The Methadone Treatment

Photo: Newspix

Jude Byrne is 44, has three children, a husband and a self-described "happy and successful life". She has been part of the injecting drug use community for 25 years, and on methadone for the last 11.

Annie Madden is an ex-injecting drug user. She is also on methadone and has been for the last eight years.

Jude Byrne and Annie Madden are Education Program Manager and Executive Officer, respectively, of the Australian Intravenous League (AIVL), the national drug users organisation. They spoke to the House of Representatives Family and Community Affairs Committee in Canberra recently as part of the inquiry into the social and economic cost of substance abuse.

"I feel very strongly that without methadone it is very likely that I would not be sitting before you here today," Annie Madden told the inquiry.

"I think it is important for you to have the chance to speak to people who have directly experienced methadone, and for me to speak about how that has improved my life and the lives of a lot of other people."

Annie Madden and Jude Byrne are clearly frustrated by those who judge 'success' in drug treatment only to be reaching the end of a continuum from heroin to methadone and off drugs altogether.

"I, clearly, and Jude as well, are examples of people who are continuing on the methadone program but for all intents and purposes are success stories for that program," Annie Madden said.

"We work full-time. We have families. We are not using. I stay on methadone because it provides me with the stability to keep that lifestyle there. I would rather stay on methadone for the rest of my life than risk going back to a problematic lifestyle just because I felt the pressure to come off methadone. I think there are a lot of people in that situation."

They also reject suggestions that methadone is an 'easy' option, especially as Australia's programs are currently administered. Methadone is prescribed by a doctor and dispensed under strict controls by pharmacists, often involving testing.

"The methadone program is a very invasive and difficult program, but it is a choice you make on quality of life," said Jude Byrne.

"If I have to turn up to the chemist every day, wait for 20 minutes while they serve everybody else and do a urinal in front of somebody I do not know, I will do it.

"But it is not something that you do easily, and it is not something that you do without thinking very hard about it. I am 44 years old; I am quite in control of my life.

"They could give me 'takeaways' and free up my spot for somebody else who would actually benefit from it. I do not need that sort of treatment. I think there is lots of room for improvement in our methadone program."

Professor Ann Marie Roche, of Flinders University's National Centre for Education and Training on Addiction, describes the apparent competition and conflict between abstinence approaches and harm minimisation approaches as the "fundamental dilemma" in dealing with the nation's drug problem.

She likes to think in terms of "hierarchies of harm".

"It is sometimes a helpful way to look at complex problems like this in the community," Professor Roche told the inquiry. "We know that we have had this escalating level of overdose death rates from heroin – heroin in conjunction, usually, with another central nervous system depressant, often alcohol, sometimes benzodiazepines, that sort of thing.

"Keeping people alive is extraordinarily important: we know that if we can get people into treatment we can reduce the death rate phenomenally. The death rate absolutely plummets. That usually means getting people onto a methadone program if they are heroin dependent: getting people into treatment and keeping them alive, keeping them out of jail and keeping their social life intact, keeping them functioning in the community as healthy individuals.

"We have close to 40 years of excellent research around the efficacy of methadone for managing heroin dependence. The research is actually stunningly good – and you cannot say this across this field, in particular. But around methadone you actually can say that unequivocally. The gold standard for best practice for heroin dependence is methadone. It is not the only option that is available but it is the biggest and best arrow in our bow. It is extremely successful.

"Having said that about methadone is not to say it does not have some limitations – because it clearly does. I will give you a very good example of this. I recently moved to South Australia from Brisbane. The Lord Mayor in Brisbane, as many of the lord mayors around Australia, has been holding public debates. We had one about 12 to 18 months ago. I was on the panel with the Lord Mayor, and I got booed and hissed vigorously about the methadone issue.

"The reason I remember it so vividly was that there were two groups. On the one hand, there was a group in the audience who were anti-methadone who were heroin users who did not want methadone because methadone

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is essentially not a very interesting drug. It is a dull drug. They wanted heroin. They did not want this not-so-interesting substitute.

"The other group was abstinence-oriented. They did not want to have people on methadone at all because it was simply drug substitution.

"You have this enormous ferment of activity and opposition around methadone. In the field, where we struggle to help people maintain their health, maintain their well-being, maintain their contribution to society, reduce their criminality, we have a very good aid at the moment and that is methadone. But it receives an enormous amount of bad press."

The AIVL say that while relatively large amounts of funding have been poured into the drug treatment area in the last few years, it is not making it to the types of treatments that are in demand.

"Too often the money is going to 12-step abstinence-based programs which, although they have their place, are not where the treatment demand lies – that is, methadone programs," said Annie Madden.

While obviously the organisation is a big fan of the methadone program, the AIVL also favours trials of other treatments.

"Methadone and other drug treatments do not work for lots of users," said Jude Byrne. "We have had lots of people up here today, but nobody understands addiction and nobody understands why some people become problematic users, which some of them do. Why then do we just let them lead these terrible chaotic lives when we know that, if we gave them heroin in a controlled setting, in many ways they could take their lives back?

"This is about human beings; if we know something is going to work, why don't we do it? It clearly does work for so many people. It just seems to be something that people cannot get their heads around because of the emotion and the illicit nature of the drug. But absolutely I think heroin trials should be tried."

It is a position also favoured by the Australian Medical Association (AMA). Dr Bill Pring, the Chair of the AMA's public health committee, told the inquiry "we are in favour of trials of a number of different drug control strategies and that is one where we would be quite happy to see a proper evaluative trial occur. We are in favour of scientific trials of such things in the first instance".

Dr Pring is also wary of the polarised debate surrounding the heroin trial.

"Is it use-minimisation or harm-minimisation? People seem to polarise whereas truly evidence-based strategies often cross those things. No-one is saying that one does not want to try to achieve decreased usage but we have also got to try to decrease the harm associated with drug use."

Australian National Council on Drugs member and Westmead Hospital Professor, Ian Webster, also favours a heroin trial, but put his view in stronger terms.

"It is an obscenity that there are reporters camped outside an injecting centre in Sydney wanting to take photographs of people. Why don't they camp outside the Accident and Emergency department of Liverpool Hospital and take photographs of people there," he told the inquiry.

While current affairs programs such as 60 Minutes keep the focus of the 'drug debate' on illicit drugs

Alcohol and Tobacco are still the big killers

The Australian Medical Association (AMA) has warned the inquiry that although illicit drug use is an important and growing problem, the two biggest killers – and the cause of the bulk of the estimated $19 billion cost to the community each year of substance abuse – remain tobacco and alcohol. The AMA pointed out that:

- around 23,000 people die each year from drug abuse problems in Australia;
- tobacco use is the major cause of drug-related death in Australia. It was associated with more than 80% of all drug-related deaths and almost 60% of all drug-related hospitalisations in 1998; in contrast, illicit drug use accounted for 4% of drug-related deaths and hospitalisations in 1997; and
- in 1996, 26% of all fatal road accidents involved drivers with a blood alcohol level of 0.05 or higher; the 1998 National Drug Strategy Household Survey showed there were more than one million victims of alcohol-related property damage and 900,000 victims of alcohol-related physical assault.

Australian National Council on Drugs member Professor Ian Webster said: "Alcohol problems are ubiquitous – 25 per cent of admissions to public hospitals are probably alcohol-related. If you go to the emergency department, you will see that. If you go to the intensive care unit, you will see that. If you go to the coronary care unit, you will see some of the effects of alcohol on coronary heart disease, although perhaps not as much. If you look at the major disease problems that doctors deal with, cancers of the throat and gut, you will see that alcohol is a major component of those. If you look at mental health problems you will see that. Many suicides take place after alcohol consumption. Alcohol is responsible for 50 per cent of drownings. Alcohol is a major contributor to many of our major health problems, and a major component of the work done in the health system."

The AMA pointed out that $4 billion was received in the 1997–98 financial year in alcohol and tobacco taxes but, of that, only $36 million was spent on drug treatment and rehabilitation programs – about 0.9 per cent.

"We have asked for a multi-party strategy on substance abuse control," the AMA's Bill Pring told the inquiry.

"There is not enough money being used to try to deal with a problem which has multi-billion dollar industries pushing the substances into people's mouths and arms and so forth. That is what we are facing ... drug control organisations are low-funded compared to industry which, in each case really, is worth billions of dollars and uses those billions of dollars to make sure that people want to keep consuming."

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