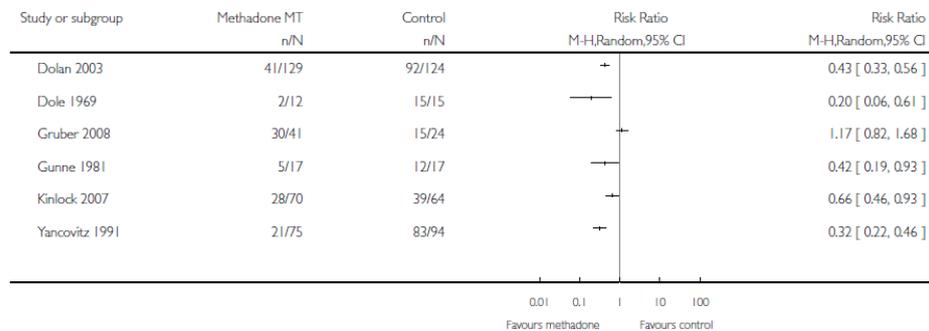
From the Cochrane review by Mattick et al, the relevant studies show that a varying percentage of methadone patients still use heroin, with one study finding 73% still using the substance.

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



EVIDENCE INDICATING FAILURE OF HARM REDUCTION POLICIES - 4

The world's most authoritative review of needle programs by the US IOM, which has historically been sympathetic to these programs, shows no protective effect

Most of the rigorous studies on the effectiveness of needle exchanges in preventing blood-borne diseases were done between 1995 and 2005. The most authoritative 2006 review by the prestigious US Institute of Medicine found no success in preventing HIV and Hepatitis C for stand-alone needle and syringe programs.

Needle programs have no demonstrated positive effect

In 2006 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 1997 review of needle exchanges, the IOM had noted the poor design and lack of rigour in most of the studies on the effectiveness of NEPs to that time, but nevertheless advocated for their implementation in the United States, *indicating that they were sympathetic to the intervention even before the evidence was in*. This bias toward harm reduction makes their later 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.

The result of all their deliberations were published in 2006, and the chapter reviewing studies on NSP is appended (Appendix B).

Preventing HIV Infection Among Injecting Drug Users in High-Risk Countries
 An Assessment of the Evidence (2007)
 Consensus Study Report

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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).”

Conclusion 3-5: Moderate evidence indicates that multi-component HIV prevention programs that include needle and syringe exchange reduce intermediate HIV risk behavior. However, evidence regarding the effect of needle and syringe exchange on HIV incidence is limited and inconclusive.

Conclusion 3-6: Five studies provide moderate evidence that HIV prevention programs that include needle and syringe exchange have significantly less impact on transmission and acquisition of hepatitis C virus than on HIV, although one case-control study shows a dramatic decrease in HCV and HBV acquisition.

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https://www.nap.edu/login.php?record_id=11731&page=https%3A%2F%2Fwww.nap.edu%2Fdownload%2F11731 p 149

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 is as ineffective against HIV as it is against HCV.

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

<http://www.mja.com.au/public/issues/mar17/wodak/wodak.html> 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."

The MJA article says it all and the Federal Government is urged to remove support from this failed harm reduction approach.

EMCDDA review does not supersede the IOM review

A 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 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 reviews. The three reviews included the 2004 Wodak/Cooney study completed for the World Health Organisation (WHO) and the 2006 Tilson et al. study 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. study 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 2006 '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 2006 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 own credit, that "(f)our of the five positive findings were generated by studies with weaker designs."

Drug Free Australia again alerts the Federal Government to the fact that there is insufficient evidence to conclude that NSPs are effective in preventing HCV (Hepatitis C) transmission, and that the evidence supporting the effectiveness of NSPs in preventing HIV transmission still remains inconclusive.

The science contradicts two 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, at lowest estimate of \$1.03 billion from an investment of \$243 million.

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.

EVIDENCE INDICATING FAILURE OF HARM REDUCTION POLICIES - 5

The science on injecting rooms shows no success across a broad range of outcomes

The most rigorous review on injecting rooms to date found reductions in overdoses, ambulance callouts and in crime. However, Drug Free Australia has irrefutably demonstrated that the Vancouver study conclusions cited for overdose reductions is contradicted by official statistics as well as the then Police Commander. The study on reduced ambulance callouts failed to note that there were superior reductions at night when the injecting facility was closed, thus discrediting its conclusions. The study finding reduced crime in Vancouver falls to the same criticisms levelled at the study on reduced overdoses. No positive outcomes have been demonstrated for injecting rooms in rigorous scientific studies

The recent June 2020 review of the Melbourne MSIR shows that the facility failed against all legislated outcomes, while simultaneously increasing crime in the North Richmond area.

The failure of injecting rooms

Reviews of scientific evaluations of SIFs (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 have used studies which methodologically fail to demonstrate the effectiveness of SIFs to alter individual or population-level outcomes.** Just two reviews, May et al. 2018 and Kilmer et al. 2018 (RAND Corporation) included only studies with a quasi-experimental design using control groups/areas, with May et al. subsequently being 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 SIF effectiveness.

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 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 currently exist.

RAND review relied on two discredited studies

The main two studies demonstrating the supposed effectiveness of a Medically Supervised Injecting Centre 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 review to that date (see the 2014 review by Potier, C., et al., Supervised injection services: What has been demonstrated? A systematic literature review. Drug Alcohol Depend. (2014), <http://dx.doi.org/10.1016/j.drugalcdep.2014.10.012> below).

C. Potier et al. / Drug and Alcohol Dependence xxx (2014) xxx–xxx

15

et al., 2004; Tyndall et al., cohort studies, 94% (n=30) 1) in Sydney, and 3% (n=1)

nsisted of 7 exhaustive pop- (Fry, 2002; Kimber et al., et al., 2004), 3 descriptive 008b; Salmon et al., 2009a, udies (Fairbairn et al., 2008; n, 2013; Kerr et al., 2007); bin et al., 2009; Small et al., tson et al., 2012), 4 cross- 2008; Navarro and Leonard, al., 2005), 3 surveys (Cruz eek and Gilmour, 2000), 3 15; Kerr et al., 2006a; Wood l studies (Kimber and Dolan,

3.3. The impact of SISs on overdose-induced mortality and morbidity

Seven studies evaluated whether SISs successfully reduced harm among SIS users (Kerr et al., 2006b, 2007b; Marshall et al., 2011; Milloy et al., 2008a, 2008b; Salmon et al., 2010; Van Beek et al., 2004). In the different studies, no death by overdose was ever reported within the SISs in which this parameter was evaluated (Kerr et al., 2006b; Milloy et al., 2008b; Van Beek et al., 2004). In Vancouver, SIS implementation led to a 35% decrease in the number of lethal overdoses in the vicinity of the SIS (Marshall et al., 2011); thus, it was evaluated that between 2 and 12 cases of lethal overdose might have been avoided each year (Milloy et al., 2008b). In Sydney, the number of calls for ambulances related to overdose was 68% lower during the operational hours of the SIS (Salmon et al., 2010; Van Beek et al., 2004).

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

Age											Town / City														
	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997		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	100 Mile House	0	0	1	0	0	1	1	0	0	0	0	0	
21 - 30	37	47	40	43	34	39	52	38	49	73	61	108 Mile Ranch	0	0	0	0	0	0	0	0	0	0	0	0	
31 - 40	55	54	64	58	49	56	97	101	111	174	141	Abbotsford	4	8	8	5	5	1	11	14	6	6	8	8	
41 - 50	66	77	75	57	72	56	65	73	62	121	81	Agassiz	0	1	2	1	1	1	0	0	0	2	1	1	
51 - 60	32	38	28	26	22	12	19	28	24	35	17	Alexis Creek	0	0	1	0	0	0	0	0	0	0	0	0	
61 and over	5	3	4	2	5	2	6	1	2	2	4	Armstrong (BC)	0	0	1	0	0	0	0	0	0	0	0	0	
												Black Creek	0	0	0	0	0	0	1	0	0	0	0	0	
Total	200	228	218	194	189	170	246	248	278	417	310	Bowser	0	1	0	0	0	0	0	0	0	0	0	0	
												Brentwood Bay	0	1	0	0	0	0	0	1	0	1	0	0	
												Bridge Lake	0	1	0	0	0	0	0	0	0	0	0	0	
												Burnaby	9	6	7	3	8	2	11	6	13	20	13	13	
												Campbell River	3	4	5	3	4	1	1	2	2	9	2	2	
												Castlegar	2	2	2	2	2	2	2	2	2	2	2	2	
												Trail	2	1	1	0	0	1	0	0	0	1	0	0	
												Ucluelet	0	0	0	0	0	0	0	0	0	0	0	1	
												Vancouver	56	54	55	67	51	49	90	87	108	191	140	140	140
												Vanderhoof	0	0	0	0	1	0	0	0	0	0	0	0	
												Victoria	3	4	1	4	7	3	2	4	4	2	4	2	
												Warfield	0	0	0	0	0	0	0	0	25	31	26	17	
												West Vancouver	1	0	1	0	0	1	0	1	0	1	0	0	
												Westbank	1	1	2	0	0	1	0	0	0	0	0	0	
												Whistler	0	0	0	0	0	0	1	0	0	0	0	0	
												White Rock	1	2	1	0	1	1	1	0	0	1	0	0	
												Williams Lake	3	0	2	0	0	0	1	1	0	1	1	1	
												Winfield (BC)	0	1	0	0	1	0	0	0	0	0	0	0	
												Wycliffe	0	0	0	0	1	0	0	0	0	0	0	0	
												Ymar	0	0	0	0	1	0	0	0	0	0	0	0	
												Unknown	1	0	0	0	0	0	0	0	0	0	0	0	
Total	200	228	218	194	189	170	246	248	278	417	310														

Originally found at:

<http://www.pssg.gov.bc.ca/coroners/publications/docs/stats-illicitdrugdeaths-1997-2007.pdf> now at <https://web.archive.org/web/20120321162004/http://www.pssg.gov.bc.ca/coroners/publications/docs/stats-illicitdrugdeaths-1997-2007.pdf>

The same study also claimed overdose reductions by 35% in the area immediately surrounding Vancouver's Insite. Drug Free Australia's Australian/Canadian team of epidemiologists and addiction specialists demonstrated in 2012 that Marshall et al. **had concealed the tripling of police numbers around Insite in 2003**,⁴ falsely claiming that this was temporary when in fact it was permanent,⁵ as attested by the DTES Area Commander at that time, John McKay (See Appendix D). Such policing served to disperse drug dealers away from the area around Insite, reducing crime and loitering, and of course ODs as users purchased their drugs elsewhere. Policing alone was shown to be demonstrably capable of reducing overdoses around Insite by 35%.⁶ **This then collapses the Vancouver study describing reduced crime around Insite, the result of tripled policing which changed from a philosophy of containment to one of zero tolerance 6 months before Insite opened.**

The 2010 Salmon et al. Addiction study, which claimed a **31%** 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 70% better** than the rest of NSW (42% reductions) when the injecting room was closed.⁷ This can be clearly seen in the ringed cells on the spreadsheet below.

⁴ https://drugfree.org.au/images/13Books-FP/pdf/Lancet_2011_Insite_Analysis.pdf, [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(12\)60054-3.pdf?code=lancet-site](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(12)60054-3.pdf?code=lancet-site)
⁵ [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(12\)60055-5.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(12)60055-5.pdf)
⁶ https://drugfree.org.au/images/13Books-FP/pdf/Lancet_2011_Insite_Analysis.pdf
⁷ <https://www.drugfree.org.au/images/13Books-FP/pdf/2017InjectingRoom.pdf>

	AMBULANCE CALLOUTS BEFORE MSIC OVER 36 MONTHS					
	During Op hours	Average per month	Outside Op hours	Average per month	Total all hours	Average per month
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					
	During Op hours	Average per month	Outside Op hours	Average per month	Total all hours	Average per month
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%	

This irrefutably indicates reductions were not due to the MSIC, 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 five studies on SIS impacts on crime in the immediate area around an SIS are voided due to the effect of increased police operations.⁸ The upshot is that there is no science which supports injecting rooms.

Latest MSIR review well-illustrates the failure

The recently released [review](#) of the North Richmond Medically Supervised Injecting Room (MSIR) evaluated the performance of the facility against its six legislated objectives, with the review's own data and comments 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.

The 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

⁸ Wood et al. 2004; Fitzgerald et al. 2010; Milloy et al. 2009; Wood et al. 2006^a; Freeman et al. 2005

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 is 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, 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 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.

EVIDENCE INDICATING FAILURE OF HARM REDUCTION POLICIES – 6

The only studies on ecstasy deaths in Australia indicate that ecstasy itself caused almost every pill death, while pill testing does in fact promote ecstasy use – the very substance causing almost all deaths

Pill testing doesn't address the causes of ecstasy deaths:

- 1. It cannot identify individual vulnerabilities to ecstasy that cause deaths**
- 2. It doesn't identify other co-used drugs such as alcohol or amphetamines which make ecstasy deadly**
- 3. It can't identify which ecstasy user will have an ecstasy-fuelled accident (mostly car accidents)**

Two Australian studies show ecstasy itself causal of most deaths

In January 2020 [data](#) on 392 ecstasy-related deaths between July 2000 and November 2018 was published in the International Journal of Drug Policy (see Appendix E). This study extended the data beyond the MDMA-related deaths from July 2000 and December 2005 examined in the only other Australian study <https://pubmed.ncbi.nlm.nih.gov/19604654/> 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 adulterant drugs mixed with ecstasy

No more than 5% of Australian ecstasy-related deaths, according to the above [study](#), were from other exotic drugs mixed into 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.

Very few deaths from party drugs other than ecstasy

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 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 toxicologist Dr Andrew Leibie as contained in DFA document "Why-have-pill-testing-when-most-ecstasy-deaths-are-from-normal-doses-of-MDMA").

Pill testing does not address the real causes of MDMA deaths

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

Causes of MDMA-related deaths	Pill testing applicability
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 will not stop MDMA-related accidents

Pill testing might prevent that 5% of deaths, but very good evidence from the second Canberra pill-testing trial indicates that it would do nothing to stop the other 95% 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 in an MDMA 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 blue shaded area in the graph below 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 of 125 – 150 mg of ecstasy 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 screens at festivals. No need for pill testing at all.

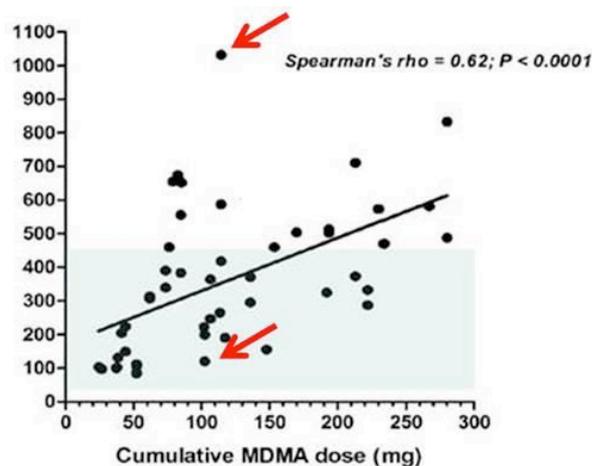


Figure 4 The relationship between maximum plasma 3,4-methylenedioxy-methamphetamine (MDMA) concentration (C_{max}) and cumulative MDMA dose consumed by the time of maximum plasma concentration ($n=49$). Correlation coefficient (Spearman's rho), P-value and line of best fit are shown ($n=49$ participants where MDMA detectable in plasma)

The clincher - users MORE likely to take ecstasy after pill testing

The Australian National University [evaluation](#) of the 2019 Canberra pill testing trial confirms that the methods used by Pill Testing Australia to classify substances they identify 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 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 has 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 saying the horse has bolted once they have spent \$100 purchasing it, and 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. 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.

Drug Free Australia is urging State Governments to consider the science on pill deaths within Australia and to remove its support for an intervention which will only increase ecstasy use and deaths.

EVIDENCE INDICATING FAILURE OF HARM REDUCTION POLICIES – 7

Australia knows what works. There is already a track-record establishing what works in this country. Tough on Drugs, between 1998 and 2007 reduced drug use by 39%, but since its prevention policies were discarded, drug use has risen 22%. The Federal Government needs to trust Australians, who **know** what is right, and reimplement prevention priorities.

Australia's Long Term National Health Plan and the upcoming National Preventive Health Strategy is an ideal vehicle to ensure these changes occur.

<https://www.health.gov.au/resources/publications/australia-long-term-national-health-plan>

There are no excuses – Australia knows what works

Australia has a proven track-record in reducing illicit drug use and has been [recognised](#) by the UNODC as leading the world in doing so.

When Tough on Drugs was introduced by the Federal Government in 1998, 22% of Australians had used an illicit drug in the 12 months previous to survey. By 2007 it was down to 13.4%, a 39% decrease overall.

Tough on Drugs, while hampered by the failed harm minimisation policies it was still carrying, provided better funding for rehabilitation centres, making the cessation of drug use more accessible. Other common sense strategies such as the media campaign emphasising parents talking to their children about drugs, contributed to this success.

While decriminalised Portugal was increasing its drug use by around 60% between 2001 and 2017, Australia very successfully achieved the opposite.

We know exactly what works.

Need to curb the 22% rise in drug use since Tough on Drugs

Since 2007 drug use has increased due to government inaction.

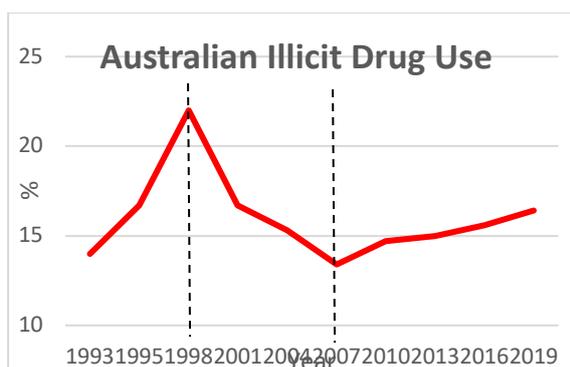


Table 5.3: Summary of recent^(a) illicit use of drugs, people aged 14 years or older, 1993 to 2013 (per cent)

Drug	1993	1995	1998	2001	2004	2007	2010	2013
Illicit drugs (excluding pharmaceuticals)								
Cannabis	12.7	13.1	17.9	12.9	11.3	9.1	10.3	10.2
Ecstasy ^(b)	1.2	0.9	2.4	2.9	3.4	3.5	3.0	2.5#
Meth/amphetamines ^(c)	2.0	2.1	3.7	3.4	3.2	2.3	2.1	2.1
Cocaine	0.5	1.0	1.4	1.3	1.0	1.6	2.1	2.1
Hallucinogens	1.3	1.9	3.0	1.1	0.7	0.6	1.4	1.3
Inhalants	0.6	0.4	0.9	0.4	0.4	0.4	0.6	0.8
Heroin	0.2	0.4	0.8	0.2	0.2	0.2	0.2	0.1#
Ketamine	n.a.	n.a.	n.a.	n.a.	0.3	0.2	0.2	0.3
GHB	n.a.	n.a.	n.a.	n.a.	0.1	0.1	0.1	*<0.1#
Synthetic Cannabinoids	n.a.	1.2						
New and Emerging Psychoactive Substances	n.a.	0.4						
Injected drugs	0.5	0.5	0.8	0.6	0.4	0.5	0.4	0.3#
Any illicit ^(d) excluding pharmaceuticals	13.7	14.2	19.0	14.2	12.6	10.9	12.0	12.0
Misuse of pharmaceuticals								
Pain-killers/analgesics ^(e)	1.7	3.4	5.2	3.1	3.1	2.5	3.0	3.3
Tranquillisers	0.9	0.7	3.0	1.1	1.0	1.4	1.5	1.6
Steroids ^(e)	0.3	0.2	0.2	0.2	—	—	0.1	*0.1
Methadone/Buprenorphine ^(e)	n.a.	n.a.	0.2	0.1	0.1	0.1	0.2	0.2
Other opiates/opioids ^(e)	n.a.	n.a.	n.a.	0.3	0.2	0.2	0.4	0.4
Misuse of any pharmaceutical ^(f)	n.a.	4.1	6.3	3.9	3.8	3.7	4.2	4.7#
Any illicit use of any drug^(g)	14.0	16.7	22.0	16.7	15.3	13.4	14.7	15.0

Table 4.6: Recent^(a) illicit use of drugs, people aged 14 and over, 2001 to 2019 (per cent)

Drug/behaviour	Proportion						
	2001	2004	2007	2010	2013	2016	2019
Illicit drugs (excluding pharmaceuticals)							
Marijuana/cannabis ^(b)	12.9	11.3	9.1	10.3	10.2	10.4	11.6#
Ecstasy ^(c)	2.9	3.4	3.5	3.0	2.5	2.2	3.0#
Meth/amphetamine ^(d)	3.4	3.2	2.3	2.1	2.1	1.4	1.3
Cocaine	1.3	1.0	1.6	2.1	2.1	2.5	4.2#
Hallucinogens	1.1	0.7	0.6	1.4	1.3	1.0	1.6#
Inhalants	0.4	0.4	0.4	0.6	0.8	1.0	1.4#
Heroin	0.2	0.2	0.2	0.2	0.1	0.2	*<0.1
Ketamine	n.a.	0.3	0.2	0.2	0.3	0.4	0.9#
GHB	n.a.	0.1	*0.1	0.1	*<0.1	*0.1	*0.1
Synthetic Cannabinoids	n.a.	n.a.	n.a.	n.a.	n.a.	1.2	0.3
New and Emerging Psychoactive Substances	n.a.	n.a.	n.a.	n.a.	0.4	0.3	*0.1#
Injected drugs	0.6	0.4	0.5	0.4	0.3	0.3	0.3
Any illicit ^(e) excluding pharmaceuticals	14.2	12.6	10.8	12.0	12.0	12.6	14.1#
Non-medical use of pharmaceuticals							
Pain-killers/pain-relievers and opioids ^(d,f)	n.a.	n.a.	n.a.	n.a.	n.a.	3.6	2.7#
Tranquillisers/sleeping pills ^(d)	1.1	1.0	1.4	1.5	1.6	1.6	1.8
Steroids ^(d)	0.2	*<0.1	*0.1	0.1	*0.1	*0.1	0.2
Methadone or Buprenorphine ^(d,g)	0.1	*<0.1	*<0.1	0.2	0.2	0.1	0.1
Non-medical use of pharmaceuticals ^(f,h)	n.a.	n.a.	n.a.	n.a.	n.a.	4.8	4.2#
Illicit use of any drug							
Any opioid ⁽ⁱ⁾	n.a.	n.a.	n.a.	n.a.	n.a.	3.7	2.8#
Any illicit^(j)	16.7	15.3	13.4	14.7	15.0	15.6	16.4

Years	Drug Policy
1985 - 1998	Harm Reduction
1998 - 2007	Harm Reduction with more robust

	prevention and rehab
2008 - 2019	Harm Reduction

Between 1985 and 1998 Australia's harm reduction policies saw ever-increasing drug use until Australia became the most drug-abusing country in the OECD. Under Tough on Drugs, with a better focus on prevention and despite Harm Minimisation policies running interference, drug use decreased. Since that prevention emphasis was discontinued by the Federal Government, drug use is again increasing.

Drug use is going up when it can be going down. There is no excuse in this nation for increasing drug use.



APPENDICES

Appendix A	Cochrane Collaboration review of methadone
Appendix B	US IOM review of NSP
Appendix C	DFA letter to Lancet published January 2012
Appendix D	Letter to Lancet by Police Commander John McKay
Appendix E	Roxburgh study on 392 ecstasy-related deaths in Australia