Submission No. 33
AUTHORISED: 28/03/07

25/02/07.

Family and Human services Committee,
House of Representatives,
Parliament of Australia,
Canberra,
ACT., 2600.

Dear Sirs,

Re: **Submission to**
Family and Human Services
House of Representatives Standing Committee on
Limitations of the Harm Minimization
Based Drug Strategy

Thankyou for undertaking your important parliamentary enquiry into the impact of illicit drugs in Australia. My experience is based on 9 years intensive involvement in the treatment of the addiction as the delegate of the Preventative and Community Medicine Committee of the Queensland Division of the Royal Australian College of General Practitioners, responsible for 8,000 of the registered 11,000 opiate detoxifications in the whole state of Queensland to May 2006 (Queensland Health data), the holder of one of the best safety records internationally with only 2 hospital admissions in 1,800 rapid opiate detoxifications, an attendee of 16 international conferences in addition medicine and science, a publisher and researcher in addiction medicine in recent years, an NHMRC grant applicant along with one of Australia's top cancer scientists, and now a senior adjunct clinical member of the University of Queensland (elect).

My response is structured under the three headings you have suggested your terms of reference.

1. The financial, social and personal cost to families who have a member(s) using illicit drugs, including the impact of drug induced psychoses or other mental disorders;
2. the impact of harm minimisation programs on families; and
3. ways to strengthen families who are coping with a member(s) using illicit drugs.

These comments are made in the context of Australia presently spending at least $500 million annually on harm minimization techniques (needles, methadone and addiction – ATODS - personnel salaries). **I agree with the committee that this needs urgent review** particularly in the context where Hepatitis C is out of control in this group and new HIV infections are starting to rise significantly obviously due to community fatigue with the harm minimization paradigm – the community are bored with the message.

I also agree with the committee that there is much which can be done to repair the damage and neglect which has occurred under the overly simplistic harm minimization paradigm.

It is frequently said by the leaders of the harm minimization (HM) movement that they take direct credit for the low HIV infection rate in Australia. This may be true. However the paradigm over which they presided has obviously fostered a trivialized view of illicit drug taking to the point where it is widely considered a trivial activity by far too many of our young people. One takes particular exception to this thinking, which has now reached almost the status of a world view when its same leading advocates are also the loudest voices for drug liberalization under any and every rubric, and then openly describe their harm minimization, foisted on the community ostensibly as an HIV protection strategy, as nothing more than a veneer for the open drug society[1].

> *"In many countries it is time to move from the first phase of harm reduction – focusing on reducing the adverse consequences – to a second phase which concentrates on reforming an ineffective and harm generating system of global drug prohibition."*[1]

Hence as HIV rising, and Hepatitis C at a persistently very high level with evidence of rapid infections of new users recruited, HM forms a grossly inadequate paradigm from within which to begin to address our new challenges. Indeed by continuing to foster its false trivial and overtly stated deceptive agenda, it has the potential to do great community harm to this nation.

Please find enclosed a concise submission from myself upon which I would be happy to enlarge at your request. I should be happy to discuss these further with you in direct evidence to the committee.

Yours sincerely,

Stuart Reece.

HARM MINIMIZATION COMMENTARY

1. **The financial, social and personal cost to families who have a member(s) using illicit drugs, including the impact of drug induced psychoses or other mental disorders.**

The harms attributable to illicit drugs may be considered under the following headings.

A) Deaths
B) Disease
C) Blood borne virus including HIV and Hepatitis C transmission
D) Drug-Related Crime
E) Family disruption – family of origin and family formation
F) Intergenerational transmission of drug taking behaviour
G) Intergenerational transmission of drug related morbidity including cancer and fetal malformations
H) Aggressive behaviours
I) Prostitution Related behaviours, crimes and risks of violence
J) Failure of achievement of major life goals
K) Long term welfare dependence
L) Maintenance of addiction, even across a major heroin drought
M) Long term mental conditions
N) Short term violent mental states including those difficult to contain
O) Lack of quality mental health services
P) Lack of quality medical protocols to treat stimulant offenders
Q) Lack of any basic sciences research and expertise within Australia on addictive drugs
R) Drug dealing in schools
S) Methadone Increases Addiction

2. **The impact of harm minimisation programs on families.**

See above.

A) Minimization of drug related harms
B) Inadequacy of drug prevention education in Australia
C) Lack of scientific veracity and contradiction of Australian drug education programs with those from overseas, particularly the leaders of scientific medicine in the USA

3. **Ways to strengthen families who are coping with a member(s) using illicit drugs.**

A) Appropriate Australian Research in Addiction in the basic sciences
B) Scientifically correct anti-drug education of our children and our community
C) Naltrexone implant demonstration studies in each capital city

D) Proper protocols for stimulant abuse treatments
E) Rimonabant Demonstration programs in selected clinics
F) Proper access to dental care
G) Improved access to mental health care for such patients particularly in emergent situations.

ABS DEATH AND YEARS OF LIFE LOST DATA

Detailed ABS death statistics have been obtained for the period 1997-2004 (see attached Tables). (Note that the data for 2005 is not due to be released until 15/03/07.) On such a list drugs are responsible for 10,987 (1.9%) of a total of 528,721 deaths, in 8th place behind other well known causes such as stroke, heart attack suicide and lung, bowel and breast cancers. It is interesting to note that HIV/AIDS claimed only 1293 lives in this time, despite the enormous publicity and funding devoted to it (Table 1A). Similarly, despite the rhetoric of the ATODS industry which we have heard for years now, alcohol was directly responsible for only 1939 deaths, or 19.5% of those ascribed to drugs.

Drugs however are responsible for 408,051 (5.0%) of 8,297,522 years of potential life lost (YPLL's) during that same period which is fifth most common and follows only suicide, car crash, heart attack and lung cancer (Table 1B).

A very interesting index is the number of years of potential life lost per death, which may be estimated by dividing the YPLL's by the number of deaths in that category. Methadone top scored at 46.3 years of life lost per death, followed by car wreck at 41.9 years and drugs at 41.2 years (Table 1C). This shows that drug related deaths score first and third in the official ABS collated statistics for 1997-2004; and indeed that methadone related deaths scored first out of all these major causes! One would suggest that this alone is reason for re-think of the Methadone Maintenance Program.

When judged by individual cause of death drugs are responsible for 41.2 years of life lost per death which is only second behind motor vehicle accident (41.9 years), explaining the unusual community distress and tragedy associated with overdose deaths. Of the drugs responsible opiates are the commonest accounting for 5799 (52.8%) deaths and 238,745 (58.5%) YPLL's.

The years of life lost due to methadone is worth considering. Table 1A ascribes only 78 deaths to methadone during this period. This figure should be clarified in that this only relates to those deaths in which methadone was the only drug involved. The full figure is 851 as shown in Table 1D. The 3613 YPLL's of Table 1B divided by the 78 deaths listed in Table 1A yields a mean number of years of life lost per methadone death of 46.3. when this is multiplied by the total number of methadone deaths including poly-drug deaths namely 851, the total number of years of life lost in which methadone was involved may be estimated at about 39,419 as indicated in Table 1E, or a whopping 9.6% of the total YPLLS lost from all causes in Australia!!! That is not bad for a problem which itself causes 1.9% of our deaths!

The massively subsidized methadone industry has never given a genuine account for this. Nor indeed are methadone prescribers for the most part held to rigorous accountability, in the same way as say, naltrexone prescribers have been inquisitioned in every state of Australia.

DISEASE BURDEN AND EXTENT OF THE PROBLEM

TABLE 1.: ABS DEATH AND YPLL DATA 1997-2004

TABLE 1A.: Deaths by Cause

Rank	Cause	No.	%
1	AMI	49671	9.4%
2	Lung Cancer	42189	8.0%
3	CVA	30021	5.7%
4	Colon Cancer	24752	4.7%
5	Suicide	16459	3.1%
6	Breast Cancer	15777	3.0%
7	MVA	14534	2.7%
8	**Drugs**	**9912**	**1.9%**
9	Alcohol	1939	0.4%
10	HIV	1293	0.2%
11	Methadone	78	0.0%
	All Causes	528721	

TABLE 1B.: YPLL-75 by Cause

Rank	Cause	No.	%
1	Suicide	630737	7.6%
2	MVA	608904	7.3%
3	AMI	509769	6.1%
4	Lung Cancer	503475	6.1%
5	**Drugs**	**408051**	**4.9%**
6	Colon Cancer	322263	3.9%
7	Breast Cancer	296617	3.6%
8	CVA	293355	3.5%
9	Alcohol	45886	0.6%
10	HIV	45170	0.5%
11	Methadone	3613	0.0%
	All Causes	8297522	

TABLE 1C.: Mean YPLL by Cause

Rank	Cause	No.	Relative Rate
1	Methadone	46.0	2.9
2	MVA	41.9	2.7
3	**Drugs**	**41.2**	**2.6**
4	Suicide	38.3	2.4
5	HIV	34.4	2.2
6	Alcohol	23.7	1.5
7	Breast Cancer	18.8	1.2
8	Colon Cancer	13.0	0.8
9	Lung Cancer	11.9	0.8
10	AMI	10.2	0.7
11	CVA	9.8	0.6
	All Causes	15.7	

These tables show that of 11 common causes of death, Drugs was ranked 8th. When judged by Years of Potential Life Lost (YPLL), Drugs was ranked 5th. When judged by the YPLL per Death, Drugs ranked 3rd behind methadone

(Note that these calculations assume a uniform 408051/9912 = 41.17 YPLL's per drug death).
(Note also that methadone deaths count only those cases where this was the only drug involved.)
Of the different drugs, by far the most serious was opiates, which ranked 1st both by numbers of deaths, and by YPLL's.
Opiate abuse forms the focus of the present study.

TABLE 1D.: Drug Related Deaths by Drug Type

Rank	Drug	No.	%
1	**Opiates**	**5799**	**52.8%**
2	Benzo's	2555	23.3%
3	Alcohol	1689	15.4%
4	Antidepressants	1639	14.9%
5	Heroin	1487	13.5%
6	Methadone	851	7.7%
7	ATS	636	5.8%
8	Paracetamol	620	5.6%
9	Other Narcotics	292	2.7%
10	Cannabis	230	2.1%
11	Cocaine	168	1.5%
	All Drug Deaths	10987	

TABLE 1E.: Drug Related YPLL by Drug Type

Rank	Drug	No.	%
1	**Opiates**	**238745**	**58.5%**
2	Benzo's	105189	25.8%
3	Antidepressants	67478	16.5%
4	Heroin	61220	15.0%
5	Alcohol	40029	9.8%
6	Methadone	39419	9.6%
7	ATS	26184	6.4%
8	Paracetamol	25525	6.3%
9	Other Narcotics	12022	2.9%
10	Cannabis	9469	2.3%
11	Cocaine	6917	1.7%
	All Drug YPLL's	408051	

1. **<u>The financial, social and personal cost to families who have a member(s) using illicit drugs, including the impact of drug induced psychoses or other mental disorders.</u>**

The harms attributable to illicit drugs may be considered under the following headings.

A) Deaths

Addressed by above remarks.

B) Disease

Drug related diseases are many. The impact of drugs on disease is not only greater than usually supposed, but also more severe. Several analyses now have demonstrated consistent findings that the addicted consume disproportionately far more medical and psychological health services than controls of the same age. Whilst Hepatitis B&C and HIV/AIDS are well known, so too is a list of disorders such as the following[2]. It is actually taken from a paper on older people's diseases; it turns out that virtually all have also been described in addiction also.

Table 2. Common Pathologic Features of Aging in Mice (after Bronson and Lipman [1991]; Cao et al. [2003a])

Hyperplasia/Neoplasia
Adrenal hyperplasia
Angiosarcoma
Harderian gland adenoma
Endometrial hyperplasia
Lung adenoma
Lymphoma
Mammary gland adenocarcinoma
Mast cell tumor
Ovarian cystadenoma
Paraovarian cyst
Pituitary adenoma
Sarcoma
Thyroid follicular cell hyperplasia
Uterine leiomyoma/leiomyosarcoma
Leukocytic Infiltrates
Kidney
Liver
Lung
Mesentery/omentum
Perineurium
Salivary gland
Genitourinary system
Hydronephrosis
Ovarian/testicular atrophy
Seminal vesicle dilation
Renal tubular dilation
Bone
Decreased cancellous bone
Degenerative joint disease
Molar teeth periodontitis
Proliferations in the head/spine
Neurological
Hydrocephalus
Neuronal lipofuscinosis
Radiculopathy
White matter gliosis
Other
Amyloidosis
Fatty change of the liver
Focal myocardial degeneration
Hepatocyte polyploidization
Thymic involution

It is also important to appreciate that many of these same disorders occur in addicts they are much more severe than are seen in non-addicts. Hence I have had three patients whose eyeball was completely replaced by fungus (Candidal endophthalmitis), many with heart valve infections requiring open heart surgery (which is of course very rare in patients in the 20-40 years age group), and one who had so many brain abscesses that I was advised that "his brain had been largely replaced by abscesses, he was fitting severely, and we could not control this; that is why he died.")

It has also been overlooked that addiction itself suppresses the immune system, thereby making patients more susceptible to infectious conditions such as those mentioned above. This has not been factored in to the HM thinking.

The gateway activity of cannabis has now been proven several scientific analyses. This has also been overlooked by ardent HM lobbies.

It is also established that all addictive drugs impede brain growth and development. Furthermore important stages of brain development occur in the teenage and early years up to about 26 years of age. Hence it must be predicted that such addictions or even supposedly "recreational" drug use – from which habitual use typically stems – MUST impede brain growth and development, probably in a permanent manner.

Indeed heath science leaders at Johns Hopkins Medical School in Baltimore accept that addictive agents are causally related to the onset of mental illness, an obvious connection which is still allegedly (according to our "experts") in dispute in this country.

C) Blood borne virus including HIV and Hepatitis C transmission

This is well known.

It is also well known that Australia leads the world in harm minimization in many respects; and has a very high rate of Hepatitis C and B amongst its drug users. One could even argue that the relatively trivial way in which drug use has been portrayed in the public health harm minimization paradigm has actually been a major cause of this calamity.

I would further note that with time, many of my Hepatitis C patients are becoming increasingly unstable and are beginning to decompensate in important ways including cirrhosis. Hence Australia's encounter with Hepatitis is only just beginning.

Australia's rate of new HIV infections has been rising since its nadir in 1994. It is now double this level, and as reports come in from all over the

country of new infections, this rate of increase seems inevitably set to rise quickly in the coming years.

D) Drug-Related Crime

It is well established by may surveys with which the FHS committee would be well aware that 70% of all property crime in this country is drug related.

E) Family disruption – family of origin and family formation

This is legendary and typically severe. It applies both to the family of origin from which they come, and any subsequent families that such patients try to establish.

F) Intergenerational transmission of drug taking behaviour

I have treated several patients who were introduced to drug at 1, 2 or six years of age by addicted and dealing families as strategies to control normal child behaviour.

G) Intergenerational transmission of drug related morbidity including cancer and fetal malformations

Evidence has been published of more than 1,000% elevation of the risk of leukaemia in the off-spring of cannabis smoking mothers.[3] This is related to extensive chromosomal damage which has also been identified in such patients.

H) Aggressive behaviours

This is now being reported increasingly from many sites in the community such as hospital admissions departments, doctors' surgeries, shopping malls etc. Its presence is underscored by large posters in hospital admissions areas declaring

> *"Violence will not be tolerated in this place. Victims will be supported in the referral of the matter to the police."*[a]

I) Prostitution Related behaviours, crimes and risks of violence

Prostitution and the sex industry generally is well acknowledged to be a major route by which drug habits are funded. The association of child abuse, violence and disease transmission with this trade has also been documented since classical times. Most of the addicted sex workers I meet admit that they would not work if their addiction could be successfully addressed. Since established prostitution is notoriously difficult to dislodge, an obvious course of action is to target effective treatments at such populations to free them from the necessity of such high gain employment. After all it is all about money.

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[a] Princess Alexandra Hospital Accident and Emergency Casualty Department

J) Failure of achievement of major life goals

The proponents of the harm minimization paradigm seem to think that it is a relatively trivial concern if teenagers and people in their twenties and thirties "get wasted" thereby "wasting a few years." Since these are the key formative years of their lives when normal life tasks such as gaining a training and or qualification, forming a stable life partnership occur, then clearly such activities will not occur in the normal way.

K) Long term welfare dependence

It would seem obvious that if patients have a malformed brain, have a mental condition, have unstable personal relationships or families of origin which cannot cope with their behaviours, have a poor employment record and no training behind them then they are likely to be long term social security dependents, as are their children. To this of course must be added the nutritional effects of nutritional deprivation from such families, and the effects of drug exposure too their offspring in utero, and even to the poisoning effects of the addictive drugs on the egg and sperm prior to fertilization.

Indeed the Barker hypothesis suggests that the changes of ageing, which seem to be accelerated in drug addicts, begin in utero and prior to conception when egg or sperm are damaged. It is therefore highly likely that ageing an degenerative changes begin in such offspring prior even to fertilization. Clearly this area merits further study.

L) Maintenance of addiction, even across a major heroin drought

The HM paradigm is obviously related to long term drug addiction. Their flagship is the methadone **MAINTENANCE** treatment (MMT) program, but includes also some of the strongest advocacy in the world for amphetamine maintenance programs (on some of the weakest evidence available). The advent of the Australian heroin drought is well known within this country. What is less well appreciated is that this was the only nation where this occurred. Of course there was no suggestion that the number of national methadone program registrants (about 32,000) declined during this time. The MMT has the ability therefore to a large extent to negate the effect of such a drought!

Clearly this can be extrapolated to other substances as their own spokesmen propose. Similar comments might therefore apply to cannabis and amphetamine programs.

M) Long term mental conditions

In addition to the impacts mentioned above on addiction impacting and degrading the normal processes of brain development, these drugs impair vitally important normal patterns of brain cell regeneration which are

required for normal processes of memory and emotional stability. Furthermore they cause cell death. This particularly applies to the stimulants, and to combinations of stimulants and cannabis which have a superadditive effect. Opiates added to this cocktail further exacerbate this cell death effect.

N) Short term violent mental states including those difficult to contain

There are myriad accounts in the community of erratic, violent aggressive and dangerous behaviour by patients either under the influence of addictive drugs, or in an acute withdrawal phase, as I am sure the committee will learn. We have of course had numerous such encounters here, many of them dangerous and personally threatening. The Committee will also be aware that doctors have been killed in such encounters such as the well publicized case of Dr. Khulod Maarouf-Hassan in Melbourne.

O) Lack of quality mental health services

It is axiomatic in clinical practice that if patients are having acute difficulty with drug induced states they receive at best summary, perfunctory and terse treatment in hospital casualty departments. The difficulties of families with such children are magnified enormously by this lack of specialist mental health support. The expenditure by the Prime Minister of $3billion on mental health under the "Beyond Blue" program has not impacted this appalling situation to any measurable extent.

P) Lack of quality medical protocols to treat stimulant offenders

It is deplorable, and a desperately sad commentary on the appalling lack of quality control within Australian medicine that radical calls for chronic stimulant prescription to stimulant abusers has gone forth from some of the highest authorities of addiction medicine in the land, at a time when leading figures in the USA have concluded that such agents are definitely neurotoxic and directly responsible for the epidemic of mental illness and criminality including reduced public safety increasingly experienced in so many of the communities which are the true casualties of this wayward misguided, and misinformed ideology.

It should be emphasized that such teachings are not only not evidence based, they run directly contrary to the dominant expert medical opinion in addiction research neuroscience – of which there is none in this country.

Q) Lack of any basic sciences research and expertise within Australia on addictive drugs

Of course it is a national disgrace that there are no basic researchers I the addiction sciences in this country.

It is my observation after many years of traveling the globe in a the course of professional education and scientific enquiry, and the abiding

impression of many leading scientists around the world, that the pattern globally is that the area of addiction toxicology is being systematically avoided, apparently for ideological reasons.

Many new biological systems are being described, both in the brain, and in other body systems. The pattern is that these affects are not being investigated systematically using the tools of modern science, even where good basic sciences reasons exist as to why this should be done.

My own estimate is that $50million over three years would go significantly far along the road to redress this imbalance. This is one of the major recommendations of the present response to the committee.

R) Drug dealing in schools

It is a matter of recent history, and was recently documented on Channel 7's today tonight" (6.30pm 26/02/07) that there is substantial drug dealing occurring in schools. This is a national outrage of the first order which cries out to be corrected.

However it is my suggestion that this will not occur while the dominant paradigm is allowed to remain that drug use, whilst sometimes of social nuisance value, is essentially harmless from a medical point of view. Of course the toxicity of these agents in the developing and immature human organism is magnified as described above.

S) Methadone Increases Addiction

It is no secret that most patients continue to use heroin even on methadone programs. Usual figures quoted are a reduction from 26 times monthly to 4-5 times. However if the total duration of the addictive habit is extended by five times, then any gain in terms of supposed reduction in injection frequency is clearly lost.

Methadone typically intensifies addiction by leaving opiate receptors permanently coated with opiates.

Methadone patients frequently experience secondary side effects particularly anxiety, so that many series report 50-70% incidence rates of also putting these patients on strong benzodiazepines particularly alprazolam. This is in its turn a strong drug and frequently associated with fatal overdose.

The exacerbation of addiction by such programs clearly needs to be factored in to any rational evaluation of them.

Moreover many series on methadone patients describe its legion of side effects which it inflicts on patients. The Committee is referred to standard texts and descriptions of this subject.

Contrariwise as noted below, naltrexone reverses all such effects non-specifically, and have a uniform anti-addiction effects extending beyond its purely opiate related effects.

2. <u>The impact of harm minimisation programs on families.</u>

See above.

A) Minimization of drug related harms
B) Inadequacy of drug prevention education in Australia
C) Lack of scientific veracity and contradiction of Australian drug education programs with those from overseas, particularly the leaders of scientific medicine in the USA

3. <u>Ways to strengthen families who are coping with a member(s) using illicit drugs.</u>

A) Appropriate Australian Research in Addiction in the basic sciences

As has been underscored numerous times in the preceding comments it is the lack of genuine "hard biological sciences" research in the toxicology of addiction which has allowed the present absurd "fairyland" like situation to develop in this country under the careful non-dissemination of the truth of the toxicity of these agents under a skillful negative kind of propaganda by our national professional leaders of the ATODS industry.

The decrepit and disheveled state of many drug affected persons is well known both the community and the Committee. It is established in addiction science that all addictive drugs impair cell growth and division. They also accelerate cell death processes, either when used singly, or in the common combinations in which they are used by patients. These changes, combined with the DNA toxicity which has been previously demonstrated for cannabis and tobacco, are the cellular and molecular underpinnings of ageing at the cellular level. These findings suggest that the poor appearance of addicted persons, together with many well known features of their pathology including poor teeth, high rate of infections, high rate of tumours and very high death rate, actually reflect an accelerated pattern of ageing at the level of the whole organism.

Similarly if these changes could be better understood, it is well possible that significant gains could be made in other related health areas. If addiction accelerates ageing, then it stands to reason that the addiction blocking agents may well slow this change down. Clearly this needs to be

quantified by further research. Similarly if addiction accelerates the development of hardening of the arteries and of cancer, then understanding such molecular pathways may well teach us valuable lessons about the causation of these diseases, including the yielding of important new molecular targets for major drug therapies.

Clearly this era needs more research. The toxicology of addiction is being neglected globally., It therefore follows that the nation which is best able to study these issues in a coordinated and collaborative fashion will lead the world in addiction science in these areas. Our estimates in Brisbane suggest that around $50million could be usefully invested by Federal Government in elucidating and further investigating these issues.

B) Scientifically correct anti-drug education of our children and our community

Of course for the truth to have any impact it must be resourced. Good educational programs in addiction studies exist in several nations and include web based computer interactive learning, cartoon like adventures of the chemical factories inside patients' brains, and the inclusion of addiction in all other school subjects which have been used successfully in the USA, Sweden and New Zealand. This is in addiction to fact packed Government web sites.

Of course there is little such material available in this country, particularly on official websites. Good sites do exist in this country (Drug Arm, Drug Awareness Council of Australia) but they only show up the gross inadequacy of the publicly funded sites which of course should be the standard bearers in this battle for truth. And official Australian sites are also grossly inadequate in comparison with their counterparts overseas.

C) Naltrexone implant demonstration studies in each capital city

The committee is well appraised that the best naltrexone implant in the world has been developed by Dr. George O'Neil in Perth. It is the best because it lasts the longest, somewhere around 5-6 months. The Government is also well aware that a trial is presently being conducted in Perth in the safety and efficacy of this device.

The Government is also aware that it usually takes in the vicinity of $1Billion to bring a drug to market, which clearly does not exist either in the Perth clinic, or within its access in terms of the resources of the West Australian Government.

This is having the effect of creating an impossibly long delay. Two years ago O'Neil advised me that we were still two years from deployment of the implant. Questioned today, he still gives the same reply.

The outcomes of this trial are already very obvious. They will be brilliant, and in addiction medicine, as radically superb as the HPV vaccine has proven in infectious disease control in that discipline.

Therefore the problem is not one of evidence or safety assurances – those determinations have already been made by the many reputable and highly skilled clinicians who have used the devices, invariably with superb results. The only shortcoming they have at present is that they sometimes need to be supplemented with further implants, when the control afforded by the first set expires. In the present situation where they are not readily available, this creates logistical problems which in practice are frequently severe.

This situation might readily be addressed by Government by equipping up-skilling and evaluating those programs which, in its six year history, have already shown promise. This way the public can be treated, further experimental and clinical data can be obtained, and the demands both of research and treatment can be constructively satisfied.

Furthermore statistically powerful evidence exists ion the Perth clinic that naltrexone implants also extinguish the use of all addictive drugs. Hence there will likely be a role for this device in the treatment of other addictions also.

Such programs need to be supported by pre- and post- treatment facilities such as addiction medical wards where patients are cared for at the appropriate stage of treatment. Families also need support. The implants of course need to be supplied and funded, as do the drugs which are usually administered in combination with it, in a manner analogous to the way in which methadone treatment is presently underwritten by state and federal governments. The treatment should also attract an appropriate Medicare item number. Providers of course will require special training and accreditation to prevent the unbridled pecuniary interests from discrediting the therapy as is well known to have occurred with the oral formulation of naltrexone. It must also be accompanied by post-treatment counselling, and housing where this is appropriate. The fiasco where patients emerge from detox, and have nowhere to go but their dealers house must be addressed, either by government of community agencies.

D) Rimonabant Demonstration programs in selected clinics

Rimonabant (Sanofi-Synthelabo "Accomplia") is a new CB1 cannabinoid blocker which has shown great promise in the treatment of virtually every chemical addiction including tobacco, alcohol, amphetamine, cocaine and opiate addition, and also for food addiction and hypertension. It is presently available in eight nations in the world, and is likely to be entering the Australian market in 2008.

Clearly there is a need to its assessment in the Australian context, particularly in parallel with naltrexone implants for refractory cases where the problematic secondary addiction is either not opiates, or is poly-drug related in addiction to opiates.

E) Proper protocols for stimulant abuse treatments

The outrageous situation where stimulants are recommended for stimulant abuse needs to be formally redressed, if not by experts inside Australia, then by offshore expertise.

The preposterous situation where the Australian people continue to be held captive the ideological preferences of an all powerful few, who remain thoroughly illiterate in the basic biological sciences, needs to be ended summarily, and be seen to be so ended.

F) Improved mental health facilities for acutely and chronically intoxicated patients.

There is a very obvious need for the up-grading of mental health facilities to cope with eh unpleasant emergencies of intoxicated and threatening patients.

Such programs need to accompany appropriate public educational roll-outs.

Yours sincerely,

Stuart Reece.

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[1] Wodak A. "The Past present and future of harm reduction. Decades of Misunderstanding." www.adrlf.org.au/documents/harmreduction1.htm 20/04/05.
[2] Lombard DB "DNA Repair, Genome Stability, and Aging" (2005) Cell 120(4) 497-512; Table 2 P500.
[3] Robison L.L. "Maternal Drug Use and Risk of Childhood Nonlymphoblastic Leukaemia Among Offspring." Cancer (1989) 63: 1904-11.