



thousands
of lives

Submission - part II

PARLIAMENTARY
JOINT COMMITTEE
ON
LAW ENFORCEMENT

**DRUG
FREE**
AUSTRALIA

In late 2000 excellent Federal policing
created the Australian heroin drought.

Overdose deaths plummeted from 1,116
in 1999 to an average 368 per year from
2001 - 2007.

Before Tough on Drugs was terminated in
2007 Federal Police were saving around
750 lives per year.

So through those years, Federal Police
literally saved
THOUSANDS OF LIVES



thousands
of lives

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Executive Summary

Drug Free Australia's submission is based on the following evidenced foundations:

- Drug prohibitions historically a great success
- Australia's Tough on Drugs was a great success
- Rejection of spurious arguments re Wars on Drugs
- Australians want less drugs, not more

Trends related to illicit drug markets

Cannabis use is increasing while the science on cannabis is demonstrating what decades of in vitro and animal studies had long indicated, that cannabis causes twice as many cancers as tobacco, is causal in a multitude of birth defects, prematurely ages users and increases psychoses risks. Cannabis, even medicinal use, is harming future generations and must be urgently rescheduled back to a prohibited drug.

Federal policing during the 1998-2007 Tough on Drugs era, saved literally thousands of lives from opiate overdose deaths. The same needs to be done with prescription opiates which are taking even more lives today.

Pressure to legalise ecstasy must be resisted, given it is responsible for almost every party pill death in Australia.

Nor is it time to liberalise any Australian drug policy given the continued rise in mental health issues amongst the population, particularly when drugs are causal.

Emerging trends and risks - new substances

Hemp CBD is the cannabinoid responsible for more cancers than any other cannabinoid, and is also causal in many birth defects, partly driving the autism epidemic.

There is also an extensive science indicating that CBD readily converts to THC, where it becomes a biological 'precursor' for the manufacture of Delta-8 and Delta-10 THC, which have similar psychotropic effects as more regulated THC medicinal products.

The TGA urgently needs to reschedule hemp CBD so it becomes a prohibited drug excepting for epilepsy-like childhood syndromes.

Involvement with harm reduction activities

The most authoritative scientific reviews of harm reduction interventions confirm that they consistently fail to demonstrate any effectiveness and are a waste of public money. This is true of the Cochrane Collaboration review for methadone maintenance, the US Institute of Medicine's review of needle and syringe programs, injecting rooms and pill testing.

A Legislative Inquiry into the failure of harm reduction must be urgently called and Australian attitudes to coerced rehabilitation extensively surveyed.

Other countries have proven track records of decreased drug use, alongside our former Tough on Drugs approach, and there are no mysteries as to what legislators need to do to save thousands of lives.

Weaknesses of decriminalisation

With San Francisco and Oregon the poster children for full decriminalisation, with residents rapidly exiting both, Portugal's failed drug policy will do the same in Australia.

Decriminalisation consistently increases illicit drug use, which also consistently increases the profits of criminal drug dealers. Decriminalisation only exacerbates societal and policing problems.

Foundational evidence driving DFA recommendations

Prohibiting drugs an unmitigated success

From the outset, Drug Free Australia will demonstrate with unassailable evidence that the pro-drug lobby, which has historically concealed but is now openly declaring their real agenda, relies on misinforming the public and its elected representatives concerning the success of drug prohibitions, which they have constantly recast as failure.

They have constantly called the international Drug Conventions which have been in place since 1912 'Prohibition' to align them with the failed prohibition of alcohol from 1919 through the 1930s. But as the results of a massive study below demonstrate, the international drug Conventions almost entirely eliminated the use of illicit drugs from 1912 through to the mid-1960s, a period of 50 years. Prohibiting use of illicit drugs was an unqualified success.

TABLE 2—Percentages Using Alcohol, Cigarettes, and Other Drugs before Selected Ages, by Birth Cohort: 1991 through 1993 National Household Surveys on Drug Abuse (n = 87 915 Respondents)

Birth Cohort	Age	Years Age was Attained	% Using (SE)						
			Alcohol, Any Use	Alcohol, Regular Use	Cigarettes, Any Use	Cigarettes, Regular Use	Marijuana	Cocaine	Hallucinogens
1919–1929	15	1934–1944	9 (1)	2 (1)	24 (2)	5 (1)	0 (*)	0 (*)	0 (*)
	21	1940–1950	63 (2)	27 (2)	64 (2)	38 (2)	0 (*)	0 (*)	0 (*)
	35	1944–1964	82 (2)	45 (2)	74 (2)	52 (2)	1 (*)	0 (*)	0 (*)
1930–1940	15	1945–1955	10 (1)	2 (1)	30 (2)	6 (1)	1 (*)	0 (*)	0 (*)
	21	1951–1961	66 (2)	31 (2)	71 (2)	43 (2)	2 (*)	0 (*)	0 (*)
	35	1965–1975	84 (1)	52 (2)	78 (2)	56 (2)	6 (1)	1 (*)	0 (*)
1941–1945	15	1956–1960	11 (1)	2 (1)	34 (2)	6 (1)	1 (*)	0 (*)	0 (*)
	21	1962–1966	73 (2)	33 (2)	75 (1)	47 (2)	6 (1)	1 (*)	1 (*)
	35	1976–1980	89 (1)	58 (2)	80 (1)	58 (2)	24 (2)	4 (1)	3 (*)
1946–1950	15	1961–1965	11 (1)	2 (*)	35 (1)	6 (1)	1 (*)	0 (*)	0 (*)
	21	1967–1971	76 (1)	35 (1)	74 (1)	43 (1)	21 (1)	2 (*)	4 (1)
	35	1981–1985	90 (1)	57 (1)	80 (1)	53 (1)	38 (2)	9 (1)	9 (1)
1951–1955	15	1966–1970	14 (1)	2 (*)	37 (1)	6 (1)	3 (*)	0 (*)	1 (*)
	21	1972–1976	82 (1)	42 (1)	72 (1)	39 (1)	40 (1)	6 (1)	13 (1)
	35	1986–1990	92 (1)	61 (1)	77 (1)	48 (1)	50 (1)	19 (1)	16 (1)
1956–1960	15	1971–1975	20 (1)	4 (*)	39 (1)	7 (1)	12 (1)	0 (*)	2 (*)
	21	1977–1981	85 (1)	49 (1)	74 (1)	39 (1)	53 (1)	13 (1)	13 (1)
	35	1986–1990	92 (1)	61 (1)	77 (1)	48 (1)	50 (1)	19 (1)	16 (1)
1961–1965	15	1976–1980	25 (1)	5 (*)	41 (1)	8 (*)	17 (1)	1 (*)	1 (*)
	21	1982–1986	85 (1)	53 (1)	70 (1)	36 (1)	55 (1)	17 (1)	13 (1)
	35	1986–1990	92 (1)	61 (1)	77 (1)	48 (1)	50 (1)	19 (1)	16 (1)
1966–1970	15	1981–1985	28 (1)	5 (*)	39 (1)	7 (*)	15 (1)	1 (*)	2 (*)
	21	1987–1991	86 (1)	54 (1)	70 (1)	33 (1)	51 (1)	16 (1)	12 (*)
	35	1986–1990	92 (1)	61 (1)	77 (1)	48 (1)	50 (1)	19 (1)	16 (1)
1971–1975	15	1986–1990	33 (1)	6 (*)	37 (1)	7 (*)	13 (1)	1 (*)	2 (*)
	21*	1992–1996	86 (1)	55 (2)	68 (2)	33 (2)	51 (3)	13 (2)	11 (1)

Note. (*) = SE < .05.

*Projections to age 21 based on ordinary least squares regression (see text).

The 1998 study here referenced followed an unprecedented number of 88,000 US citizens in cascading age cohorts. It analysed their licit and illicit drug use from their teens until their mid-thirties, measuring drug use from 1934-1996.

It is clear from the survey results for illicit drugs that there was zero to negligible use through to the mid-1960s where, even then, it was the younger age cohorts, a small part of the population that began experimenting with cannabis. Cannabis use began to explode from the mid-60s on, with use of cocaine and hallucinogens increasing from the mid-70s.

The banning of particularly harmful drugs had worked extremely well for 50 years. Faced with the clean-slate naivete of generations never confronted with the realities of illicit drug use, pro-drug opportunists launched a '60s counter-attack, beginning with promoting illicit drugs as the mystical path to personal enlightenment. Soon joined by artists and musicians who positioned drugs as good clean fun, societal use and associated deaths started an ascent towards the situation the US faces today, with 108,000 drug-related overdose deaths in 2021.

It has never been the case that the prohibiting of drugs failed, but rather that the pro-drug elements within society began a war of attrition against a highly successful drug policy.

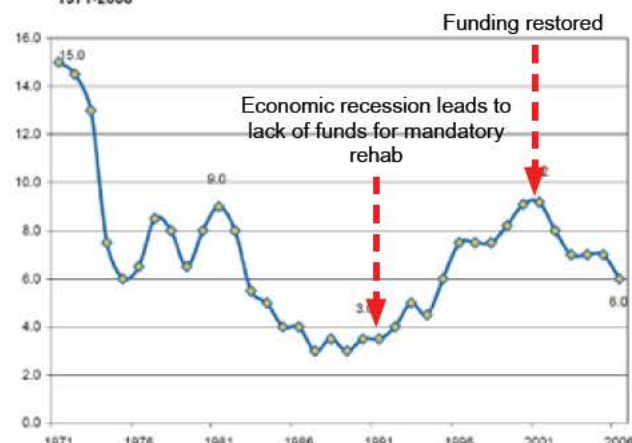
Prohibiting drugs still very successful

To the argument that national policies prohibiting the use of illicit drugs can never work in the more recent conflict with the pro-drug movement, that is, in the post 1960s environment since the pro-drug lobby declared war on anti-drug policies, the example of Sweden demonstrates that restrictive drug policies remain very successful.

During the 1960s Sweden was the most drug-liberal country in Europe, with the highest levels of drug use as a result. After discontinuing their amphetamine prescription programs for addicts in the late '60s, Sweden implemented its restrictive drug policy which targeted drug prevention programs uniformly at all schools, used thoughtful and caring policing of drug use as well as mandatory rehabilitation programs. The result was reductions in drug use from the highest levels in Europe to the lowest levels amongst OECD countries by the early '90s.

Restrictive drug policies work well, even when surrounded by countries with pro-drug policies. Iceland has recently had similar success.

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



Australia's Tough on Drugs' success

In 1998 the Federal Government, though bound to harm reduction policies since 1985, introduced more prevention aspects into Australian drug policy with its Tough on Drugs Strategy. Between 1998 and 2007, cannabis use halved, the use of Speed and Ice was down 40%, and heroin use reduced by 75% as can be seen by Table 2.1 (below) from page 8 of the 2010 National Drug Strategy Household Survey, to which more than 26,000 Australians responded.

While cocaine use increased by 15%, and ecstasy by 46%, a cause for concern, the overall picture does not resemble the pro-drug lobby's alarmism about unstoppable increases in Australian drug use. In some areas Australian drug use is significantly decreased. It is clear the pro-drug lobby consistently seeks to mislead Australians and its politicians. Any objective assessment would find that the results are mixed, certainly not a failure, with the balance of results giving cause for optimism. All of this was while Australia was hobbled with a continuing harm reduction drug policy which will later be shown to be running interference against any drug prevention approach.

The success of Australia's Tough on Drugs policy was celebrated in a United Nations in their publication, "Drug Policy and Results in Australia."

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
Tobacco	29.1	27.2	24.9	23.2	20.7	19.4	18.1 ↓
Alcohol	77.9	78.3	80.7	82.4	83.6	82.9	80.5 ↓
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) excluding pharmaceuticals	13.7	14.2	19.0	14.2	12.6	10.9	12.0 ↑

Australia never had a failed War on Drugs

Pro-drug lobbyists such as Australia21 constantly claim that Australia has waged a war on drugs which has failed:

"The war (on drugs) has failed internationally and in Australia" (p 12) and "Act urgently: the war on drugs has failed and policies need to change now." (p 14)

But any realistic assessment will demonstrate that Australia has never had a War on Drugs - it has been handing free needles to drug users, maintaining opiate users for up to 40 years on methadone and giving drug users injecting rooms. This cannot possibly be construed as a war on drugs. Since 1985 we have been busy facilitating drug use - anything but a war.

Again, a dispassionate assessment must ask, "What policing 'war' on anything is premised on eradicating it?" And what are we to make of the 'war' (if we now must call it that) on drink driving waged by our police? Are we now to legalise drink driving because the police have failed to eradicate it? And do we now legalise rape, stealing and human sex trafficking because the police have failed to eradicate them?

Rather we maintain our policing of anti-social behaviours to control them rather than eradicate them. If we don't the resulting societal harms are catastrophic. The pro-drug lobby's catchcry - "The war on drugs has failed" must be treated as false, misleading and ultimately vacuous.

Australians want less drug use, not more

As can be seen in Table 9.7 from the 2019 National Drug Strategy Household Survey, the vast majority of Australians do not approve the regular use of illicit drugs.

96-99% disapprove of the regular use of heroin, speed/ice, cocaine and ecstasy while 80% disapprove of the regular recreational use of cannabis.

In light of this very evident disapproval, it is also quite evident that Australians do not want more drugs, but less drugs. This puts the pro-drug lobby totally at odds with Australian attitudes towards drug use, and their representatives in Parliament should be guided by those attitudes when legislating policing and police priorities.

Pro-drug lobby has outed itself

For decades, harm reduction peak bodies and advocacy organisations such as Harm Reduction Australia and Australia21 have been denying that they are pro-drug. Their claim has been that their harm reduction stance leads them to support the drug user in their drug use, but this does not mean that they are supportive of the pro-drug initiatives of drug legalisation.

All this has changed in the last few years, with most of these organisations now openly supporting the legalisation of recreational cannabis use, and others the legalisation of ecstasy. This belies the incremental approach they have taken to reach this point. Harm reduction, with its acceptance and embrace of illicit drug use, has been but a stepping stone to the ultimate end - the 'right' of the drug user to use their illicit drug of choice, despite there being a univocal international consensus that there is and never has been a right to use illicit drugs.

Later in this submission we will deal with the wholesale failure of harm reduction interventions, using the most authoritative reviews worldwide - those by the Cochrane Collaboration which is the gold standard of reviews, and also the US National Institutes of Health's Institute of Medicine (IOM) with its dozens of research scientists and reviewers.

Thus the pro-drug lobby is out of the closet, and needs to be seen by political representatives and police in their true light.

Table 9.7: Personal approval⁽¹⁾ of the regular use by an adult of selected drugs, people aged 14 and over, 2007 to 2019 (per cent)

Drug	Proportion										Persons				
	Males					Females					Persons				
	2007	2010	2013	2016	2019	2007	2010	2013	2016	2019	2007	2010	2013	2016	2019
Alcohol	51.7	51.5	51.7	52.4	52.8	38.9	38.9	38.6	39.8	40.1	45.2	45.1	45.1	46.0	45.4
Tobacco	15.8	17.4	17.3	18.1	17.7	12.9	13.3	12.2	13.2	13.1	14.3	15.3	14.7	15.7	15.4
Illicit drugs (excluding pharmaceuticals)															
Marijuana/cannabis	8.7	11.0	12.6	17.8	23.6#	4.8	5.3	7.0	11.2	15.6#	6.6	8.1	9.8	14.5	19.6#
Ecstasy	2.5	3.0	3.3	3.9	5.3#	1.5	1.7	1.6	1.8	2.3#	2.0	2.3	2.4	2.9	3.8#
Methamphetamine ⁽²⁾	1.5	1.5	1.6	1.6	1.6	0.9	0.9	1.1	0.8	0.9	1.2	1.2	1.4	1.2	1.2
Cocaine/crack	1.6	2.2	1.9	2.0	3.0#	1.0	1.2	1.3	1.4	1.7	1.4	1.7	1.6	1.7	2.3#
Hallucinogens	2.1	3.2	4.5	5.1	8.0#	1.2	1.6	1.7	2.4	3.2#	1.7	2.4	3.1	3.7	5.6#
Inhalants	1.0	1.3	0.9	0.9	1.2	0.7	0.6	1.0	1.0	0.8	0.8	1.0	0.9	1.0	1.0
Heroin	1.3	1.5	1.3	1.3	1.5	0.7	1.0	1.1	1.0	0.8	1.0	1.2	1.2	1.1	1.1
Pharmaceuticals															
Over-the-counter pain-killers/pain-relievers ⁽³⁾	n.a.	14.4	14.8	19.5	n.a.	n.a.	14.3	14.2	18.7	n.a.	n.a.	14.3	14.5	19.1	n.a.
Prescription pain-killers/pain-relievers ⁽³⁾	n.a.	13.4	13.0	13.2	13.3	n.a.	12.6	12.2	12.1	11.5	n.a.	13.0	12.6	12.7	12.4
Tranquilisers, sleeping pills ⁽⁴⁾	4.8	7.2	9.5	10.1	10.1	3.4	5.7	6.8	8.5	8.5	4.1	6.4	8.2	9.3	9.3
Steroids ⁽⁵⁾	2.3	3.0	3.0	3.0	3.1	0.9	1.4	1.5	1.8	1.6	1.6	2.2	2.2	2.4	2.4
Methadone or buprenorphine ⁽⁶⁾	1.1	1.5	1.3	1.6	1.8	1.0	1.0	1.2	1.1	1.2	1.0	1.2	1.3	1.3	1.5

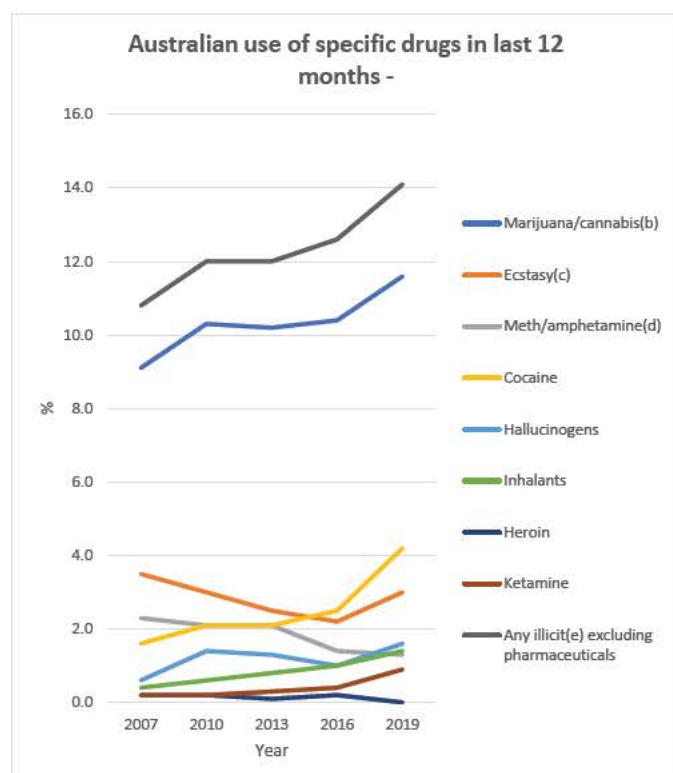
Trends related to illicit drug markets

Drugs with increased demand

Drug Free Australia submits the results of the last major National Drug Strategy Household Survey of 25,000 Australians, performed in 2019.

Since the end of the Tough on Drugs Federal drug policy in 2007 there has been increased use of specific drugs as follows:

Cannabis	27% increase
Cocaine	2.6 times increase
Inhalants	3.5 times increase
Hallucinogens	2.7 times increase
Ketamine	4 times increase



Federal-funded agencies such as NDARC will no doubt provide real time increases in drug availability as per their separate surveys, and there can be no doubt that police are already fully apprised on any of these changes.

CANNABIS

Illicit cannabis use must be a police priority

Medical journal studies from 2021 and 2022 now demonstrate that cannabis, whether used medicinally or recreationally, is not fit for human consumption of any kind, excepting perhaps for children with epilepsy-like conditions such as Dravet's and Lennox-Gastaut syndromes.

Massive new population studies are now demonstrating what has been known from in vitro and animal studies for decades - that cannabis is genotoxic, mutagenic, oncogenic and teratogenic as follows:

- causal in 33 cancers, as compared to 14 for tobacco
- causal in 70% of pediatric cancers
- causal in 89 of 95 birth defects
- accelerates user aging by 30%

The mechanisms by which cannabis causes these unacceptable harms to individuals are now understood, with cannabis literally shattering chromosomes, where the body's DNA repair mechanisms do not always work correctly, creating mutations which are passed on for three or four generations to offspring.

This makes cannabis a drug which can no longer be considered only as harmful to the individual user - whether a medicinal or recreational cannabis user. With users' children, grandchildren and great-grandchildren affected by cancers and birth defects flowing from their

use, cannabis use in any form is no longer tenable.

Parliamentary Inquiry to reschedule cannabis needed

Illicit drug use has historically been deemed such on the basis of the harms drug users inflict on those around them.

While cannabis has caused considerable self-harm through suicide, the recent science, particularly as it relates to cannabis causing very significant harms to future generations of Australians, puts it squarely within the criteria of all prohibited substance. Additional harms - drugged driving, aggression, violence and homicide - are as unacceptable as the harms of heroin.

Given that the significant cancer and birth defect harms to future generations are as likely, or more likely, to accrue to Australians using cannabis medicinally, a Federal Parliamentary Inquiry is urgently required to test the science and consider its social implications. Such an Inquiry is likely to have future impacts on the Federal and State policing of cannabis use.

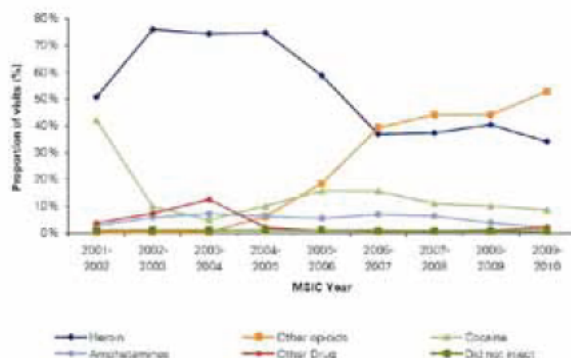
OPIATES

Deaths related to prescription painkillers

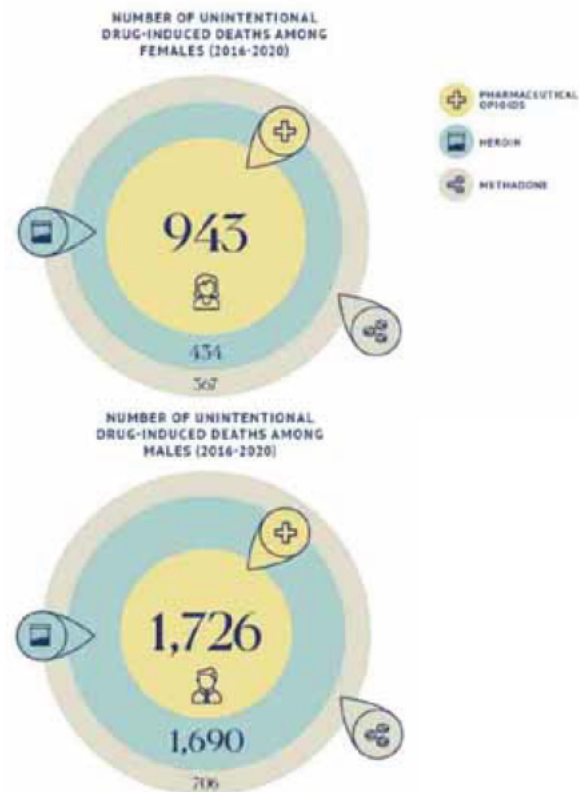
It is a matter of historical record that illicit heroin ceded its position as Australia's most deadly drug to prescription opiates 15 years ago.

A graph from the 2010 KPMG evaluation of the Sydney Medically Supervised Injecting Centre (MSIC) indicates the shift within use particularly as it related to use within that facility. The shift at that time was due to prescription opiates becoming cheaper than heroin, where federal policing had caused the heroin drought dating from the year 2000 and higher prices for heroin.

Figure 8-1: Type of drug injected¹¹³



At that time there was also a shift in the majority of opiate overdose deaths being due to prescription opiates rather than heroin. According to the Penington Institute's latest report on drug-related deaths in Australia, prescription opiate deaths now dwarf those from heroin.

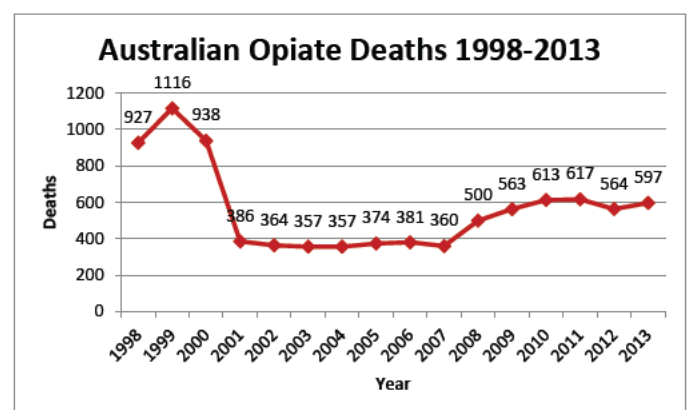


Federal policing reduced opiate deaths

A review of opiate deaths by year within Australia demonstrates that Federal policing between 1998 and 2000 successfully reduced opiate deaths by 68%, targeting the supply lines for heroin into Australia and thereby causing the heroin drought in 2000 and thereafter.

Thousands of lives saved

The lessons Australians should have taken from the results of diligent policing are that this policing has saved literally thousands of lives with Tough on Drugs mortality levels more than 750 deaths lower per year than their 1999 peak which was then continuing to trend upwards.



From the 350 opiate overdoses per year between 2001 and 2007 to the 1,173 average death per year between 2016 and 2020, continued policing has again



kept literally thousands of families intact by reducing the loss wrought by opiate use, albeit with decreasing effect over the years.

Federal policing capable of doing it again

With the current high mortality now deriving from prescription opiates, Federal policing needs to focus on reducing their illicit availability to opiate users. Policing will need to be supported by tighter legislation for this to be achieved.

Priority - rehab for prescription opiates

Another lesson learnt from the Tough on Drugs policy is that the increased drug rehabilitation places offered by the Tough on Drugs Strategy saved many opiate users from lives given to addiction.

In line with the observations above, legislators must again prioritise rehabilitation beds, particularly for users of illicit prescription opiates. Rehabilitation providers will need to deal with these addictions in a different way to that of heroin use. Drug courts, in tandem with diligent policing, have every chance of reducing opiate related deaths as did Tough on Drugs - but only if there is the political will.

ECSTASY

Ecstasy use trending downward

While ecstasy use can be moreso an issue for State Police, its production through precursor chemicals and its availability despite interdiction efforts to stop batch importation from other countries is very much of concern to the Australian community, and thus for Federal Police.

Between the household surveys conducted in 2007 and 2019, ecstasy use trended downward from 2007 and 2016, with an uptick in 2019. This reversal of the trend is likely due to the national publicity given to the first pill testing trial in Canberra in 2018. Because this trial was conducted on the almost entirely false premise that pill testing would reduce ecstasy hospitalisations and deaths, a rise in use was to be expected, driven by false perceptions about testing kits and future festival-based pill testing availability.

In Pill Testing Australia's second evaluation of their pill testing trial in 2019, the ANU evaluators found from their survey of participants 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." Thus any uptick in use while pill testing is being promoted is supported by the surveyed responses of pill testing participants themselves.

The false science propagated by the Australian media

as offered them by Harm Reduction Australia and Pill Testing Australia asserted that ecstasy deaths were due to dangerous contaminants or other deadly drugs mixed with MDMA in ecstasy pills. This had been shown false in a 2009 study of MDMA-related deaths, where the MDMA itself had been shown to be the main cause of deaths.

More recent reports from NDARC on ecstasy use show a decreasing trend once again, albeit through the COVID-19 years where music festivals, which had hosted much of Australia's ecstasy use, were scuttled or had reduced turnouts for fear of contracting COVID.

Despite this downturn, Pill Testing Australia's misinformation aimed at State Governments will put pressure on drug traffickers to bring more ecstasy into the country, or others to produce more at home. This will put pressure on Customs and Federal Police.

Ecstasy legalisation must be rejected

An October 2019 medical journal study by Dr Amanda Roxburgh, of the mostly drug-liberal National Drug and Alcohol Research Centre (NDARC), examined 392 ecstasy-related deaths in Australia between the year 2000 and 2018 and recorded only a handful of deaths from impurities or dangerous contaminants in ecstasy pills. A tiny percentage were from other drugs such as PMA or NBOMe mixed with MDMA in ecstasy pills, with no indication whether it was these drugs or the ecstasy in the pill that caused the deaths.

Given that MDMA was therein shown to be the cause of almost all 392 deaths, and with only one instance of four deaths from a bad batch where MDMA was mixed with two other drugs, MDMA itself can be fingered for almost every death as per the following breakdown.

Fourteen percent of the 392 deaths in Roxburgh's study were from ecstasy acting alone, often singling out users with idiosyncratic reactions to the substance. In 1995 five friends purchased ecstasy pills from a dealer but only Anna Wood, Australia's first MDMA casualty, died. These deaths are not overdoses - New Zealand's first fatality, Ngaire O'Neill, took only a tiny amount of ecstasy, and is typical of many ecstasy deaths.

Another 48% of the deaths were from ecstasy consumed with other drugs such as alcohol, amphetamines or cocaine, creating toxic synergies causing death.

29% of deaths were from fatal accidents, mostly car accidents, involving ecstasy intoxication. Clearly, legalised ecstasy pills with pharmaceutically standardised dose, strength and purity would cause just as many deaths, and this fact negates any argument for pill testing. Likewise, pill testing has no point if it guards only against non-existent or rare occurrences while

simultaneously promoting and normalising the use of a drug which causes multiple deaths.

Ambient temperature causes deaths

Making ecstasy use entirely unpredictable, scientific studies with rodents show that changes in social context and ambient temperature cause deaths. Rats given one fifth the lethal dose of MDMA have exhibited brain temperature increases when merely put into a social situation with other rats, but when combined with an increase in ambient temperature from 22 degrees to 29 degrees Celsius, which rats would normally tolerate well, all rats died from hyperthermic overheating. This explains why experienced ecstasy users die taking identical pills on differing occasions. It is clear that the music festival context creates its own dangers.

Policing saves more lives than pill testing

In light of the reality that it is MDMA that is causal in most deaths and that festivals themselves heighten the chance of ecstasy deaths, the continued policing of drugs which will inhibit the use of drugs is likely to save many more lives than will the false science of pill testing.

MENTAL HEALTH

Drug use increasing mental health issues

Drug Free Australia seeks to also highlight an issue which is fortunately already recognised by the Federal Health Department. From an Australian Institute for Health and Welfare webpage, the following increases in mental health issues are detailed,

Mental health is fundamental to the wellbeing of individuals, their families and the population as a whole (ABS 2018). According to the 2019 National Drug Strategy Household Survey (NDSHS) estimates, 16.9% of the general population aged 14 and over had been diagnosed or treated for a mental health condition in the previous 12 months. This increased from 15.9% in 2016 (AIHW 2020). The proportion of people aged 18 and over experiencing high or very high levels of psychological distress also increased, from 11.7% in 2016 to 14.0% in 2019 (AIHW 2020).

Not the time for liberalising drug policy

Such mental health issues, which importantly predate any issues presented by COVID-19 and associated lockdowns, signal that the prevention of Australian drug use must remain a high priority for the Federal Government.

This is not the time to be liberalising drug policy. Mental health issues are correlated with violence and additional unacceptable harms such as suicide and homicide.

A MOST IMPORTANT CONSIDERATION

A note on political libertarianism and drugs

At a time when political authoritarianism in the wake of COVID-19 measures is coming back into political vogue, the Australian Government needs to ensure that it is not misled by the faux libertarianism presented by the pro-drug lobby.

Their argument, which will push for the full legalisation of particular illicit drugs, will constantly be that drug users have a 'right' to their drug of choice, and that libertarianism demands that they be given the freedom every other person has with personal choices.

However the most ardent proponent of libertarianism, John Stuart Mill, firmly stated that all should be given liberty to pursue their desires so long as their freedom does not trample on the freedom of others. Even Mills saw drugs of addiction as refractory to the libertarianism he espoused.

In a majority of cases, the illegal drugs lead to a drug user causing harm to a whole constellation of people around them - partner, children, siblings, their children's grandparents (who in many cases fill the parenting vacuum), friends, workmates, other road users, the general community. Just as for those alcoholics who struggle to avoid harm to others who, despite using a very legal drug still are naturally stigmatised because of those very harms they cause, illicit drug users have attracted a stigma that is largely as unmanufactured and contrived as is that for the alcoholic based on the harms they cause to others.

These unacceptable harms are very real, attested to by the very nomenclature of the many 'harm reduction' programs run with government funding for users. Drug Free Australia stands against the unfair stigmatisation of drug use, but recognises that stigmatisation for real harm caused to others is understandable - even the LGBTQ community believes it has a right to draw a line in the sand by stigmatising those that don't abide by their agenda where they perceive harm to their cause.

The lobby seeking to legalise certain drugs will try to cloud these realities for legislators, and Drug Free Australia urges that Parliamentarians be clear-sighted about the issues.

Emerging trends & risks - new substances

Readily available CBD a 'precursor' for THC

On 15 December 2020 the TGA downgraded Cannabidiol (CBD) preparations of up to 150 mg/day from prescription-only to pharmacy availability, making it generally accessible without any real impediment.

Medicinal cannabis products containing the psychotropic cannabinoid THC remained prescription only.

Yet CBD readily converts to THC, making it a biological 'precursor' for the higher Scheduled substance. It also is likely to contain traces of THC at manufacture.

This raises a whole range of issues which we will explore here - however the upshot, not from the totality, but from each of a plethora of separate issues, is that CBD must necessarily be re-evaluated and rescheduled.

This, of course, is an issue for the TGA and legislators, but will have consequences for policing.

CBD desperately needs rescheduling

Drug Free Australia asserts that CBD needs to be urgently reevaluated by the TGA and legislators in light of the following scientific studies, mostly published in 2021 and 2022:

- Studies show it quite clearly does not do what is claimed for it, therefore is not that needed
- CBD is genotoxic, that is, it destroys the integrity of genetic information within those who use it
- It is the most cancer-causing of all cannabinoids
- It is implicated in causing pediatric cancers
- It is responsible for multiple birth defects
- It is finding its way into the human food chain and thus will cause all the harms listed above to non-users

DOESN'T DO WHAT IT CLAIMS

Many claims made for CBD

Cannabidiol (CBD) has been aggressively promoted to the public as a substance with miraculous properties. Even those articles that claim scientific support use mostly very limited studies which lack the rigour of random control trials. For instance, Forbes magazine listed the scientifically-verified conditions alleviated by CBD use as anxiety and depression, childhood epilepsy-like conditions, PTSD, opioid addiction, ALS, unmanageable pain, diabetic complications, protection against neurological diseases and arthritis. This list is conservatively short as compared to its advertised benefits on internet advertising services where every malady seemingly finds its answer in this wonder drug - even as a cure to cancer.

Claims don't stand up to scientific scrutiny

The common experience with claims about cannabis has been that when rigorous clinical trials are conducted, the claims evaporate. This is best evidenced by the 2017 National Academies of Medicine review of cannabis, led by a committee of 16 professors and epidemiologists and 15 reviewers of similar qualification. Notably, amongst this group are those who have a history of being strongly pro-cannabis. In this review of reviews, very few claims for cannabis were found to have any rigorous research support. When it comes to scientific rigour, CBD shows little benefit, while being the most lethal of the cannabinoids.

CBD no better than placebo for pain

62% of Australians use medicinal cannabis for chronic pain, despite a 2018 review of 103 previous studies

comprising almost 10,000 patients finding that cannabis is not adequate to treat chronic pain and useful only as an adjunct to other pathways such as opiates.

Given that CBD is increasingly being marketed as a safe and effective substance for pain relief, there is an increasing amount of research coming to hand demonstrating that CBD is ineffective. A JAMA review of 20 studies found that CBD is no more effective than placebo. Other related studies are determining no benefit for CBD with final stage cancer patients as it relates to the alleviation of pain, depression, anxiety and quality of life.

When it is again considered that 62% of Australians use cannabis for chronic pain relief, the role being given to a substance such as CBD with its many physiological dangers is inordinately great, and alarming.

A further implication is that other conditions for which CBD is anecdotally useful need to be subjected to clinical trials. If its effectiveness in regards to pain evaporates once subject to scrutiny, there needs to be greater scientific clarity around other claims being made for it. These too may readily evaporate under scientific scrutiny.

IF CBD IS NOT THAT NECESSARY FOR THE WELL-BEING OF AUSTRALIANS, IT MUST BE RE-EVALUATED AGAINST RECENTLY ESTABLISHED, VERY SERIOUS HARMS AND RESCHEDULED ACCORDINGLY.

DAMAGING PHYSIOLOGICAL EFFECTS

Genotoxicity of CBD uncontroversial

Dr Stuart Reece, a Professor at the University of Western Australia and possibly the world's most authoritative source on cannabis physiology and biochemistry, has confirmed that the genotoxicity of CBD is uncontroversial. Dr Reece, along with Dr Gary Hulse, is well-published in areas such as cannabis genotoxicity, teratology and epigenetics.

In e-mail communication with Drug Free Australia dated 27 June 2019 Dr Reece confirmed that the CBD effect on mitochondria is highly significant, well recognised and uncontroversial. He further stated that it is now accepted that mitochondrial toxicity can become reflected in genotoxicity also through the balance mechanisms between mitochondria and nucleus, which is likewise uncontroversial.

Notably, the genotoxicity of CBD is admitted in authorised prescribing information with the US FDA and with the European Medicines Agency. It even appears on the labels of hemp oil marketed by Woolworths in Australia.

CBD the most carcinogenic cannabinoid

In the first run of data on US cancer rates as they relate to cannabis use across the various state drug policy regimes, CBD was found to be the most carcinogenic of the cannabinoids selected for inclusion in the study, with CBD likely causal in 12 of the 27 cancers there confirmed as compared to 7 for THC.

As is the case with tobacco, which was likewise verified in the study to be causal in 14 cancer types, any health authority would not allow it to be marketed as the cure for numerous maladies given the risks it presents.

Precisely the same should be the case with CBD products, where Australia's regulatory body was informed in 2021 of the carcinogenic nature of CBD, but nevertheless moved shortly thereafter to remove regulatory strictures on its availability, leading to serious questions about the TGA's current philosophy on safety.

CBD implicated in autism epidemic

The often-voiced claim that CBD is benign, presenting no significant harms to a patient, needs to be reassessed in the light of an evolving science on CBD.

In a recent letter to the New England Medical Journal, Dr Stuart Reece and his research colleague Dr Gary Hulse wrote the following,

As one of the major cannabinoids and a high-dose ligand at CB1R's cannabidiol is implicated in the close spatial (northeast USA), temporal (recent years) and demographic (young adults) association between cannabis use and mental illness chronicled by SAMHSA and the nationwide surge in autism recently linked to cannabidiol.

CBD is more strongly implicated in autism prevalence than THC, and cannabis moreso than opiates according to this study. This has been established by waste-water data which establishes the strength of THC and various other cannabinoids in cities across the US correlated against increases in autism in those US States that have legalised access to recreational and medicinal cannabis.

CBD more causal in certain birth defects

Reece and Hulse, in their aforementioned letter to the New England Journal of Medicine assert the following:

Cannabidiol is a known chromosomal clastogen, epigenotoxin and mitochondrial toxin and was linked to the 29% surge in Colorado birth defects, led by cardiovascular defects, just as in Canada; and the pattern of rise of Downs syndrome, anotia and absent arms in Alaska and Oregon; and parts of France after it was added to the food supply; or

the emergence of new cannabis-related defects like atrial septal defect in Colorado, Alaska, Oregon, Kentucky and Hawaii.

While cannabis is implicated in growing rates of gastroschisis (a birth defect where babies are born with their intestines hanging outside the body) in States and countries which are legalising cannabis for medical and recreational use, it is CBD more so than THC that appears causal in these population studies.

In e-mail communication dated 21 January 2019 between Drug Free Australia and Dr Stuart Reece who was one of the researchers that uncovered the association between cannabis and gastroschisis, Reece stated that,

The order of potency for both gastroschisis and autism is CBD>THC>Opioids.

This statistical finding alone suggests more study needs to be done on CBD's relationship to birth defects, given the known DNA damage demonstrated to have been caused.

Major genotoxic mechanisms of cannabis

2016 marked the year that, like tobacco before it, the mechanisms by which cannabis causes cancer and birth defects were published.

Cannabinoids act directly on chromosomes, literally shattering or pulverising them. This process of 'chromothripsis', first discovered in 1967, should be able to be reversed by the body's DNA repair capabilities, which normally have sophisticated verification mechanisms with an error or mutation rate of 10^{-8} . In germ cells the rate is 100 times lower. Chromothripsis

explains "the high rate of micronuclei, chromosomal fragments and abnormal chromosomes (truncated arms, chain and ring chromosomes and double minute circles) which are frequently seen in malignant tissues."

Chromothripsis, combined with epigenetic mechanisms which entail mutations being passed to future generations, well explains the mutagenic nature of cannabis, as well as the many congenital abnormalities associated with its use.

CBD READILY CONVERTS TO THC

CBD symptoms similar to THC

Research published in the journal Cannabis and Cannabinoid Research shows that more than 40% of children with epilepsy who were given CBD orally had adverse events that included THC like symptoms. The research challenged the widely accepted premise that CBD is not intoxicating. There is evidence that CBD is biotransformed to metabolites that have similar effects as THC.

Notably, the FDA-listed Adverse Reactions for CBD include THC-like symptoms such as suicidal ideation, depression and anxiety. Their advice is as follows:

Antiepileptic drugs (AEDs), including EPIDIOLEX, increase the risk of suicidal thoughts or behavior in patients taking these drugs for any indication. Patients treated with an AED for any indication should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, or any unusual changes in mood or behavior.

Pooled analyses of 199 placebo-controlled clinical trials (mono- and adjunctive therapy) of 11 different AEDs showed that patients randomized to one of the AEDs had approximately twice the risk (adjusted Relative Risk 1.8, 95% CI:1.2, 2.7) of suicidal thinking or behavior compared to patients randomized to placebo. In these trials, which had a median treatment duration of 12 weeks, the estimated incidence rate of suicidal behavior or ideation among 27863 AED-treated patients was 0.43%, compared to 0.24% among 16029 placebo-treated patients, representing an increase of approximately one case of suicidal thinking or behavior for every 530 patients treated. There were four suicides in drug-treated patients in the trials and none in placebo-treated patients, but the number is too small to allow any conclusion about drug effect on suicide.

The increased risk of suicidal thoughts or behavior with AEDs was observed as early as 1 week after starting drug treatment with AEDs and persisted for the duration of treatment assessed. Because most

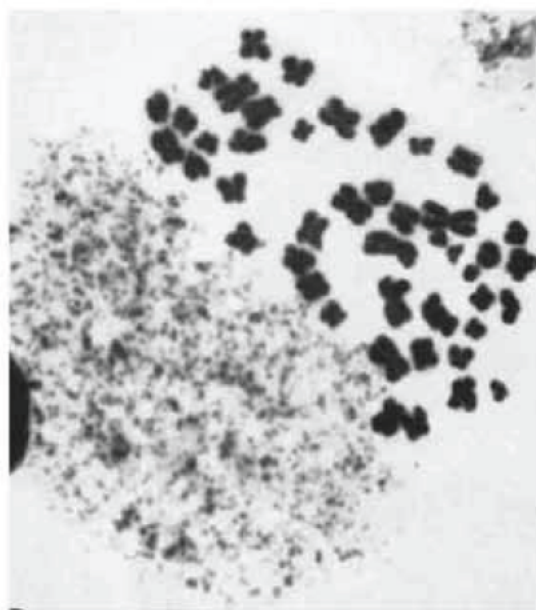


Fig. 1. Chromosomal Pulverization.
Original Report of Chromosomal Pulverization. Figure 7, Kato H., Sandberg AA (1967). "Chromosome Pulverization in Human Binucleate Cells. Following Colcemid Treatment." J. Cell Biol. 34 (1): 35-45. Re-used by permission.

trials included in the analysis did not extend beyond 24 weeks, the risk of suicidal thoughts or behavior beyond 24 weeks could not be assessed.

Orally ingested CBD metabolises to THC

Concerning the transformation of orally-ingested CBD into THC, even the US Hemp Connoisseur magazine recognizes that more study is needed. They write:

Much research has involved the administration of THC and CBD to patients for symptoms such as fibromyalgia, Crohn's disease and insomnia, but researchers have been circumspect in declaring their results and have called for further testing. Watanabe's research, though conducted on mice, may hold true for humans – but that must be the subject of future studies. As Georgetown University Medical School's Dr. Robert du Pont pointed out, there are an estimated 400 components in the cannabis plant, making it difficult to determine exactly which component is providing relief when cannabis is ingested for medical reasons.³

Could anomalies in results have resulted from the way gastric juices break down CBD within the human body? In a 2016 study published in Cannabis and Cannabinoid Research, by John Merrick and associates, it was noted that, "In recent epilepsy research, pediatric subjects receiving orally administered CBD showed a relatively high incidence of adverse events ($\leq 44\%$), with somnolence ($\leq 21\%$) and fatigue ($\leq 17\%$) among the most common."⁴ This led the researchers to more closely investigate the accepted premise that CBD is non-psychoactive. They came to the conclusion that, "Gastric fluid without enzymes converts CBD into the psychoactive components $\Delta 9$ -THC and $\Delta 8$ -THC, which suggests that the oral route of administration may increase the potential for psychomimetic adverse effects from CBD.

CBD readily converts to Delta-8/10 THC

The University of Connecticut, commenting on $\Delta 8$ -THC (which is equally as psychoactive as $\Delta 9$ -THC) being produced from hemp, and the differing legalities across US states notes that the following is just another way that unregulated CBD can produce an illicit recreational product.

Newswise — One is an illegal drug found in marijuana while the other is marketed as a safe herbal alternative. But the claimed differences between them aren't backed by science, a group of UConn researchers report on Nov. 1 in Drug and Alcohol Dependence.

Tetrahydrocannabinol, or THC, is the psychoactive

compound produced by cannabis plants. The federal government lists $\Delta 9$ -THC (pronounced delta-9-THC) on the Schedule 1 list of dangerous drugs with no accepted medical use. But other versions of THC that differ only by the location of a double bond, such as $\Delta 8$ -THC, remain quietly quasi-legal on the federal level.

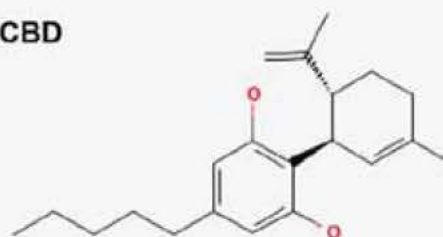
The legality differences between the various versions of THC are causing conflict between the hemp and cannabis industries. There is also potential for harm to consumers. Although $\Delta 8$ -THC is viewed as an herbal extract of hemp, many manufacturers use solvents and chemical processes that can leave harmful residues in the product, and there are no standards for purity or safety. Because there are no limits, some products contain ridiculously high levels of $\Delta 8$ and other THC variants that could potentially cause harm due to the sheer dosage. And states do not agree on its safety or legality. Some states, such as Connecticut, have made $\Delta 8$ -THC as controlled as $\Delta 9$ -THC, while in others it remains legal. Cannabis producers allege the distinction is giving rise to unfair competition between the hemp and marijuana markets.

If regulating $\Delta 9$ -THC as an illegal drug is based on the fact that it has physical and psychoactive effects, then the first step to rational regulation of $\Delta 8$ -THC would look at whether it, too, has those effects. And people who have experience with both say it does; most agree the effects of $\Delta 8$ are similar to $\Delta 9$.

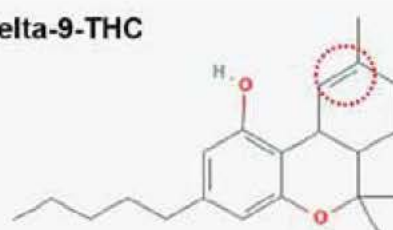
Basic Chemistry

The reason CBD so readily converts to THC is simply because they share the same molecular formula - $C_{21}H_{30}O_2$. CBD and THC are isomers of one another in that they contain the same number and type of molecules.

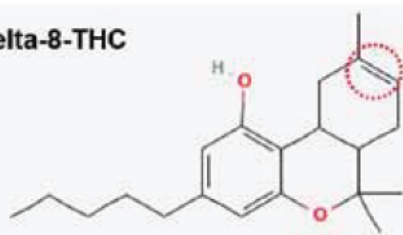
CBD



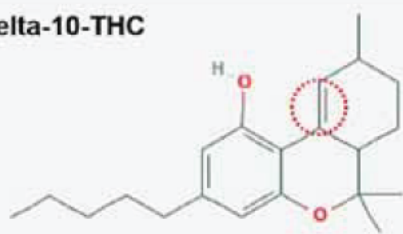
Delta-9-THC



Delta-8-THC

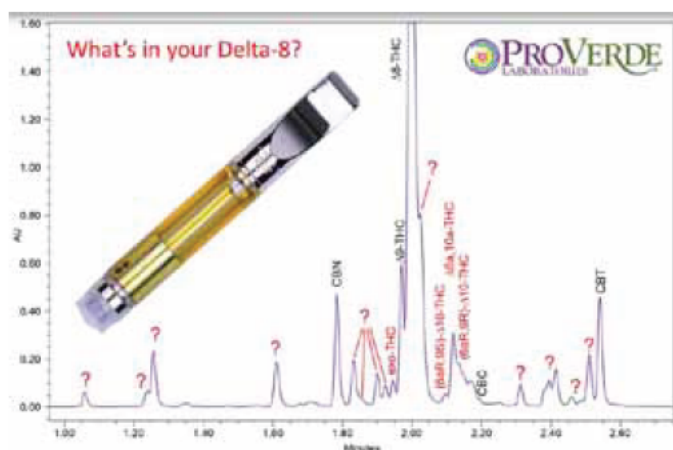


Delta-10-THC



While the Australian TGA has clearly stated that manufacture of $\Delta 8$ -THC is illegal, the substance, which can nevertheless be readily produced from hemp CBD, is reported to at best be 1/3rd less potent than $\Delta 9$ -THC. Another isomer THC-P is reported to be 30 times stronger than $\Delta 9$ -THC. Given that the latter has side-effects that include cyclic nausea, vomiting, anxiety, paranoia, as well as triggering psychosis and schizophrenia in teens, the ease of manufacture of these derivatives should be a major target for concerned legislators and police.

Additional issues are that there are unknown chemicals in $\Delta 8$ -THC with unknown long-term physiological effects.



OTHER CBD/THC CONCERNS

THC in CBD hemp accumulates in the body

It is important to recognise that CBD, a product of low THC hemp where THC cannot exceed 0.3%, nevertheless will most likely have low quantities of THC present. A Health Canada study recognises the issues around THC accumulation in the body thus,

According to Canada's national health department, Health Canada, "In theory the ripened seeds of

According to Canada's national health department, Health Canada, "In theory the ripened seeds of Cannabis contain no detectable quantity of THC. However, because of the nature of the material it is almost impossible to obtain the seeds free from extraneous THC in the form of residues arising from other parts of the plant which are in close proximity to the seeds. Although it is required for the seeds to be cleaned before any subsequent use, the resinous nature of some of the material makes complete cleaning extremely difficult."

Since THC and the over 60 other cannabinoids are fat-soluble, i.e., store themselves in the fatty tissues of the brain and body, even a very small amount may be damaging, especially if ingested regularly. Fat-soluble substances accumulate in the body.

THC has a half-life of about seven days, meaning that one-half of the THC ingested or inhaled stays in the brain and body tissue for seven days. Traces can stay in body tissues for a month or more. The only important substance that exceeds THC in fat solubility is DDT.

A risk assessment done for Health Canada states that, "New food products and cosmetics made from hemp – the marijuana plant – pose an unacceptable risk to the health of consumers. It also says that hemp products may not be safe because even small amounts of THC may cause developmental problems. "Those most at risk," the study says, "are children exposed in the womb or through breast milk, or teen-agers whose reproductive systems are developing."

"Hazards associated with exposure to THC include acute neurological effects and long-term effects on brain development, the reproductive system and the immune system," the study says. "Overall, the data considered for this assessment support the conclusions that inadequate margins of safety exist between potential exposure and adverse effect levels for cannabinoids (the bio-active ingredients) in cosmetics, food and nutraceutical products made from hemp."

Hemp THC ingestion beyond health limits

Quite apart from accumulations of THC in body fats and the health risks presented by it, there is another issue of large quantities of hemp ingredients being used in hemp edibles. The following demonstrates that a serving of hemp seed flour chips can have, despite being 0.3% THC, 8 times as much THC allowable for a typical serving. Add to this the accumulation of cannabinoids as described at our previous heading, and there is real cause for concern about hemp edibles opening up the consumer to various dangers caused by THC.

Using what I call "Farm Bill Math", the definition for hemp in the 2018 Farm Bill allows for 3 milligrams (mg) of THC per gram (same as 1,000 milligrams) by product weight. At face value, this may not seem like a big deal, until one realizes the weight of many food products that we and our children consume. For example, a bag of Tostitos Corn Chips specifies that one serving size is 7 chips, which has a listed weight of 28 grams. Thus, each chip would weigh about 4 grams (28 grams divided by 7 chips). Assuming that these chips could be made from hemp seed flour, one chip could legally contain up to 12 mg of THC (4 grams X 3 mg/gram). Also consider the 28 grams serving size, or 7 chips, noted on the Tostitos bag. This serving size could contain up to 84 mg of THC (28 grams X 3 mg THC/gram)! Corn chips also contain very little moisture in the form of water (low dry weight); it is only about 1% to 2.5%, so likely hemp-based chips would be very similar.

It is important to keep in mind that in Colorado, a product that contains THC is limited to 10 mg per serving for public health and safety reasons. Therefore, in Colorado, only one hemp-based corn chip (containing 0.3% THC by dry weight) would be roughly equivalent to the legal serving size of THC.

Animal products transfer CBD dangers

As previously recorded in this document, cannabinoids entering the food chain with hemp being introduced as animal feed, presents genuine risks to humans. This may not only be through the Thalidomide-like phenomenon of human babies being born without limbs, but may have other manifestations given the accumulation of cannabinoids in the body. The US FDA has ruled that hemp feed and CBD 'medication' cannot be used with animals that are part of the human food chain.

The U.S. Food and Drug Administration (FDA) has issued warning letters to four companies illegally selling unapproved animal drugs containing cannabidiol (CBD) that are intended for use in food-producing animals. The companies include Haniel Concepts dba Free State Oils, Hope Botanicals, Plantacea LLC dba Kahm CBD and Kingdom Harvest. While the FDA does not know the current extent of CBD use in food-producing animals, the agency is taking steps regarding these unapproved and potentially unsafe products now to help protect animals and the safety of the food supply.

Unapproved drugs like these CBD products have not been evaluated by the FDA to determine whether they are effective for their intended use, what the proper dosage might be, how the products could interact with FDA-approved drugs, or whether

they have dangerous side effects or other safety concerns.

The FDA is concerned about these CBD products for food-producing animals not only because CBD could pose a safety risk for the animals themselves, but also because of lack of data about the safety of the human food products (meat, milk and eggs) from the animals that have consumed these CBD products.

Summary of concerns about CBD

We have questioned whether CBD is as needed by the Australian community as the hype has indicated and also demonstrated that its health harms to the user and to their children and future generations are extremely serious.

The TGA and legislators need to re-evaluate hemp-based products for human consumption and reschedule accordingly. This should be a matter of urgency. If CBD is rescheduled, as it should be, there will be considerable implications for policing, given the current widespread cultivation of hemp.

Involvement with harm reduction activities

Harm Reduction consistently fails

When the world's best scientific reviews show that every harm reduction intervention implemented has failed to demonstrate any positive effect, it is time for Federal Parliament to change its drug policy stance.

Legislative Inquiry desperately needed

Australia introduced Harm Reduction as the underlying foundation to its drug policy in 1985 and has never implemented any review of the policy since that date. The determinant of whether this policy should continue should be on its own terms, where it has always claimed that harm reduction policies should be 'evidence-based'.

However the term 'evidence-based' should never be reliant on small, poorly designed studies, which appear more so designed for media headlines and swaying government funding, but only on rigorous reviews.

Science uniformly condemns harm reduction

The world's most authoritative reviews on a range of harm reduction interventions consistently discard small, poorly designed studies for only those with robust methodologies and outcomes. In every case, harm reduction interventions when rigorously reviewed have uniformly failed to show any effectiveness:

- **Methadone maintenance** - no effectiveness
- **Needle/Syringe programs** - no effectiveness
- **Injecting rooms** - increased drug use, deaths and reduced public amenity
- **Pill testing** - increased use of Ecstasy

In a country where 96-99% of Australians do not approve the use of the specific drugs for which harm reduction interventions exist, continuation is untenable.

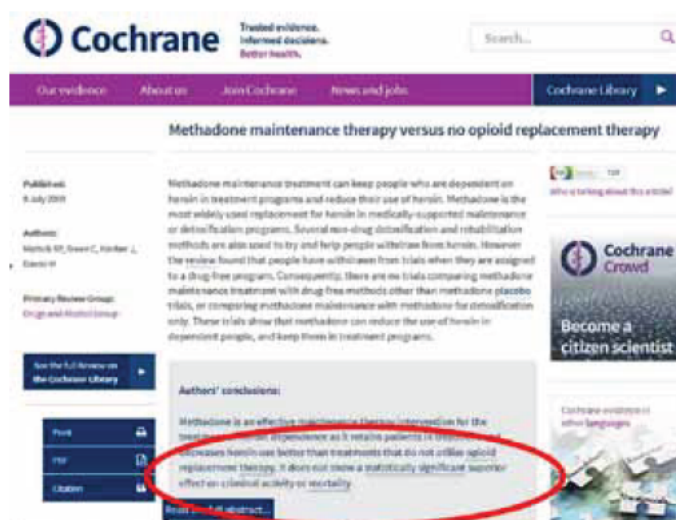
METHADONE

Cochrane Collaboration - methadone a failure

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 2009 review of well-designed journal studies by the gold standard of reviews, the Cochrane Collaboration found no such effectiveness for methadone maintenance.

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



Many methadone users still use heroin

From the Cochrane review by Mattick et al, the relevant studies show that a varying percentage of

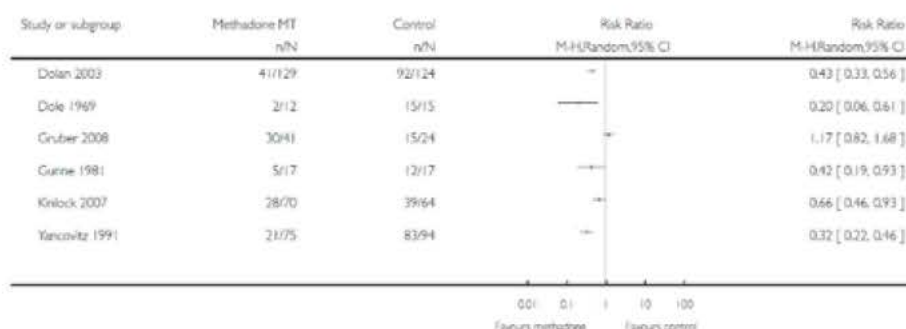
methadone patients still use heroin, with one study finding 73% still using the substance. High heroin use percentages are corroborated by other studies.

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



Results suggest even more are using heroin

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

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

NEEDLE & SYRINGE PROGRAMS

NSP - 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 1995 review of needle exchanges, the IOM had noted the poor design and lack of rigour in most of the studies on the effectiveness of NSPs to that time, but nevertheless advocated for their implementation in the United States, 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 2007. While the IOM report found that multi-

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

"evidence regarding the effect of needle and syringe exchange on HIV incidence is limited and inconclusive"

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

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

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

False claims for NSP and HIV prevention

The fact that Australia has low rates of HIV transmission can be easily explained by the initial small pool of infected users, by the success of Australia's Grim Reaper television advertising campaign, and to high rates of freely available HIV testing.

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

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

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

The MJA article presents reality and the Federal Government is advised to remove support from this

failed harm reduction approach.

EMCDDA review does not supersede IOM

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

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

However the 2010 Palmateer study makes a critical error in its 'review of reviews', failing to adequately look into the primary studies guiding those reviews, as well as uncritically accepting the conclusions of the three former reviews. The three reviews included the 2004 Wodak/Cooney 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 this Inquiry 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.

Two error-filed Australian studies on NSP

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

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

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.

Drug Free Australia urges the Inquiry to follow the current science in its drug policy positions and elevate evidence-based decisions over ideology for the sake of Australian lives.

INJECTING ROOMS

Only two rigorous reviews to date

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.

Only RAND review remaining

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

and Barcelona.

Of these five studies, Marshall et al. found a 35% reduction in opiate overdose fatalities in the immediate area surrounding Vancouver's Insite, while Salmon et al. 2010 found a greater reduction in ambulance callouts for overdose in the Kings Cross postcode housing the Sydney MSIC than for the rest of New South Wales. Donnelly and Mahoney found a null effect of the Sydney MSIC on crime in the Kings Cross neighbourhood, while Myer and Belisle found a significant reduction in property and violent crime in the area surrounding 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 relies 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.).

Deaths only increased in Vancouver

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 overdose mortality for Vancouver after Insite's 2003 opening as per screenshot of their records 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 A).


**BRITISH
COLUMBIA**

**BC Coroners Service
Illicit Drug Deaths 1997 to 2007**

Ministry of Public Safety and Solicitor General

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
18 and under	1	0	1	0	1	0	0	0	0	0	0	185 Mile House	0	0	0	0	0	0	0	0	0	0	0
19-29	37	42	40	42	39	38	32	31	29	21	19	185 Mile House	0	0	0	0	0	0	0	0	0	0	0
30-39	11	10	10	10	10	10	10	10	10	10	10	Abbotsford	0	0	0	0	0	0	0	0	0	0	0
40-49	80	77	75	67	72	66	60	55	52	52	41	Abbotsford	0	1	2	1	1	1	0	0	0	0	1
50-59	52	50	48	38	32	13	19	20	24	30	17	Abbotsford	0	0	0	1	0	0	0	0	0	0	0
60 and over	7	5	4	2	5	7	0	1	3	7	4	Abbotsford	0	0	0	0	0	0	0	0	0	0	0
Total	200	226	218	184	180	179	240	240	276	417	210	Abbotsford	0	1	2	1	1	1	0	0	0	0	1
												Black Creek	0	0	0	0	0	0	0	0	0	0	0
												Bonnieville	0	1	0	0	0	0	0	0	0	0	0
												Bracknell	0	1	0	0	0	0	0	0	0	0	0
												Bracknell	0	1	0	0	0	0	0	0	0	0	0
												Bracknell	0	1	0	0	0	0	0	0	0	0	0
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The same study also claimed overdose reductions by 35% in the area immediately surrounding Vancouver's Insite. Drug Free Australia's Australian/Canadian/US team of epidemiologists and addiction specialists demonstrated in 2012 that Marshall et al. *had concealed the tripling of police numbers around Insite in 2003*, falsely claiming that this was temporary when in fact it was permanent, as attested by the DTES Area Commander at that time, John McKay (See Appendix B).

Such policing served to disperse drug dealers away from the area around Insite, reducing crime and loitering, and of course overdoses as users purchased their drugs elsewhere. Policing alone was shown to be demonstrably capable of reducing overdoses around Insite by 35%. *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.*

Sydney study's own data falsifies it

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. This can be clearly seen in the ringed cells on the spreadsheet below.

	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					Total all hours
	During Op hours		Outside Op 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. 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):

- Reduce discarded needles on streets** - "Local people record no difference in seeing discarded injecting equipment" (p 76 of the review)
- 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)
- 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)
- Referrals to treatment and other services** - "in the first year of operation (the MSIR) has not demonstrated higher levels of service take-up for MSIR users as compared with other people who use drugs." (p 48).
- 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.
- 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.

See Appendix C for similarities in all evaluation results for the Sydney injecting room.

Drug Free Australia has urges both NSW and Victorian governments to fully review the science on injecting rooms to see whether the funds invested in these interventions can be better used elsewhere. Clearly, the science does not favour injecting rooms.

PILL TESTING

Ecstasy causal in almost all pill 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. This study extended the data beyond the MDMA-related deaths from July 2000 and December 2005 examined in the only other Australian study of ecstasy deaths.

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

Very few deaths from adulterants

No more than 5% of Australian ecstasy-related deaths, according to the above study, 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 other party drugs

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

Again there are a handful of deaths from party drugs other than ecstasy, with a number of NBOMe deaths identified by Google search between 2012 and 2016, where evidence indicates the deceased users knew what they were taking. Notably, three Melbourne deaths in January 2017 were caused by pills containing 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").

But pill testing greenlights ecstasy

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

Causes of MDMA-related deaths

- Individual vulnerabilities to MDMA - Pill testing cannot test for individual vulnerabilities
- MDMA used with alcohol, cocaine etc - Pill testing tests pills, not user blood samples
- Accidents, mostly car accidents - Pill testing 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

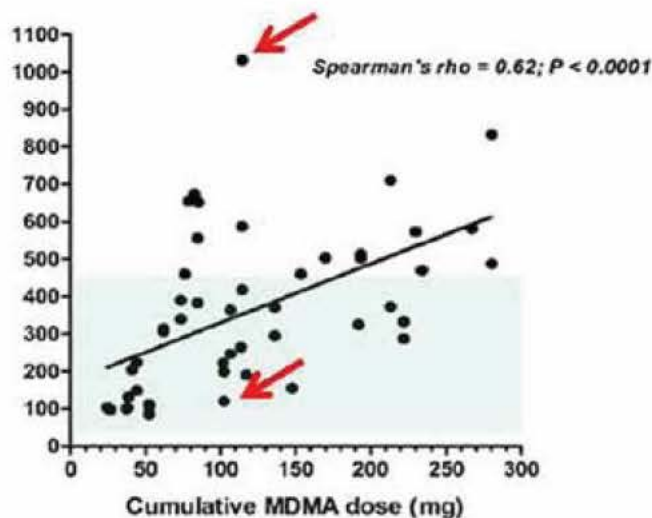


Figure 4 The relationship between maximum plasma 3,4-methylenedioxymethamphetamine (MDMA) concentration (C_{max}) and cumulative MDMA dose consumed by the time of maximum plasma concentration ($n=49$). Correlation coefficient (Spearman's rho), P-value and line of best fit are shown ($n=49$ participants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

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.

Users MORE likely to take ecstasy once tested

The Australian National University evaluation of the 2019 Canberra pill testing trial confirms that the methods used by Pill Testing Australia to classify 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 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 urges the Inquiry to consider the science on pill deaths within Australia and to remove its support for Harm Reduction and any intervention which will only increase ecstasy use and deaths.

SUMMARISING HARM REDUCTION

Any Federal Inquiry that seeks to visit the subject of harm reduction, and how policing should relate to it must recognise the following:

- Australia's drug policy since 1985 has made harm reduction a central plank
- The science on harm reduction interventions consistently shows a failure to demonstrate any statistically significant positive effectiveness
- Worse still, some specific harm reduction programs such as injecting rooms and pill testing have been shown to increase drug use, which only puts more demand on policing at a State and Federal level
- Consistent with the science, Australia has only ever seen ongoing increases in drug use over the last 37 years, excepting when Tough on Drugs, with a greater emphasis on rehabilitation and prevention, was operative. Australia then reduced its drug use by 39%, drawing the applause of the United Nations Office of Drug Control. It saved thousands of lives.
- Given a science demonstrating the failure of harm reduction interventions, the harm reduction approach - which was also still operative under Tough on Drugs - can only have interfered with Tough on Drugs between 1998 and 2007, where the already successful reductions in drug use could have been even more significant.

SUCCESSFUL INTERVENTIONS

Government must follow Sweden's success

In 2007 the United Nations Office on Drugs and Crime (UNODC) produced a booklet titled Sweden's Successful

Drug Policy – A Review of the Evidence.

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

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



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

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

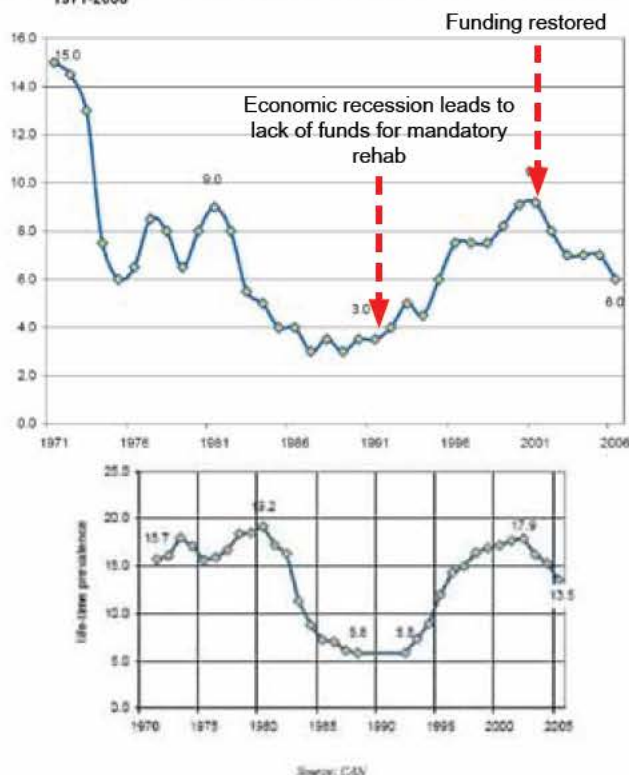
- Coerced rehabilitation
- Education
- Thoughtful and caring policing while maintaining criminal sanctions

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

Following are graphs from the UN report showing the percentage of Swedish high school age young people (aged 15-16) and Swedish conscripts (aged 18-19) that have ever experimented with illicit drugs. Sharp decreases in illicit drug experimentation are evident in the 80's when the Swedes heavily funded their restrictive program, and then increased in the 90's once they relaxed funding for their drug program due to a poorer economy. In 2004, the Swedish government admitted it had become too relaxed about illicit drug use, and increased funding again. High school student lifetime prevalence for illicit drug use was back to 6% in 2006.

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

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



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

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

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

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

Iceland shows what kind of education works

A resilience-based approach to drug prevention was very successfully trialed in Iceland, as reported in the journal, Substance Abuse, Treatment, Prevention and Policy 2008, 3:12.

Adolescent cannabis use was reduced by 65% as per documentation at Appendix D.

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

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

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

- Educating parents about the importance of emotional support, reasonable monitoring, and increasing the time (we don't have an emphasis on this...) they spend with their adolescent children.
- Encouraging youth to participate in organized recreational and extracurricular activities and sports.
- Working with local schools in order to strengthen the supportive network between relevant agencies in the local community.

The research underlined the importance of the adolescent-parent relationship, the powerful influence of the peer group, and a commitment to facilitate the participation of adolescents in guided recreational and extracurricular activities, such as sports and organized youth work. The research helped to conceptualize the prevention effort as one that sought both to reduce the potentially-modifiable risk factors for substance use while at the same time strengthening community-level protective factors. Thus, the approach focused not only on reducing risk factors, but also on mobilizing society to foster responsible guardianship, community attachment, and informal social control, all on the

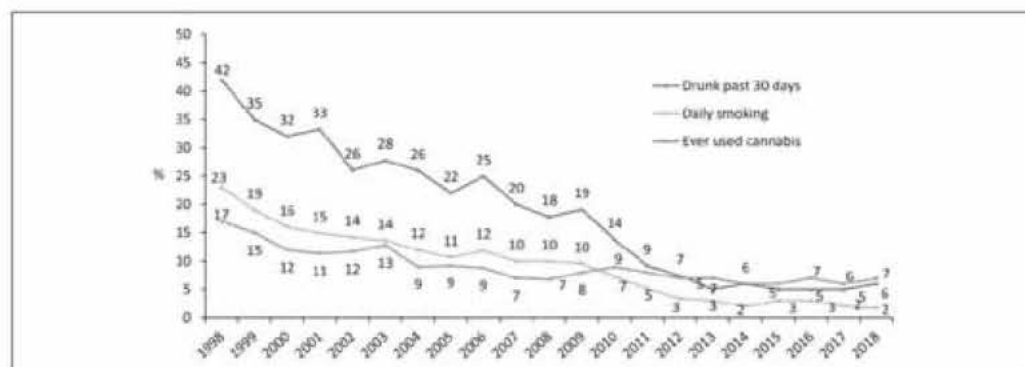


FIGURE 2 Annual Percentage of Self-Reported Substance Use Among Icelandic Adolescents, 1998-2018
SOURCE: Kristjánsson et al. (2016).

local community level. This effort has come to be known as the Icelandic Model of Adolescent Substance Use Prevention. It is important to demonstrate that this approach is not merely a "program" in the conventional sense with a given time frame, but rather a long-term effort to alter society on behalf of young people in Iceland in order to decrease the likelihood of adolescent substance abuse...

Table 4.6: Recent⁽¹⁾ illicit use of drugs, people aged 14 and over, 2001 to 2019 (per cent)

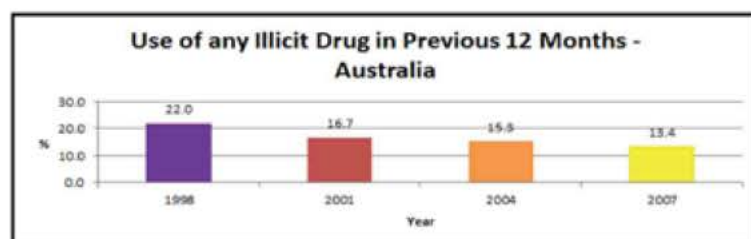
Drug/behaviour	Proportion						
	2001	2004	2007	2010	2013	2016	2019
Illicit drugs (excluding pharmaceuticals)							
Marijuana/cannabis ⁽²⁾	12.9	11.3	0.1	10.3	10.2	10.4	11.6 [†]
Ecstasy ⁽³⁾	2.9	3.4	3.5	3.0	2.5	2.2	3.0 [†]
Meth/amphetamine ⁽⁴⁾	3.4	3.2	2.3	2.1	2.1	1.4	1.3
Cocaine	1.3	1.0	1.8	2.1	2.1	2.5	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	0.8	0.3	0.2	0.2	0.3	0.4	0.9 [†]
GHB	0.8	0.1	*0.1	0.1	*0.1	*0.1	*0.1
Synthetic Cannabinoids	0.8	0.8	0.8	0.8	1.2	0.3	0.2
New and Emerging Psychoactive Substances	0.8	0.8	0.8	0.8	0.4	0.3	*0.1 [†]
Injected drugs	0.6	0.4	0.5	0.4	0.3	0.3	0.3
Any illicit ⁽⁵⁾ 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 ⁽⁶⁾	0.8	0.8	0.8	0.8	0.8	3.6	2.7 [†]
Tranquillisers/sleeping pills ⁽⁷⁾	1.1	1.0	1.4	1.5	1.6	1.6	1.8
Steroids ⁽⁸⁾	0.2	*0.1	*0.1	0.1	*0.1	*0.1	0.2
Methadone or Buprenorphine ⁽⁹⁾	0.1	*0.1	*0.1	0.2	0.2	0.1	0.1
Non-medical use of pharmaceuticals ⁽¹⁰⁾	0.8	0.8	0.8	0.8	0.8	4.6	4.2 [†]
Illicit use of any drug							
Any opioid ⁽¹¹⁾	0.8	0.8	0.8	0.8	0.8	3.7	2.9 [†]
Any illicit ⁽¹²⁾	16.7	15.3	13.4	14.7	15.0	15.6	16.4

Since Tough on Drugs was discontinued in 2008, illicit drug use has increased 22%.

Tough on Drugs – reductions of 39%

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

Television advertising such as this and this was used

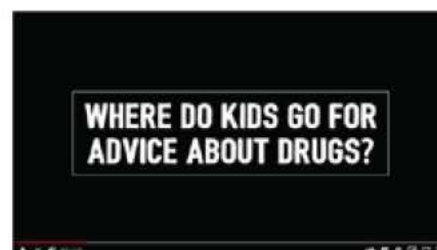


to put Australia's drug problem, which was then the highest in the developed world, front and centre with the Australian public.



Every household with children in Australia was posted a booklet on how parents should talk to their children about drugs.

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



A proven pathway to less drug use

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

That policy must include resilience-based education in high-schools and a priority on coerced rehabilitation of drug users via Australia's drug courts.

2025 household survey must ask more

For decades now the NDS Household Survey has asked Australians about their support for largely drug-liberal measures, reflecting a progressive bias. It has failed to ask whether Australians support drug courts mandating rehab, federal funding for Naltrexone maintenance and other important interventions based on a premise of 'less drugs, not more.'

Consider the costs

With a conservative estimate of social and economic costs of \$25 billion per year in Australia for illicit drug use, there are plenty of savings to be made by rehabilitating away Australia's drug problem. The high cost of drug use can justify considerable funding for reducing the tremendous cost to the country and citizens.



CRYPAR illustrates the ongoing anomaly

The central question regarding Australian governments adherence to harm reduction policies against all good evidence demonstrating a lack of effectiveness, is Why?

If Australia espouses a drug policy that is evidence-based and yet the evidence shows a failure to demonstrate positive effect, and at worst, a clear negative signal indicating increases in drug use levels across the Australian population, then Parliamentarians should be bound to act.

CRYPAR, a program centred on early intervention by police with at-risk young people who were offending or likely to offend, has been set for closure by the Queensland Government which initiated it. Qualitative results were very positive while quantitative results were similar to the results of needle and syringe programs, where results were inconclusive.

The anomaly with government drug policy is that CRYPAR is being closed, despite the qualitative success of the program, while Australia's harm reduction programs continue unchallenged in the face of no demonstrated effect. Programs such as injecting rooms and pill testing indicate demonstrable increases in drug use - something which Australians do not want - and yet every support is given.

The Federal Government needs to cease all commitment to harm reduction and encourage States to do the same. It is an ideology for which its time has come.

Weaknesses of decriminalisation

Evidence must adjudicate drug policy

There is currently a push particularly by the NSW Greens and ACT Labor/Greens who want to decriminalise all drugs following the failed Portugal model.

Given that Australia still asserts that all drug policy must be evidenced-based, we will here demonstrate from copious evidence that drug decriminalisation:

- will decimate the social fabric of any country or State that implements it, as so painfully visible in cities such as San Francisco and in Democrat States like California and Oregon, where citizens are lining up to leave
- will only increase the use of illicit drugs, which goes against the values held by Australians, where we have demonstrated in our first chapter that Australians want less drug use, not more
- will make criminal suppliers only more wealthy as use of their criminally supplied drugs increases

We can't become another San Francisco

So many people are fleeing California and shifting to other US states, that California will lose a representational seat in Congress as a result, such has been the exodus.

One of the major reasons cited by those who are leaving is the unchecked issues with homeless people who are very visibly camping on major city streets throughout California.

Because drugs are causal in many mental health cases, which in turn are involved in most cases of homelessness, much of the problem can be slated back to California's liberalisation of drug policy in the last decade, including the 2014 decriminalisation of all hard drugs. This is a policy the ACT Government appears to

be rushing to emulate, with grave policing implications.

A 2019 article in the centrist Forbes magazine well-describes the connection between California's liberalised drug policies and the homelessness which is driving residents away to other states. From the article:

"I've rarely seen a normal able-bodied able-minded non-drug-using homeless person who's just down on their luck," L.A. street doctor Susan Partovi told me. "Of the thousands of people I've worked with over 16 years, it's like one or two people a year. And they're the easiest to deal with." Rev. Bales agrees. "One hundred percent of the people on the streets are mentally impacted, on drugs, or both," he said.

The decriminalisation of all drugs is a central cause of California's homelessness problem, as stated in the Forbes article:

Bales says people have little incentive to do treatment (i.e. rehab – our clarification) when there is no threat of jail time. . . . Things went further in this direction with the passage of Proposition 47 in 2014, which decriminalized hard drugs and released nonviolent offenders from prison without providing after-care support.

"Our guests went from 12 - 17% addicted to 50% or higher," Bales says. "Policymakers need to understand that if you allow the use, you also allow the sales, and if you allow the sales, then you allow the big guys to break your legs when you owe them money," says Bales.

Australians want less drug use, not more. According to the 2019 Federal Government NDS Household Survey 99% of Australians do not give their approval to the regular use of heroin, ice and speed, as with cocaine (97%) and ecstasy (96%). If Australian States want to recreate the problems of San Francisco and L.A. it will

decriminalise all drug use.

Removing the possibility of a criminal conviction is precisely what makes Australian drug courts and MERIT programs a success in getting users off to rehab and off their drugs, rather than continuing to harm themselves, their children, partners, parents, friends and workmates. Liberal drug policies helped create California's problems.

We don't want to be like Oregon

Decriminalisation in Oregon has had very measurable harms with a 217% increase in opiate mortality since decriminalising all drugs in mid-2021. Within 10 months overdose deaths had increased from 280 to 607 deaths. Not even a year had elapsed.

These are the real world impacts of decriminalisation. We will return to Portugal in more detail after recording the standard arguments against decriminalisation.

ARGUMENTS AGAINST DECRIMINALISATION

Drugs harm much more than the user

- Illicit drug use adversely affects a whole constellation of people – the drug user's partner, their children, their children's grandparents, siblings, friends, workmates, other road users, and the rest of the community (crime, welfare etc) drawn into the vortex of their drug use
- The unacceptable harms of drug use are attested by a simple fact – our governments have spent hundreds of millions of dollars on 'harm reduction' programs for drug use – it's in the name

Why there must be legal consequences

- Illicit drug use has historically attracted a conviction because of the unacceptable harms it causes to so many. For instance, the value of lost retirement and savings for grandparents raising their grandchildren due to drug-dependent parental neglect represents a 'stolen' cost infinitely greater than petty sums attracting criminal sanctions for shoplifters or embezzlers
- 96-99% of Australians do not approve the regular use of heroin, ice, speed, cocaine or ecstasy, suggesting that Australians would want less drug use, not more, which only rehab and recovery can achieve, making them mandatory. Decriminalisation will never drive recovery – it removes all meaningful limits or deterrence value in drug laws (e.g. by scrapping our drug courts), being little different to fully legalising drugs practically-speaking
- With no legal coercion for a user to cease drug use

by entering rehab, drug use markedly increases as it has in Portugal (their preferred model), which decriminalised all illicit drugs in 2001 only to see drug use rise 59%, overdose deaths rise 59% and drug use by high school minors up 60% by 2017. By comparison, Australia's Federal Tough on Drugs policy from 1998 to 2007 reduced comparable drug use 42% and overdose deaths 68% by maintaining convictions and funding more rehab. Portugal increased societal harms, Australia reduced them

- Drug Free Australia promotes 'spent' convictions, where a criminal record is totally erased if a drug user can return drug free tests over a three-year period

Keeping drugs illegal works

- 73% of Australians say they have no interest in illicit drugs. Relevant to the remainder that likely would have an interest, 32% of Australians say they don't use drugs because of their illegality. If cannabis was legalised here, 10% who've never tried it would use it, and 3% who use it would use more, multiplying the established harms caused by cannabis
- Changing the legal status of drugs removes these deterrents. When cannabis was decriminalised in the ACT in 1992, 43% of Territorians thought it was now legal to use, explaining its skyrocketing use by 1993 where monthly use amongst lifetime users went from 0% to 31%

All use is problematic

- The argument that few have problematic drug use is contradicted by Australia's most prolific researcher on heroin use, Prof. Shane Darke, who wrote that very few heroin users "use it in a non-dependent, non-compulsive fashion."
- Their argument ignores the harms of occasional use where, for instance, 29% of ecstasy deaths in Australia are from car crashes endangering the lives of passengers as well as people in other vehicles. Their argument is akin to saying that drivers who speed on our roads without causing loss of life should not be penalised for speeding. But the law does not work that way. And occasional users still promote their drug use to friends and family who can become dependent, in fact 3 in every 5 Australian illicit drug users were introduced to drug use this way

There is no 'right' to use drugs

- A recent Uniting Church document supporting drug decriminalisation argued that our drug laws should "reflect the essential worth and rights of

every person.” But Australian drug users have never been denied any right available to any other Australian. Of greatest importance, there has NEVER been a UN right to use drugs. In fact the UN Convention on the Rights of the Child accords each the right to live unaffected by illicit drug use and the UN Drug Conventions have always kept drugs illegal

- The aforementioned document argues for Equity in drug policy, i.e. all drug use should be treated the same – all must be decriminalised. This is the same principle that guided international drug policy for 110 years – all drugs with unacceptable harms, whether heroin or cannabis, should be equally illegal

A more detailed response to the ACT/NSW Uniting Church document is found at Appendix E.

PORTUGAL'S FAILURE

Portugal decriminalisation feeding criminal supply

As already stated, Portugal's increased drug use since decriminalising the use of all drugs in mid-2001, has only served to enrich its criminal class. Increased illicit drug use yields increased profits for criminals.

Following is a more detailed look at what has happened in Portugal.

The truth on Portugal's decriminalisation

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

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

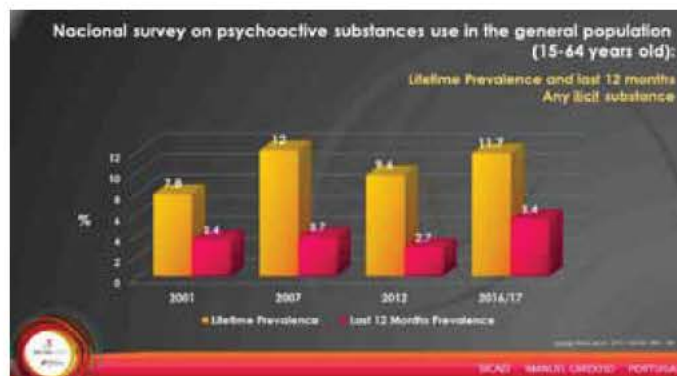
By 2017 drug use was 59% higher than in 2001

The figures for overall illicit drug use in Portugal for their last survey in 2017 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%

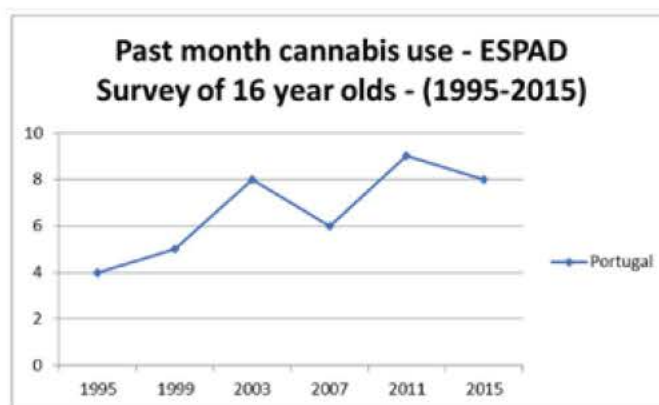


Note that Portugal's drug use in 2017 for those aged 15-64 was 59% higher than in 2001. This would be an alarming outcome for any country, demonstrating that Portugal's drug policy fails to deter rising drug use.

Portugal's model includes more treatment. Its decriminalisation model includes increased treatment expenditures. Despite the extra treatment, the model has not worked.

High School drug use 60% higher in 2015

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.



Drug deaths in Portugal increased 59%

Claims that there were significant decreases in

Overdose deaths > Trends > EMCDDA 'Selection B'

Download as Excel file (.xlsx)

Search:

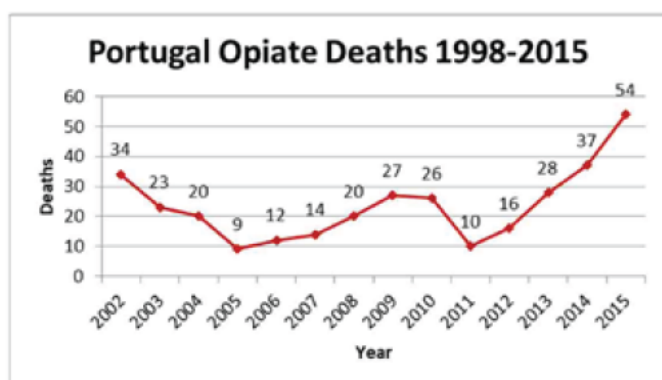
Country	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000
Poland	1	2	2	0	0	1	1	0	1	1	1	1	0	1	1	1	1
Portugal	54	37	28	16	10	26	27	20	14	12	9	20	23	34			
Romania *	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

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

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.

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.

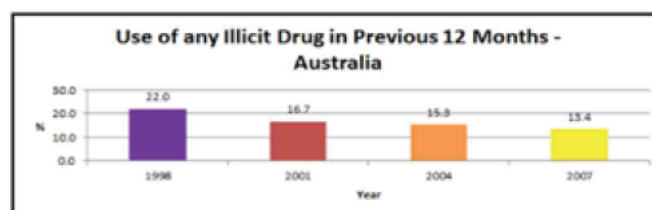


Early decreases between 2002 and 2005 are part of the same decreasing trend in opiate use, as noted previously, which predated decriminalisation with reductions from 0.9% in 1998, to 0.7% in 2000. These decreases were not due to decriminalisation because they were not a part of it. Decriminalisation 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. Entire Portugal data at Appendix F.

Compare Tough on Drugs to Portugal

Portugal's drug use graph should be compared with Australia's Tough on Drugs results charted 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 will certainly indicate similar increases in opiate use.

This is not what Australians want or expect.

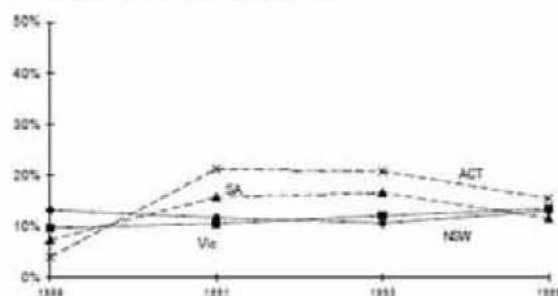
INCREASED USE ELSEWHERE

Decriminalisation accelerated Australian use

South Australia decriminalised cannabis in 1987, followed by the ACT in 1993. The following graphs 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.

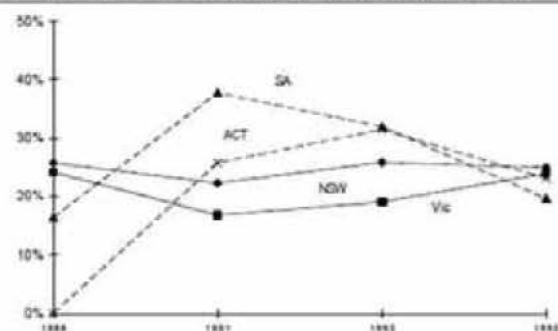
SA offences went from 6,231 in '87/'88 to 17,425 in '93/'94 and when researchers asked users about the increases, many said "We thought cannabis was now legal."

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



Source: NDS 1988, 1991, 1993, 1996

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



Source: NDS 1988, 1991, 1993, 1996; those who have never tried marijuana are excluded

Decriminalisation in the USA increased use

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

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

By contrast, increases in US cannabis use overall from 1973-76 were negligible, as per the US Household Surveys (below). We note that the reducing use from

the US 1980s 'Just Say No' campaign is also evident in the same survey results, something drug law reformers try to deny.

CRIMINAL PROFIT

Increased use = increased criminal profit

There can be absolutely no dispute that decriminalisation lines the pockets of criminals dealing in drugs.

If Federal Parliament wants to implement drug policies that fit with Australian attitudes towards illicit drug use, and wants to do everything to maximise Federal and State policing of illicit drug use, then it must do everything to avoid boosting the influence and reach of the criminal class, from which police work to protect society.

Such a conclusion is so obvious as to be facile, and Drug Free Australia urges politicians to act for Australians rather than other interests.

Decriminalisation's diffusion effect

A final issue for policing is the diffusion effect of decriminalisation, where legislation allows for reasonably substantial amounts of an illicit drug to be carried by individuals without being deemed to be a drug dealer.

Because penalties for drug dealing remain high in any decriminalisation regime, top level drug dealers use a whole array of drug users to deal drugs - all carrying the smaller quantities that don't attract any criminal penalty.

Decriminalisation thus exacerbates the problem of drug dealing through the diffusion effect.

This needs to be carefully considered in this Inquiry, given the implications for policing.

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	26.0	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
35+ 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	36.7	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
35+ 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

Recommendations

1. A **Parliamentary Inquiry**, as a matter of urgency, examining the need for the up-Scheduling of medicinal cannabis, as well as hemp CBD, given that scientific studies have established in 2021 and 2022 that it is:

- causal in 33 cancers, more than double tobacco's 14 cancers
- causal in 70% of pediatric cancers
- causal in 89 of 95 birth defects including autism
- transmitting all of the above to future generations, thereby severely damaging individuals other than the users themselves
- a chief cause of mental health disorders

Such an Inquiry needs to examine the current science and legislate for the sake of Australia's future.

2. Federal Police give careful study to CBD as a biological 'precursor' to Delta-8/10 derivatives which have the dangers of Delta-9 THC.
3. In that Federal Police were able to save literally thousands of lives via excellent work during the 1998-2007 Tough on Drugs era, that Federal Police again be given similar scope to curtail the criminal supply of prescription opiates, wherever those investigations might lead.
4. Reject all calls for the legalisation of Ecstasy, given that Australian studies have demonstrated that MDMA is responsible for almost all Australian party pill deaths.
5. A **Parliamentary Inquiry** be set up, as a matter of urgency, on the failure of Harm Reduction programming in Australia where the most authoritative reviews and evidence shows:
- **Methadone maintenance** - no effectiveness
 - **Needle/Syringe programs** - no effectiveness

- **Injecting rooms** - increased drug use, deaths and reduced public amenity
- **Pill testing** - increased use of Ecstasy

6. Lead Australia's drug policy by discouraging States from decriminalising all drugs on the grounds that all decriminalisation attempts have only ever increased drug use, thereby lining the pockets of drug dealers who make more sales and frustrating policing efforts.
7. Outright reject the ACT's moves to decriminalise the use of all drugs by overriding their legislation, as the Federal Government did in 1996 with heroin on prescription and also clarify that their legislation to legalise cannabis use is overridden by Federal agreements to international Drug Conventions.
8. Consult with drug prevention agencies within Australia as to **what questions need to be added to the National Drug Strategy Household Survey for 2025** that reflect drug prevention priorities, such as:
- Australians' support for 'mandatory rehabilitation' for long-term drug users
 - support for government-funded Naltrexone maintenance programs to get users off drugs
 - Rehab programs in prison
9. With a conservative estimate of social and economic costs of \$25 billion per year in Australia for illicit drug use, (where costs of cannabis' cancers, birth defects and premature aging are not included), prioritise Federal funding for rehabilitation to ultimately remove those costs, making abstinent outcomes the carrot for all Federal-funded programming using the existing government-funded fee-for-outcomes model utilised for the long-term unemployed.

Appendices

LIST OF APPENDICES

Appendix A

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

Appendix B

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

Appendix C

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

Appendix D

Iceland success documentation

Appendix E

Detailed response to Uniting Church document urging decriminalisation of all drugs

Appendix F

Entire data on Portugal with full explanation of their conflicting mortality tables in the EMCDDA annual reports

Overdose deaths and Vancouver's supervised injection facility

The report by Brandon Marshall and colleagues (April 23, p 1429),¹ in which it is claimed that the opening of a supervised injection facility on Sept 21, 2003, in Vancouver, BC, Canada, was associated with a 35% decrease in overdose deaths in its immediate surrounding, contains serious errors.

The claim that all overdose deaths in Vancouver declined between 2001 and 2005 is strongly affected by the highly questionable inclusion of the year 2001—a year of much higher heroin availability and overdose fatalities than all subsequent years. A study period starting from 2002 in fact shows an increasing trend of overdose deaths both for Vancouver and for the Downtown Eastside area in which the facility, Insite, is situated (figure),² the control areas compared in Marshall and colleagues' study.

Curiously, the higher availability of heroin up until 2001, which declined by 2002 and which has remained low since that year, was specifically tracked in two previous articles^{3,4} by three of the current paper's researchers and therein treated as extraordinary. In their latter 2007 study,⁴ the aforesaid three researchers noted that, in a large cohort of Vancouver drug users, 21% had reported non-fatal overdoses in the previous 12 months in 1997, dropping to 12% at the beginning of 2001 and to 5% by the end of 2001, rising to 6% in 2004. They clearly point to reduced heroin supply as the reason, and yet in the *Lancet* paper specifically state that "we have no evidence that significant changes in drug supply or purity occurred during the study period", which of course was 2001 to 2005.

Of even greater concern is the statement in the *Lancet* paper that "we know of no changes in policing policy that could have confounded our results". Again, three of the

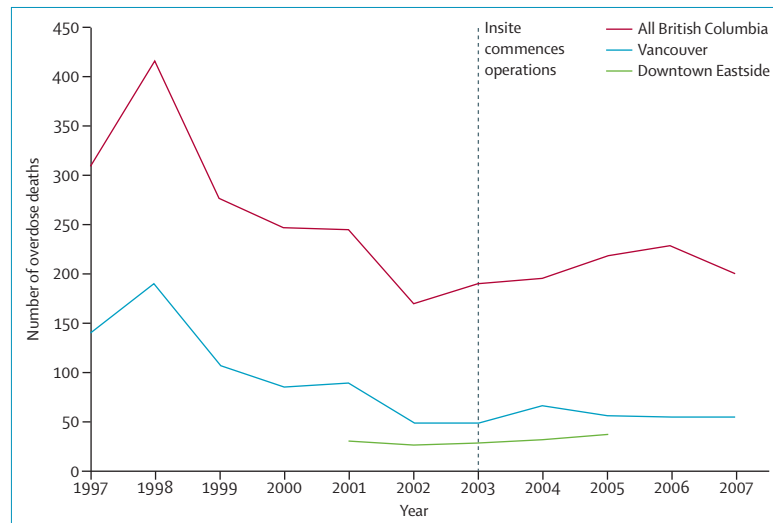


Figure: Drug overdose deaths 2001–05

researchers were so well apprised of major policing changes in the area immediately around Insite during 2003, the same year it opened, that they wrote a 2004 article tracking the "displacement" of drug users out of the policed area around Insite and into other areas of Vancouver.⁵ In that article they record counts of discarded needles reducing by 46% in the policed areas whereas needle counts in other areas of Vancouver increased by similar proportions. Most of the overdoses that were the subject of the questionable 35% reduction immediately around Insite lay specifically in the 12 city blocks patrolled by 48–66 police added in 2003 and operative to this day (personal communication). This major change in policing around Insite is clearly the most likely cause of any real reductions in overdoses that might be found in the immediate vicinity of the injection facility.

Finally, Marshall and colleagues do not declare that 41% of British Columbia's overdose mortality is non-injection-related.⁶ This being the case, the researchers had the obligation of declaring the specific proportion of deaths that were non-injection-related in the vicinity of Insite, compared with the rest of Vancouver.

An extended analysis is available online. We declare that we have no conflicts of interest.

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Robert DuPont, Colin Mangham

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- 1 Marshall BDL, Milloy M-J, Wood E, Montaner JS, Kerr T. Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. *Lancet* 2011; **377**: 1429–37.
- 2 Ministry of Public Safety and Solicitor General. Illicit drug deaths 1997 to 2007. <http://www.pssg.gov.bc.ca/coroners/publications/docs/stats-illicitdrugdeaths-1997-2007.pdf> (accessed Dec 7, 2011).
- 3 Wood E, Stoltz JA, Li K, Montaner JS, Kerr T. Changes in Canadian heroin supply coinciding with the Australian heroin shortage. *Addiction* 2004; **101**: 689–95.
- 4 Kerr T, Fairbairn N, Tyndall M, et al. Predictors of non-fatal overdose among a cohort of polysubstance-using injection drug users. *Drug Alcohol Depend* 2007; **87**: 39–45.
- 5 Wood E, Spittal PM, Small W, et al. Displacement of Canada's largest public illicit drug market in response to a police crackdown. *CMAJ* 2004; **170**: 1551–56.
- 6 Milloy MJ, Wood E, Reading C, Kane D, Montaner J, Kerr T. Elevated overdose mortality rates among First Nations individuals in a Canadian setting: a population-based analysis. *Addiction* 2010; **105**: 1962–70.

For the extended analysis see http://www.drugfree.org.au/fileadmin/Media/Global/Lancet_2011_Insite_Analysis.pdf

Submissions should be made via our electronic submission system at <http://ees.elsevier.com/thelancet/>

Authors' reply

Gary Christian and colleagues raise various concerns in reference to our paper that showed a 35% reduction in overdose mortality within the vicinity of Vancouver's supervised injecting facility. They refer to publicly available data from the British Columbia Vital Statistics Agency to argue that overdose deaths increased rather than decreased in the geographic area of interest between 2001 and 2005. This apparent discrepancy can be explained by several problematic assumptions that underlie Christian and colleagues' critique.

First, our study focused on an a-priori-defined area in close proximity to the supervised injecting facility that included 41 city blocks, the centroid of each being within 500 m of the facility. The data considered by Christian and colleagues refer to a much larger region (ie, the entire local health area) that includes about 400 city blocks (figure). As shown clearly in figure 3 of our paper,¹ the reduction in overdose mortality was only noted in close proximity to the supervised injecting facility, with the effect diminishing strikingly beyond this area.

Second, although we restricted our analysis to deaths deemed by the coroner to be caused by an accidental illicit drug overdose, the data referred to by Christian and colleagues include all drug-induced deaths (eg, suicides and adverse effects of drugs in therapeutic use).² Finally, we examined mortality rates as opposed to absolute death counts to account for changes in the population at risk.

Christian and colleagues further claim that the noted reduction in overdose mortality was due to increased heroin availability in 2001; however, we have previously published data to show that daily heroin use remained stable between 2001 and 2005.^{3,4} These data were referenced in our original report. Additionally, publicly available assessments of the police crackdown to which Christian and colleagues refer show that this operation ended within weeks of the

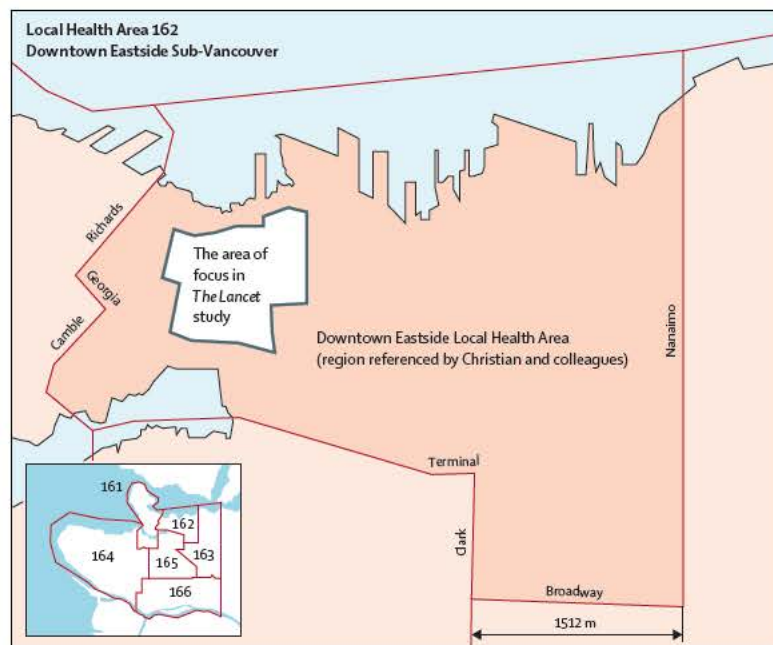


Figure: Comparison of geographic regions defined as the area of interest in our paper versus that referred to by Christian and colleagues

Figure modified and reproduced from publicly available documentation maintained by BC Stats. For this documentation see <http://www.bcstats.gov.bc.ca/data/pop/maps/LHApdf/hamap162.pdf>.

opening of the supervised injecting facility and was not ongoing as they claim;⁵ therefore, any brief displacement of drug users would have probably resulted in a conservative bias by differentially reducing overdose mortality in the area of interest before the facility's opening.

Finally, regarding mode of drug use, we note that coroners' records do not indicate whether deaths were injection-related or not. However, if we restrict our analysis to records in which injection drug use was indirectly suggested, including for example discarded injection paraphernalia surrounding the decedent (ie, 85% of the original 89 deaths occurring within 500 m of the supervised injecting facility), our estimate for the reduction in overdose mortality is slightly greater at 36%.

The results of our study show that Vancouver's supervised injecting facility had a localised yet significant effect on overdose mortality. These facilities can and should be a central component of evidence-based responses to reducing drug-related harms in communities

with a high burden of overdose related to injection drug use.

JSGM has received educational grants from and served as an ad-hoc adviser to or speaker at various events sponsored by Abbott Laboratories, Agouron Pharmaceuticals, Boehringer Ingelheim, Boreon Pharma, Bristol-Myers Squibb, DuPont Pharma, Gilead Sciences, GlaxoSmithKline, Hoffmann-La Roche, Immune Response Corporation, Incyte, Janssen-Ortho, Kucera, Merck Frosst Laboratories, Pfizer Canada, Sanofi Pasteur, Shire Biochem, Tibotec, and Trimeris. All other authors declare that they have no conflicts of interest.

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- 1 Marshall BD, Milloy M-J, Wood E, Montaner JSG, Kerr T. Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. *Lancet* 2011; **377**: 1429-37.
- 2 British Columbia Vital Statistics Agency. Selected vital statistics and health status indicators. <http://www.vs.gov.bc.ca/stats/annual/2005/pdf/ann05.pdf> (accessed Oct 22, 2011).

- 3 Wood E, Stoltz JA, Li K, Montaner J, Kerr T. The cause of the Australian heroin shortage: time to reconsider? *Addiction* 2006; **101**: 623–25.
- 4 Urban Health Research Initiative of the British Columbia Centre for Excellence in HIV/AIDS. Drug situation in Vancouver. <http://uhri.cfenet.ubc.ca/images/documents/dsiv2009.pdf> (accessed Dec 9, 2009).
- 5 Dandurand Y, Griffiths C, Chin V, Chan J. Confident policing in a troubled community: evaluation of the Vancouver Police Department's city-wide enforcement team initiative. <http://www.vancouveragreement.ca/wp-content/uploads/ConfidentPolicing2004sm.pdf> (accessed Oct 22, 2011).

In the MAPS trial, Cathryn Glazener and colleagues¹ noted similar high rates of incontinence at 12 months after radical prostatectomy or transurethral resection of the prostate in patients randomised to therapist-guided pelvic-floor muscle training or to standard care. We did a similar trial after radical prostatectomy,² which Glazener and colleagues state had unexplained differential dropout from the control group. We wish to add some comments on this matter as well as on other aspects of Glazener and colleagues' Article.

First, the relatively high dropout rate (13 of 53) in the control group of our trial² did not jeopardise the

randomisation efficacy of the two groups. Additionally, the heterogeneity of a Cochrane meta-analysis, to which Glazener and colleagues suggest that our trial added, is due to variability in several features, such as patient selection, surgeon technique and volume, definition of urinary incontinence, duration and frequency of training, and choice of control.

Second, in our trial, long-term physician-guided pelvic-floor muscle training until urinary continence was achieved or for up to 12 months proved to be more effective than no training. This effect is supported by the results of a randomised trial by Overgård and colleagues,³ which showed that patients who received long-term physiotherapist-guided pelvic-floor muscle training compared with those training on their own had a significantly lower incontinence rate at 12 months (3 of 36 vs 11 of 39), despite a similar continence rate at 3 months.

Third, although in the MAPS trial¹ a pad test was not used because of practical difficulties and the apparently more important role of subjective incontinence measures, we consider it important to discriminate the degree of incontinence, since in our² and others'⁴ experience pelvic-floor muscle training seems to be more effective for mild and moderate incontinence.

We declare that we have no conflicts of interest.

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1 Glazener C, Boachie C, Buckley B, et al. Urinary incontinence in men after formal one-to-one pelvic-floor muscle training following radical prostatectomy or transurethral resection of the prostate (MAPS): two parallel randomised controlled trials. *Lancet* 2011; **378**: 328–37.

2 Manassero F, Traversi C, Ales V, et al. Contribution of early intensive prolonged pelvic floor exercises on urinary continence recovery after bladder neck-sparing radical prostatectomy: results of a prospective controlled randomized trial. *Neurourol Urodyn* 2007; **26**: 985–89.

A second letter was sent to Lancet on 6 April 2012, a letter which Lancet chose not to publish. We note that the Chief Editor of Lancet is a co-Board member of a drug law reform organisation of which two of the authors of the erroneous Lancet study which we have here addressed are also members as per http://www.icsdp.org/network/scientific_board.aspx.

Gary Christian
DFA Research Coordinator

The Lancet Editor

We have read the authors' response and respectfully repeat our request for retraction of the study on the grounds that the authors' conclusions are based on demonstrable fallacies.

The central fallacy which invalidates the study is the claim that the authors knew of no changes in policing that could otherwise explain their findings. We have previously demonstrated that there was a police crackdown commencing at the mid-point of the study period so effective that drug use indicators were reduced by 46%. This occurred precisely in the Vancouver city blocks where the highest concentrations of overdose mortality studied by the authors had previously occurred. These policing changes readily explain the 35% decrease in overdose mortality around Insite claimed by the authors.

The authors' response also incorrectly claims that the April 2003 crackdown ceased after 6 months, when Insite opened in September 2003. To support that claim the authors cite a City of Vancouver evaluation of the crackdown. However, if read in its entirety, this document clearly states, "as of August 2004, the initiative is still ongoing, albeit in a slightly modified form." [i] [i] At best, the authors' response lacks the appropriate rigour.

Furthermore, we have forwarded a written statement by the Vancouver Police commander directing the ongoing crackdown throughout the second half of the Lancet article's study period ending 2005. This statement unambiguously contradicts the authors' response that the crackdown ceased in September 2003. There was, in fact, only a change of operational name for the policing crackdown (CET became BET) with no significant change in operational approach, personnel or strategy. The continuation of the crackdown to this day is beyond conjecture. On these grounds alone, the authors' central claim about the impact of Insite is rendered invalid. There are, however, other substantive errors in the authors' response.

Plummeting heroin use between 1998 and 2002, which the authors continue to deny in their response, is verified in another study of Vancouver's VIDUS cohort by the same authors. It states, "As indicated in Fig. 1, the proportion of participants reporting a non-fatal overdose has declined steadily since enrolment, with 21% of individuals reporting a non-fatal overdose in 1997 compared with just 6% in 2004. The most substantial decline occurred during 2001, with the proportion of participants reporting a non-fatal overdose declining from 12% to 5% during this year." [ii] [ii]

Consistent with this, Vancouver experienced a 74% decrease in heroin mortality between 1998 and 2002, with non-fatal overdoses decreasing in the VIDUS cohort between 1997 and 2001 (as would be expected) by 76%, as per quote above. Yet the authors' response cites largely irrelevant VIDUS cohort *daily heroin use* figures rather than overdose percentages, in a study focusing on overdose mortality. Where Canadian heroin users were estimated to inject on average four times daily, daily use figures will remain relatively unchanged even

though the average number of daily injections declines along with a 75% reduction in heroin supply and a 75% reduction in overdoses.^[iii]^[iii] Tracking non-fatal overdoses and overdose mortality is a more accurate measure of fluctuations in supply, as is done by these same researchers in two previously studies quoted in our analysis, and by Australian researchers correlating overdose mortality with a heroin drought.^[iv]^[iv] Elevated heroin supply and elevated overdoses ended with 2001, making that year invalid for inclusion in the study period. Its inclusion creates the illusion of a subsequent decline in overdose mortality. In fact there is a trend towards an increase in overdose mortality from 2002 onwards, starting the year before Insite opened.

We also note that the authors' response claims there are flaws in our analysis. We refute these as follows.

1. Contrary to the authors' assertion, Vital Statistics coroner's data are never used in our analysis to infer any increases in overdose deaths in the 41 block area where the claimed 35% decline occurred. Rather, BC Coroner's data is used to show that there was an increasing trend in overdose deaths for the CONTROL AREA of the City of Vancouver, and the Vital Statistics coroner's dataset was used to show that the same increasing trend was true for the 400+ block area around Insite from 2002-2005.
2. Contrary to the authors' assertion, we did exclude the 5 of 155 Vital Statistics deaths, leaving the same 150 DTES non-intentional overdoses on which the authors deliberated. We thereby demonstrated increases in DTES area deaths for 400+ city blocks from 2002 to 2005 even after these 5 intentional/other deaths were excluded.
3. The authors are also incorrect in their statement that we failed to do an in-depth analysis of the 41 block area where the 35% decrease was alleged to have occurred. Rather, our analysis contains a map with the exact location of all 89 deaths within the 41 block area. We further demonstrated that two-thirds of these deaths fall within the 12 block area patrolled by the 48-66 extra police deployed since April 2003. This suggests that the majority of these deaths likely happened in the pre-Insite comparison period when these blocks were an 'open drug scene'.
4. We have noted elsewhere that, "When . . . increases in overdose deaths are compared against population growth in both Vancouver and the DTES the increases in deaths well overwhelm any changes in population. The Lancet study, at Table 2, calculates a 3% change in Vancouver's population between 2001 and 2005, yet drug deaths increased by a much greater 14% from 2002. The Lancet study calculated an 8% increase in population for the DTES, yet drug deaths increased by 37% from 2002. In the scenario where all 5 intentional/other deaths, as discussed previously, occurred in the DTES in 2005 alone, the increase in drug deaths would still be 18%, well beyond the 8% population increase for that area of Vancouver."^[v]^[v]

In summary, in their response to our analysis, the authors have failed to satisfactorily address any of our criticisms. The Lancet Insite article therefore remains seriously flawed on multiple grounds. It should be retracted.

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(England and Wales).

[i][i] Dandurand Y et al., Confident Policing in an Troubled Community – Evaluation of the Vancouver Police Department's City-wide Enforcement Team Initiative p 49 <http://www.vancouveragreement.ca/wp-content/uploads/ConfidentPolicing2004sm.pdf>
[ii][ii] Kerr T, Fairbairn N, Tyndall M, Marsh D, Li K, Montaner J, Wood E. Predictors of non-fatal overdose among a cohort of polysubstance-using injection drug users. Drug and Alcohol Dependence 87 (2007) p 40 <http://www.ncbi.nlm.nih.gov/pubmed/16959438>
[iii][iii] Canadian Government's Final Report of the Expert Advisory Committee, Vancouver's INSITE service and Other Supervised Injection Sites: What has been learned from the Research? See par. 4 of Background section <http://www.hc-sc.gc.ca/ahc-asc/pubs/sites-lieux/insite/index-eng.php#insite>
[iv][iv] WA DAO, Heroin trends tracking: relationships between indices of heroin and crime. DAO Monograph No. 3 pp 20-22 http://www.dao.health.wa.gov.au/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=63&PortalId=0&TabId=211
[v][v] Pike G, Santamaria J, Reece AS, DuPont R, Mangham C, Christian G, Analysis of the 2011 Lancet study on deaths from overdose in the vicinity of Vancouver's Insite Supervised Injection Facility. Journal of Global Drug Policy & Practice Vol 5 Iss 3, Fall 2011 <http://www.globaldrugpolicy.com/Issues/Vol%205%20Issue%203/Vol%205%20Issue%203%20sm.pdf>

From: John McKay
Sent: Friday, 23 March 2012 8:28 AM
To: 'Gary Christian'
Subject: Fw: Statement to Lancet

STATEMENT TO LANCET

Beat Enforcement Team (BET) - Vancouver Police Department 2003 - 2006

John Mc-Kay - then Officer in Charge (BET)

Downtown East Side Vancouver - Policing Rationale

The inception of what eventually became known as the Beat Enforcement Team (BET) occurred in early 2003. At that time the Vancouver Police Department recognized that the Vancouver Agreement between 3 levels of government with the so called "4 Pillars approach" was going to have a major effect on the VPD's ability to successfully police the Down Town East Side (DTES) of Vancouver. This was largely due to the harm reduction pillar which emphasized the value of the Supervised Injection Site which was going to be located in the heart of the DTES in the 100 block of East Hastings.

While the VPD could not at the time argue against the 4 Pillars approach – harm reductionists using statistics and opinion on European Model success – they believed that there had to be some control over the situation in the DTES because of the impact on the community once the dealers figured out that their clients were not being charged and indeed allowed to be in possession of the drugs. VPD feared that there would be a free for all and open warfare between dealers who wanted a greater share of the clientele. As well, the harm reduction philosophy might bring "drug tourists" into the area which would add to the policing problem.

Appendix B

Closely associated to the drug use in the DTES was the movement of stolen property into the local pawnshops of which there were 49 in the immediate area. Selling stolen property was a method of obtaining hard cash for the purpose of buying drugs.

In order to maintain some control over the potential outcomes of the new harm reduction philosophy the VPD began what was known as the Beat Enforcement Team. This unit was made up of 4 squads of police, administration staff, and a police Inspector totaling 65 personnel.

The unit consisting of 65 officers was originally named CET for Citywide Enforcement Team. The name was used because other parts of the city also wanted more beat cops so the effort in the DTES was disguised as a unit that could go anywhere to patrol, hence the name "Citywide Enforcement Team." The original concept under Inspector Doug Lepard, the OIC CET, and DCC, Bob Rich, was to have members stand on the corner and intercept drugs and stolen property. They had a high profile and there was some success with the mandate which was to disrupt the flow of stolen property etc.

The mission of BET was to interrupt the flow of stolen property and disrupt the trafficking of drugs in the area. As the officer in charge of the unit from September 2003 – September 2006 it was my role to achieve these goals.

In order to achieve these goals I spent as much time on the street as possible learning and from several good civilian contacts who had been working in the area for years I was able to glean a lot of background knowledge about the people and the issues around addiction. I implemented a combination of surveillance, undercover work, high presence uniform police and intelligence driven tactics. In a nutshell we shut down all but 7 pawnshops for failure to comply with the law on property and due to specifically targeted undercover operations we gained a lot of success in getting rid of the dealers. Many of these operations such as Operation Lucille, New Boy, became high profile media covered events.

It is my understanding that the effect of 65 police officers in the DTES is negated in the Lancet analysis produced by the harm reduction proponents. That attitude is much too convenient for them because the truth of the matter is that the police were integral to the lowered death rates by being on the street and in and out of the various Single Residence Occupancy hotels in which the addicts reside. The projects and contacts that police made in SROS and on the street with the mentally ill also helped to lower death rates because of the positive nature for the most part of the officers assigned to that beat.

John McKay - Principal
Defensive Tactics Institute
www.dtdefensivetactics.com

Loyalty above all; except Honour!



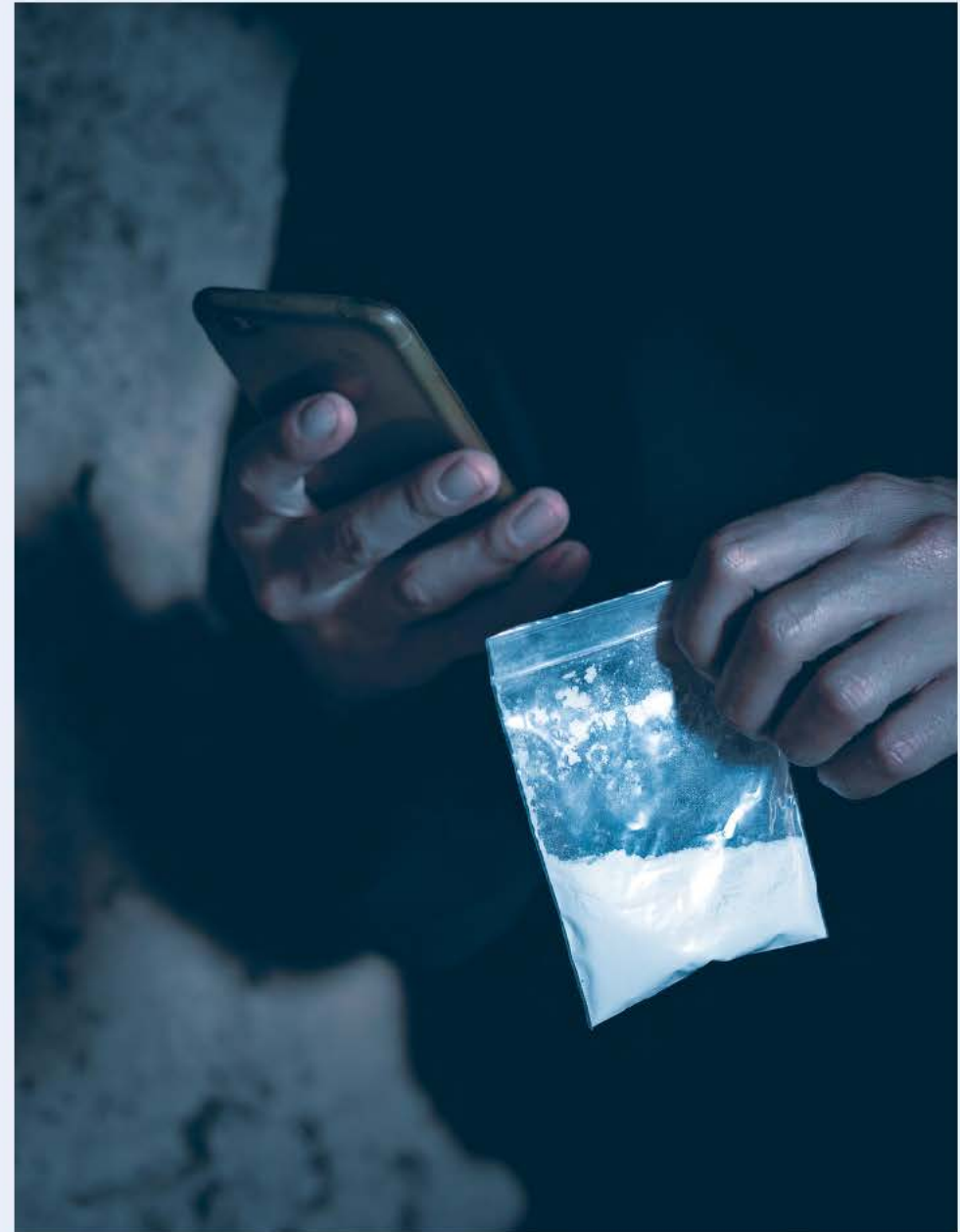
NSW & VICTORIAN INJECTING ROOMS

...definitively enriching the drug trade, failure to meet objectives



Central Issues & Compiled Evidence

1. 99% of Australians do not approve heroin use, thereby indicating they would not approve any government interventions aiding and abetting increased opiate use
2. Staggering numbers of overdoses in Australia's injecting rooms are caused by users experimenting with drug cocktails or increased opiate doses. This inevitably entails purchasing more drugs which must inevitably enrich local drug dealers
3. Research data indicates injecting rooms do not improve local amenity
4. Research data indicates injecting rooms do not reduce blood-borne virus transmissions
5. Injecting rooms uniformly have very poor referral outcomes
6. Injecting rooms have demonstrated a clear honey-pot effect, attracting dealers to the streets outside the facility, prompting expensive preventative policing operations
7. Policing operations have been mostly responsible for reductions in ambulance callouts for overdose in local areas, not injecting rooms
8. For the cost of saving 1 life in an injecting room, many users can enter rehab, saving lives



The failure of NSW and Victorian injecting rooms

According to the last 2016 National Drug Strategy Household Survey of 25,000 Australians, **99% do not approve of regular heroin use.**¹

While 55% of Australians surveyed support injecting rooms as an intervention² there has been a program of constant misinformation about injecting rooms by supporters fed to a gullible or complicit Australian media. If the same media reported the reality that injecting rooms are demonstrable accessories to the drug trade, condemnation would unquestionably be as high as the 99% disapproval rate of heroin use.

NORTH RICHMOND MSIR

Overdose rates

Overdose (OD) rate - **23.5 per 1,000 injections**³

Street OD rate - 0.2/1,000 injections (MSIC)⁴

MSIR OD rate – 102 times higher than normal street OD rates⁵

Testimony by ex-clients of the MSIC in rehab⁶ is that the overdose rates are so extraordinarily high because clients **experiment with higher doses** of drugs in the facility⁷

Experimentation with higher doses inevitably means that **more drugs are purchased from local dealers** to service the inordinate overdose rates, lining drug dealers' pockets. This conclusion is inescapable and is damning for injecting rooms

This makes the MSIR **a government-funded accessory to the North Richmond drug trade**, where extra drugs purchased created OD rates 102 times higher than normal

KINGS CROSS MSIC

Overdose rates

Highest OD rate – 14.6/1,000 injections (2010)⁸

Pre-MSIC street rate – 0.2/1,000 injections⁹

MSIC OD rate – up to 63 times higher than clients' pre-MSIC rate of OD¹⁰

Testimony by ex-clients of the MSIC in rehab is that the overdose rates are so extraordinarily high because clients **experiment with higher doses** of drugs in the facility

Experimentation with higher doses inevitably means that **more drugs are purchased from local dealers** to service the inordinate overdose rates, lining drug dealers' pockets. This conclusion is inescapable and is damning for injecting rooms

This makes the MSIC **a government-funded accessory to the Kings Cross drug trade**, where extra drugs purchased created OD rates 63 times higher than normal

NORTH RICHMOND MSIR

Public Amenity – MSIR Objectives (d) and (e)

The MSIR **failed** to improve public amenity with local residents reporting no reductions in discarded needles, and local businesses reporting increases¹¹

Public injection was reported by less residents and businesses after the MSIR opened¹², but increases in discarded needles inevitably entails more public injections. Policing crackdowns, which appear to have more so been during hours the MSIR was open, would likely have moved public injection to night-time when less people were around to see it

Reductions in Blood-Borne Virus Transmissions – MSIR Objective (f)

Failure to demonstrate that MSIR clients were less likely than other users to report using others' used injecting equipment¹⁷

Providing a gateway to drug treatment – MSIR Objective (b)

Failure to demonstrate any higher uptake of treatment services than other non-MSIR drug users

While 22%¹⁹ of MSIR clients at intake expressed a desire for referral to treatment, only 8% were in fact referred²⁰

Extensive policing to reduce honey-pot effect

Adding to the failure against objectives listed above, police complained of surging crime²⁴ around the MSIR, and residents of a honey-pot effect²⁵ where drug dealers were drawn to the streets directly outside the MSIR

The very high costs of the extensive policing added around these facilities around the time of their implementation **is a best-kept secret** concealed by injecting room evaluators/ reviewers from the media. Cost evaluations of injecting rooms worldwide never add these real and very high costs of policing to the costs of running these facilities

KINGS CROSS MSIC

Public Amenity – MSIC Objective 3

The heroin drought, which started 6 months before the MSIC opened¹³, drastically reduced discarded needles across the entirety of Australia. The MSIC's 4th Evaluation¹⁴ **failed** to demonstrate any reductions beyond those caused by the drought. The 2010 KPMG Evaluation¹⁵ made no attempt to get relevant data and failed to mention changed policing¹⁶ since 2001 which would undoubtedly affect needle counts

Reports by residents (1st Evaluation and KPMG Evaluation) of seeing less public injecting were unquestionably the result of the heroin drought and no account was taken by KPMG of changed policing since 2001

Reductions in Blood-Borne Virus Transmissions – MSIC Objective 4

Failure to demonstrate in any one of its many Evaluations any objective reductions in injection-related BBV transmissions¹⁸

Providing a gateway to drug treatment – MSIC Objective 2

Abnormally low levels of referral to treatment at only 11% of clients referred.²¹ A Scottish study of methadone users found 57%²² wanted to get clean, which would be similar to Australian heroin users. By comparison 22% of Victorian MSIR clients at intake expressed a desire for referral to treatment²³

Extensive policing to reduce honey-pot effect

The 1st MSIC Evaluation had ample data demonstrating a visible honey-pot effect²⁶ where dealers were drawn to the doors of the MSIC. Not one of the many MSIC Evaluations even mentioned the ongoing implementation of sniffer dog policing one month after the MSIC opened which aimed to move drug dealers out of the Kings Cross postcode

The very high costs of the extensive policing added around these facilities around the time of their implementation **is a best-kept secret** concealed by injecting room evaluators/ reviewers. Cost evaluations of injecting rooms worldwide never include these real and very high costs of policing to the costs of running these facilities

NORTH RICHMOND MSIR

Policing operations reduced ambulance callouts – MSIR Objective (c)

Failed to reduce ambulance callouts. On any of the streets of Melbourne, the MSIR's 112,831²⁷ opiate injections in its first 18 months would have caused just 26 overdoses, (25 non-fatal and 1 fatal) according to the MSIC's 1st Evaluation.²⁸ 19, at most, would likely be attended by an ambulance²⁹

Overdoses in the MSIR, which should have numbered no more than 26 anywhere else outside an injecting room, would reduce ambulance callouts in North Richmond by just 5%.³⁰ However the MSIR Review records the facility calling 30 ambulances to take their clients to hospital in 18 months³¹, which means **it increased**, not decreased, **ambulance callouts**

The review egregiously claimed callout reductions of 36%,³² which were clearly due to heightened police operations³³ around the MSIR

Save lives from fatal overdose – MSIR Objective (a)

On any of the streets of Australia, one heroin user will die for every 109,500 opiate injections.⁴¹ The MSIR recorded around 75,000 opiate injections per year in its first 18 months of operation, **clearly not enough to save even one life in 18 months**⁴²

For the \$6 million⁴³ spent by the MSIR to save one single life, the Victorian government could provide 73 optimally-funded residential rehab beds for a full year.⁴⁴ **The same funding can save one life (which can nevertheless be lost tomorrow injecting elsewhere) or make many users drug-free.** The MSIR is multiplying policing expenditures with growing crime, while failing to stop overdoses by clients for the 58 in every of their 60 opiate injections they average OUTSIDE the MSIR.⁴⁵ Successfully rehabilitated users reduce the need for police expenditures and ambulance interventions as drug use is ceased altogether. Closure of the MSIR will immediately stop the mass experimentation with drugs currently happening, an experimentation which is likely to only promote more opiate-related deaths outside the facility.

KINGS CROSS MSIC

Policing operations reduced ambulance callouts

With less than 50,000 opiate injections per year³⁴ the MSIC would at best reduce overdoses in the Kings Cross community by 11 ambulance callouts per year³⁵

The MSIC's 2007 4th Evaluation claimed 80% reductions in ambulance callouts in Kings Cross against reductions of 61% throughout NSW as caused by the national heroin drought.³⁶ This was a reduction 31% better than the rest of NSW during the hours the MSIC was open. During the hours it was closed there was a 69% better reduction in callouts,³⁷ demonstrating that the **sniffer dog policing** of Kings Cross, introduced within a month of the MSIC opening, ³⁸ **was likely responsible**. NSW Parliament Hansard records that sniffer dog policing was active not only during the day, but highly active at night³⁹ into the hours shortly before dawn⁴⁰

Save lives from fatal overdose – MSIC Objective 1

On any of the streets of Australia, one heroin user will die for every 109,500 opiate injections. The MSIC averaged around 51,000 opiate injections annually over its first 9 years of operation⁴⁶, **clearly not enough to save even one life in two years of operation**

For the \$6 million spent by the MSIC to save one single life,⁴⁷ the NSW government could provide 73 optimally-funded residential rehab beds for a full year. **The same funding can save one life (which can nevertheless be lost tomorrow injecting elsewhere) or make many users drug-free.** The MSIC multiplies policing expenditures to stifle drug-related crime in Kings Cross, while failing to stop overdoses by clients for the 95% of injections they average OUTSIDE the MSIC. Successfully rehabilitated users reduce the need for police expenditures and ambulance interventions as drug use is ceased altogether. Closure of the MSIR will immediately stop the mass experimentation with drugs currently happening, an experimentation which is likely to only promote more opiate-related deaths outside the facility.

Endnotes

1. <https://www.aihw.gov.au/reports/illegal-use-of-drugs/2016-ndshs-detailed-data>

Table 9.7: Personal approval of the regular use by an adult of selected drugs, people aged 14 years or older, 2007 to 2016 (per cent)

Drug	Persons			
	2007	2010	2013	2016
Tobacco	14.4	15.3	14.7	15.7#
Alcohol	45.3	45.1	45.1	46.0
Cannabis	8.7	8.1	9.8	14.5#
Ecstasy	2.0	2.3	2.4	2.9#
Meth/amphetamine ^(a)	1.2	1.2	1.4	1.2
Cocaine/crack	1.4	1.7	1.6	1.7
Hallucinogens	1.7	2.4	3.1	3.7#
Inhalants	0.8	1.0	0.9	1.0
Heroin	1.0	1.2	1.2	1.1
Pharmaceuticals ^(a)	13.7	22.4	23.2	27.8#
Prescription pain-killers/analgesics ^(a)	n.a.	13.0	12.6	12.7
Over-the-counter pain-killers/analgesics ^(a)	n.a.	14.3	14.5	19.1#
Tranquillisers, sleeping pills ^(a)	4.1	6.4	8.2	9.2#
Steroids ^(a)	1.7	2.2	2.2	2.4
Methadone or buprenorphine ^(a)	1.0	1.2	1.3	1.3

Statistically significant change between 2013 and 2016.

(a) For non-medical purposes.

Note: The list of response options changed across survey waves. Comparisons should be interpreted with caution.

Source: NDHS 2016

2. <https://www.aihw.gov.au/reports/illegal-use-of-drugs/2016-ndshs-detailed-data>

Table 9.22: Support^(a) for measures relating to injecting drug use, people aged 14 or older, by sex, 2007 to 2016 (per cent)

Measure	Males				Females				Persons			
	2007	2010	2013	2016	2007	2010	2013	2016	2007	2010	2013	2016
Needle and syringe programs	63.8	65.2	64.6	64.8	70.2	71.8	69.6	66.9	67.0	68.5	67.1	66.9
Regulated injecting rooms	47.8	49.7	53.3	54.5	52.1	53.3	55.4	55.4	49.9	51.5	54.3	55.0
Methadone/buprenorphine maintenance programs	65.0	66.2	63.6	65.1	70.5	72.3	70.5	70.6	67.7	69.3	67.0	67.9
Treatment with drugs other than methadone	66.2	67.5	63.7	65.4	70.9	71.3	68.4	66.7	65.5	69.4	68.0	67.0
Trial of prescribed heroin	32.2	34.6	35.2	36.5	33.6	35.0	32.9	33.6	32.9	34.8	34.1	35.1
Rapid detoxification therapy	76.7	75.9	67.2	67.5	80.9	80.0	71.7	71.3	78.8	77.9	69.4	69.4
Use of Naltrexone, a drug that blocks the effects of heroin and other opiates/opioids	73.5	75.1	66.4	65.8	76.0	75.8	69.5	66.7#	74.7	75.5	67.9	66.3#
The availability of take-home Naltrexone, a drug that reverses the effects of a Heroin/Methadone/Morphine overdose	n.a.	n.a.	n.a.	66.1	n.a.	n.a.	n.a.	63.2	n.a.	n.a.	n.a.	64.7

Statistically significant change between 2013 and 2016.

(a) Support or strongly support (calculations based on those respondents who were informed enough to indicate their level of support)

Note: Question was modified in 2013. Measures taken to address problems associated with heroin use, was removed and measures taken to address problems associated with injecting drug use was reworded and new responses were added. Therefore comparisons to previous waves should not be made.

Source: NDHS 2016

3. The MSIR [review](#) records that the facility had a total [116,802 supervised injections](#) (p x) in its first 18 months, of which [96.6%](#) (p x) were heroin injections which are subject to fatal overdose. This gives 112,831 heroin injections against 2,657 (p x) overdoses or 23.5/1,000 injections
4. Clients of the Kings Cross MSIC were considered by the 2003 [1st MSIC Evaluation](#) to be at higher risk of overdose than normal (p 62) and so the previous overdose rates of MSIC clients, as recorded when registering to use the facility, can well be used as normative for the MSIR. 44% (see p 8) of MSIC clients had overdosed before registering, with a heroin-use career spanning an average 12 years (see p 8) and a median average of three overdose episodes in the 12 years (see page 16). From this data, their average rate of overdose can be calculated. Using the MSIC Evaluation's own assumption of 'at least' three injections per day per dependent heroin user (see p 58), and keeping in mind that, for example, [8 injections per day](#) for heroin users is not extraordinary, we can calculate the number of injections per user per year (3 x 365 = 1,095 injections per year), then calculate one non-fatal overdose every 4 years giving a rate of 1/4,380 injections (4 x 1,095 injections) or 0.23/1,000. The real rate would be quite a deal lower given that 3 injections per day is a low estimate, and this is the rate for only 44% high risk clients in the MSIC, where the other 56% have no overdoses but many injections
5. Their staggering overdose rate of 23.5/1,000 injections can be divided by the normative rate of overdose (see

footnote 4) of 0.23/1,000 giving the result of 102 times higher than normal

6. See Hansard record of speeches by NSW MLC Gordon Moyes [file:///C:/Users/gxian/Documents/Drugs/Interventions/Injecting%20Room/ADRAAnalysis/Lobbying/Full%20Day%20Hansard%20Transcript%20\(Legislative%20Council,%2026%20June%202007,%20Proof%20-%20NSW%20Parliament.htm](file:///C:/Users/gxian/Documents/Drugs/Interventions/Injecting%20Room/ADRAAnalysis/Lobbying/Full%20Day%20Hansard%20Transcript%20(Legislative%20Council,%2026%20June%202007,%20Proof%20-%20NSW%20Parliament.htm) and by NSW Andrew Fraser MP [https://web.archive.org/web/20121102211713/https://www.parliament.nsw.gov.au/Prod/parliament/hanstrans.nsf/V3ByKey/LA20101021/\\$File/541LA217.pdf](https://web.archive.org/web/20121102211713/https://www.parliament.nsw.gov.au/Prod/parliament/hanstrans.nsf/V3ByKey/LA20101021/$File/541LA217.pdf) recording the observations of MSIC ex-clients on why the overdose rate is so imaginably high.
7. The [1st MSIC Evaluation](#) (see p 62) noted that "In this study of the Sydney MSIC there were 9.2 heroin overdoses per 1000 heroin injections in the MSIC, and this rate of overdose is likely to be higher than among heroin injectors generally. The MSIC clients seem to have been a high-risk group with a higher rate of heroin injections than heroin injectors who did not use the MSIC, they were often injecting on the streets, and they may have taken more risks and used more heroin in the MSIC." The evaluators never bothered to measure this inordinately high rate of overdose against MSIC clients' own histories of overdose or rates of overdose derived therefrom. The rates were high because of unchecked MSIC client experimentation with more drugs and drug cocktails – see speech by NSW Upper House MLC Gordon Moyes [file:///C:/Users/gxian/Documents/Drugs/Interventions/Injecting%20Room/ADRAAnalysis/Lobbying/Full%20Day%20Hansard%20Transcript%20\(Legislative%20Council,%2026%20June%202007,%20Proof%20-%20NSW%20Parliament.htm](file:///C:/Users/gxian/Documents/Drugs/Interventions/Injecting%20Room/ADRAAnalysis/Lobbying/Full%20Day%20Hansard%20Transcript%20(Legislative%20Council,%2026%20June%202007,%20Proof%20-%20NSW%20Parliament.htm) and by Andrew Fraser MP [https://web.archive.org/web/20121102211713/https://www.parliament.nsw.gov.au/Prod/parliament/hanstrans.nsf/V3ByKey/LA20101021/\\$File/541LA217.pdf](https://web.archive.org/web/20121102211713/https://www.parliament.nsw.gov.au/Prod/parliament/hanstrans.nsf/V3ByKey/LA20101021/$File/541LA217.pdf)
8. See 2010 MSIC Evaluation by [KPMG](#) (p 154) for the overdose rates per year up to 2010
9. See endnote 4 above
10. The MSIC overdose rate of 14.6/1,000 injections can be divided by the normative rate of overdose (see footnote 4) of 0.23/1,000 giving the result of 63 times higher than normal.
11. p 76 of the MSIR [review](#) states that "Local people record no difference in seeing discarded injecting equipment" Also, "There was an increase in the median number of discarded syringes seen by business respondents during the trial (six to 10 per month)" (p 76)
12. DFA notes that [the review's](#) cited (small) reductions in reported sightings of public injecting ([p xx](#)) are clearly countered by increases in publicly discarded injecting equipment ([p xx](#)) which inevitably indicates INCREASED public injecting. Policing crackdowns during [daytime](#) obviously increased night-time injecting, when public injecting is less likely to be observed by local residents or businesses. This increase in public injecting is witnessed by the increases in ambulance callouts at night (p 71)
13. The heroin drought commenced December 2000 https://www.researchgate.net/publication/237404353_The_Australian_Heroin_Drought_and_its_Implications_for_Drug_Policy and the MSIC opened May 6, 2001. Australia has never recovered from the heroin drought
14. <https://kirby.unsw.edu.au/report/sydney-medically-supervised-injecting-centre-msic-evaluation-report-4> see page 32ff
15. <https://www.health.nsw.gov.au/aod/resources/Documents/msic-kpmg.pdf> see p xi
16. Sniffer dog policing commenced 1 month after the MSIC opened (see speech by Clover Moore <https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#docid/HANSARD-1323879322-25542/link/11>) in the Kings Cross postcode and very successfully <https://www.zdnet.com/article/sniffer-dog-avoidance-a-wireless-app-with-bite/> moved dealers out of the postcode into neighbouring postcodes, particularly next-door Darlinghurst
17. MSIR [review](#) (p 100) states that "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."
18. 2010 MSIC Evaluation by [KPMG](#) (p 4) records that "... It is not possible however to attribute any change in infection notifications to the operation of the MSIC" –DFA notes that the KPMG Evaluation, in assessing evidence regarding blood-borne virus transmissions, made no mention of the obvious heroin drought which was responsible for less needles being distributed by pharmacies and needle & syringe programs, and which remained active in 2010 and beyond. Nor did they make any mention of sniffer dog policing driving dealers, drug purchases and their associated overdoses to other areas of Sydney

Appendix C

19. MSIR [review](#) p 50
20. MSIR [review](#) p 55
21. See p 17 https://drugfree.org.au/images/pdf-files/library/injecting_rooms/DFA_Analysis_Injecting_Room_2010.pdf
22. <https://www.tandfonline.com/doi/abs/10.1080/09687630600871987>
23. MSIR [review](#) p 50
24. <https://tpav.org.au/news/journals/2019-journals/june/safe-injecting-rooms>
25. <https://www.heraldsun.com.au/news/victoria/police-target-drug-traffickers-and-crime-in-richmond-during-operationapollo/news-story/c7b10e05340619b9282588ca81889bd9>
26. 2003 [1st MSIC Evaluation](#) p 146ff
27. See endnote 3
28. The 2003 [1st MSIC Evaluation](#) (p58) cited the Darke et al. study which found that there 1 fatal overdose in every 24 overdoses, the remainder being non-fatal overdoses. On this data we can calculate the number of injections per overdose, given that there is solid Australian [data](#) indicating that [one in every 100](#) dependent heroin users die each year from a fatal opiate overdose. If dependent heroin users are injecting 'at least' 3 times a day, as calculated by the 1st MSIC Evaluation (p58), there is one death for every 109,500 injections (3 injections per user per day x 365 days in a year x 100 users for which one injection will be fatal). There will be 24 overdoses per 109,500 injections, giving a rate of 1/4,563 injections, very similar to the previous overdose rates recorded by MSIC clients when registering to use the MSIC. Using the MSIC clients previous overdose rate of 1/3,480 injections we find that the 112,831 opiate injections in the MSIR SHOULD have only caused 26 overdoses, of which one would be fatal
29. Again we are being extremely generous – the Darke et al. study mentioned in endnote 28 found that an ambulance attended only 51% of their examined overdoses. We have more generously calculated according to the registration data of Kings Cross MSIC clients which had 74% of previous overdoses attended by an ambulance. Thus 19 of the 26 expected overdoses from 112,831 injections in the MSIR would have likely caused an ambulance callout. If we had calculated on Darke et al.'s 51% it would have been just 13 callouts that would be foregone by the presence of the MSIR
30. In the 18 months before the MSIR there were 382 ambulance callouts within a 1 km radius. If the (generous) 19 callouts are deducted, we would normally have expected the MSIR to reduce that number to 363 (382 minus 19 callouts), which is a 5% reduction
31. MSIR [review](#) p xi
32. MSIR [review](#) p 69
33. <https://www.heraldsun.com.au/news/victoria/police-target-drug-traffickers-and-crime-in-richmond-during-operationapollo/news-story/c7b10e05340619b9282588ca81889bd9>
34. The KPMG Evaluation recorded 604,022 injections (p ix) in 9 years, of which a maximum 76.5% (p 107) were opiate injections, averaging 51,275 opiate injections per year
35. With the 446,976 opiate injections over 9 years (see previous endnote) expected to produce an overdose for every 4,380 injections, (see endnote 4) the number of expected overdoses would be 102, or 11 per year over 9 years.
36. See the 2007 [4th MSIC Evaluation](#) p 24ff
37. In the Salmon et al. 2010 [study](#) on ambulance callouts, which replicated data from MSIC [Evaluation 4](#) compare data on daytime callouts versus callouts outside MSIC operating hours (p 680)
38. NSW Parliament Hansard, "Police Sniffer Dogs" 23 October 2001 <https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#docid/HANSARD-1323879322-25542/link/11>
39. <http://www.mapinc.org/drugnews/v01/n1987/a09.html?4817>
40. See speech by Mrs A Megarrity <https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#docid/HANSARD-1323879322-25542/link/11>
41. See endnote 4
42. The MSIR review recorded 112,831 heroin injections during the first 18 months (see endnote 3), averaging 75,221 injections for the first 12 months (it was actually less than that due to a slow startup for the MSIR). The MSIR needed 109,500 injections to claim one life saved, and 75,000 injections does not even come close
43. https://www.parliament.vic.gov.au/images/stories/committees/lrrcsc/Drugs_Final_Victorian_Government_Response_to_the_Parliamentary_Inquiry_into_Drug_Law_Reform_X1wNyVpZ.pdf records funding of \$4 million per year which gives \$6 million in 18 months
44. In August 2018 the NSW Legislative Council's Portfolio Committee No.2 (Health and Community Services) Report 49 recommended "That the NSW Government significantly increase funding to drug and alcohol related health services" (Recommendation 2). The NADA submission https://www.nada.org.au/wp-content/uploads/2019/03/NADA-Submission-NSW-AOD-Beds_120319.pdf recommended \$224.95 of funding per bed day for residential rehabs, which equals \$82,106 per annum or 73 bed years for the \$6 million to save one life in an injecting room. If patients are offered 6 months of rehab each over 140 users will have been assisted towards being drug-free, freeing them from the morbidity of non-fatal overdoses and freeing the community of crime and public nuisance
45. The MSIR review (p ix) indicates MSIR clients average 14 opiate injections per week which is 728 per year, or 60 per month on average. There were 112,831 heroin injections in 18 months recorded by the MSIR by the 3,936 clients, giving an average of 29 injections per client in 18 months or 19 per year, averaging a little over 1.5 injections per month. 58 of clients' average 60 injections per month were not in the MSIR.
46. The 2010 [KPMG](#) Evaluation recorded a total of 604,022 injections (p ix) in the 9 years evaluated, of which 76.5% were opiate injections (p 108). This gives 461,473 opiate injections, averaging 51,275 opiate injections annually.
47. In 2007 the MSIC cost \$2.7 million to operate according to the 2007 [4th Evaluation](#) (p35). With current operating costs unable to be identified from MSIC records or State budgets, \$3 million per year in 2020 is a very conservative estimate



WWW.DRUGFREE.ORG.AU

Development and Guiding Principles of the Icelandic Model for Preventing Adolescent Substance Use

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Adolescent substance use—the consumption of alcohol, tobacco, and other harmful drugs—remains a persistent global problem and has presented ongoing challenges for public health authorities and society. In response to the high rates of adolescent substance use during the 1990s, Iceland has pioneered in the development of the Icelandic Model for Primary Prevention of Substance Use—a theory-based approach that has demonstrated effectiveness in reducing substance use in Iceland over the past 20 years. In an effort to document our approach and inform potentially replicable practice-based processes for implementation in other country settings, we outline in a two-part series of articles the background and theory, guiding principles of the approach, and the core steps used in the successful implementation of the model. In this article, we describe the background context, theoretical orientation, and development of the approach and briefly review published evaluation findings. In addition, we present the five guiding principles that underlie the Icelandic Prevention Model's approach to adolescent substance use prevention and discuss the accumulated evidence that supports effectiveness of the model. In a subsequent Part 2 article, we will identify and describe key processes and the 10 core steps of effective practice-based implementation of the model.

Keywords: *adolescence; Icelandic model; implementation; practice-based evidence; prevention; substance use*

► INTRODUCTION

Preventing alcohol, tobacco, and other harmful drug use among youth remains an ongoing challenge, especially in many advanced economies of the world. From a public health perspective, the most sensible approach to prevention is to avert or delay the onset of alcohol, tobacco, and other drug use as long as possible. Early drug use impairs psychosocial and neurocognitive development and increases youth vulnerability to later use of licit and illicit substances, academic failure, high-risk sexual behavior, and mental health problems (Atherton, Conger, Ferrer, & Robins, 2016; Windle & Zucker, 2010), and is strongly predictive of later dependence (Kendler, Myers, Damaj, & Chen, 2013; Moss, Chen,

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& Yi, 2014). Nonetheless, despite the need for effective primary prevention, most programs and approaches fail to show long-term impact and societal benefits (Hopfer et al., 2010; Kumpfer, Smith, & Summerhays, 2008).

Although there are examples of prevention approaches that have demonstrated success, such as the Strategic Prevention Framework developed by Substance Abuse and Mental Health Services Administration (Anderson-Carpenter, Watson-Thompson, Chaney, & Jones, 2016) and Communities That Care (Hawkins et al., 2008), a separate noteworthy success story in primary prevention of substance use comes from Iceland. This article is the first of a two-part series that describes the theory- and practice-based processes associated with the successful implementation of the Icelandic Model for Primary Prevention of Substance Use. Here we discuss the development of the Icelandic Prevention Model (IPM), present a brief theoretical overview, and summarize the accumulated evidence of effectiveness of the approach in reducing rates of adolescent substance use in Iceland. This is followed by an introduction to the five guiding principles underlying the model. We conclude by placing the model and the evidence in support of its effectiveness in context within the wider literature of the field.

► MODEL DEVELOPMENT AND EVIDENCE OF EFFECTIVENESS

Context

In the 1990s, Iceland ranked comparatively high on adolescent alcohol, tobacco, and other harmful drug use as evidenced by results from the European School Project on Alcohol and Drugs (ESPAD)—a comparative study of 35 European countries conducted every 3 to 4 years (ESPAD Group, 2016). To illustrate, in 1999, the rate of ever smoking tobacco among 10th-grade youth in Iceland was 56% and 69% on average in Europe; the rate of drunkenness in the past 12 months was 56% in Iceland and 52% in Europe; and 15% had reported use of cannabis substances (hashish, marijuana) in Iceland, similar to other parts of Europe. For many years leading up to this point Iceland had been utilizing traditional methods of primary substance use prevention, namely, individual, school-based instructional and educational programs, with the aim of educating or leading youth away from initiating substance use (Palsdottir, 2003; Sigfusdottir, Thorlindsson, Kristjansson, Roe, & Allegrante, 2009). In response to the alarming rates of adolescent substance use in the mid-1990s and with sponsored funding from the government of Iceland and the Reykjavik City Council, a group of policy makers

and administrative leaders, elected officials, and social scientists came together to explore new ideas for initiating a different, bottom-up collaborative approach to substance use prevention that has since become known as the Icelandic Prevention Model (Sigfusdottir et al., 2009; Sigfusdottir, Kristjansson, Gudmundsdottir, & Allegrante, 2011).

Model Development

Since its formulation, the IPM has been grounded in classic theories of social deviance that were developed in sociology and criminology (Akers, 1977; Hirchi, 1969; Merton, 1938), rather than based in traditional health behavior change theories (Glanz, Rimer, & Viswanath, 2015). The mutual viewpoint of these deviance theories is that most individuals are capable of deviant acts but that only under certain environmental and social circumstances will those acts become common patterns of behaviors among dominant groups of adolescents. Major reasons for such behavioral patterns thus include (a) lack of environmental sanctions by the social environment (e.g., from parents and other adults), (b) low individual and/or community investment in traditional and positive values (e.g., high educational aspirations), and (c) lack of opportunities for participation in positive and prosocial development (e.g., organized recreational and extracurricular activities such as sports, music, drama, after school clubs, etc.). Thus, from this theoretical perspective, children are viewed as social products and not as rational individual actors, and hence alcohol, tobacco, and other drug use is viewed as attributes of the social environment (Sigfusdottir et al., 2009) and engrained in both risk and protective factors that comprise key determinants of the ongoing cycle of substance use.

Echoed by this theoretical view, the goal of the approach from the outset was to “mobilize society as a whole in the struggle against drugs” (Palsdottir, 2003), with emphasis on community engagement and collaboration leading to long-standing and gradual environmental and social change rather than short-term solutions. Rooted in research evidence from the social and behavioral sciences, the preventive cornerstone of the approach was to strengthen protective factors and mitigate risk factors at the local community level within each of the domains of parents and family, the peer group, the school environment, and leisure time outside of school (Nash, McQueen, & Bray, 2005; Scholte, Poelen, Willemsen, Boomsma, & Engels, 2008; Watkins, Howard-Barr, Moore, & Werch, 2006), all of which are potential domains of ongoing practice-based assessment and intervention (see Figure 1). The 10 core

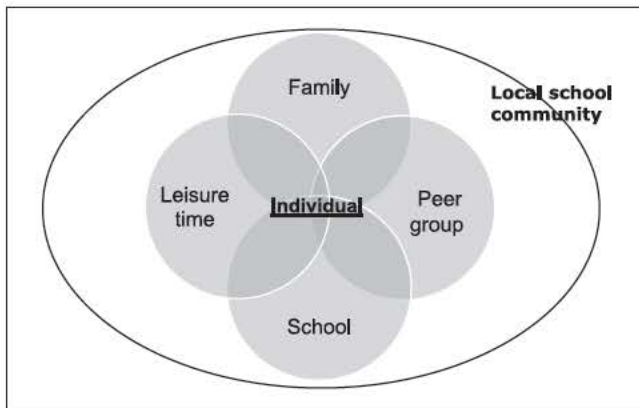


FIGURE 1 Domains of Community Risk and Protective Factors in the Icelandic Prevention Model

steps to this effective intervention process are outlined in the related second article within this issue of *Health Promotion Practice*.

Evaluation and Evidence of Effectiveness

Since the original development of the model, Iceland has led the decline in substance use in all of Europe. In 2015, the rate of ever smoking tobacco was 46% among 10th-grade adolescents in Europe but had plunged to 16% in Iceland; average rates of current alcohol use were 48% in Europe but 9% in Iceland; and average rates of lifetime use of cannabis substances remained at 16% in Europe, similar to 1999, but declined to 5% in Iceland (see Figure 2 for standard trend measures from the Youth in Iceland studies). In all instances, the 2015 rates in Iceland represented either the lowest or the second lowest of all 35 countries that participated in the ESPAD study that year (ESPAD Group, 2016). Corresponding to these changes in substance use, Iceland had also witnessed large reductions in risk factors and strengthening of protective factors. For example, 10th-grade students reporting parents knowing with whom they spend time in the evenings increased from ~50% in 2000 to just over 74% in 2016. Even more dramatic, while 80% of 10th-grade students reported having been “outside after midnight” once or more during the 7 days prior to the annual survey in 2000, this ratio had declined to approximately 31% in 2016. During the same time, participation in organized sports with a club or team four times per week or more often had increased from 26% in 2000 to approximately 37% in 2016 (Kristjansson et al., 2016). Using a quasi-experimental, group-based design, we conducted an evaluation to assess central elements of the IPM (Kristjansson,

James, Allegrante, Sigfusdottir, & Helgason, 2010). Municipalities that had consistently been a part of the model since 1997 formed the intervention group and were compared to those that had consistently been outside of the formal model. It should be noted that given the geographical isolation and small population of the country, potentially contaminating spillover effects from the model to outside areas could be expected. However, despite these challenges, the evaluation demonstrated a significant difference in group trends over time in smoking and alcohol use, parental monitoring, party lifestyle, and participation in organized sports, with the treatment group being favored in all instances.

Since the mid-1990s, much has changed in the adolescent environment in Iceland that has been influenced by widespread implementation of the model. Some of those changes are holistic and onetime alterations, while several notable others are ongoing and continuous. First, municipalities and schools that include over 80% of the country’s population now routinely utilize annually updated survey data to monitor trends and potential changes in substance use and risk and protective factors among youth and use this information to organize responses and set strategies for the year ahead. Second, most municipalities and many schools now employ designated personnel with dedicated time to engage in primary prevention activities. In addition, government-funded community nongovernmental organizations have been set up to strengthen and improve the collaborative aspect of parenting at the local school-community level. Finally, municipalities have as a matter of policy increased funding dramatically for recreational and extracurricular activities for children and adolescents, making such activities available to all through a user-friendly voucher system.

► FIVE GUIDING PRINCIPLES

The IPM is built on a foundation of five guiding principles (see Table 1). Each principle can be thought of as a unique dimension of an overall approach that provides direction for how each step in the community intervention process ideally should be implemented (see Kristjansson et al., 2019). Although different steps in the process may emphasize a given guiding principle more or less heavily, every step of the model should include each of these principles. When choosing among competing strategies, the guiding principles can be consulted as a means of identifying the strategy most in keeping with the intended design of the IPM and local needs. Below, is a brief summary of each of these principles and associated dimensions.

Appendix D

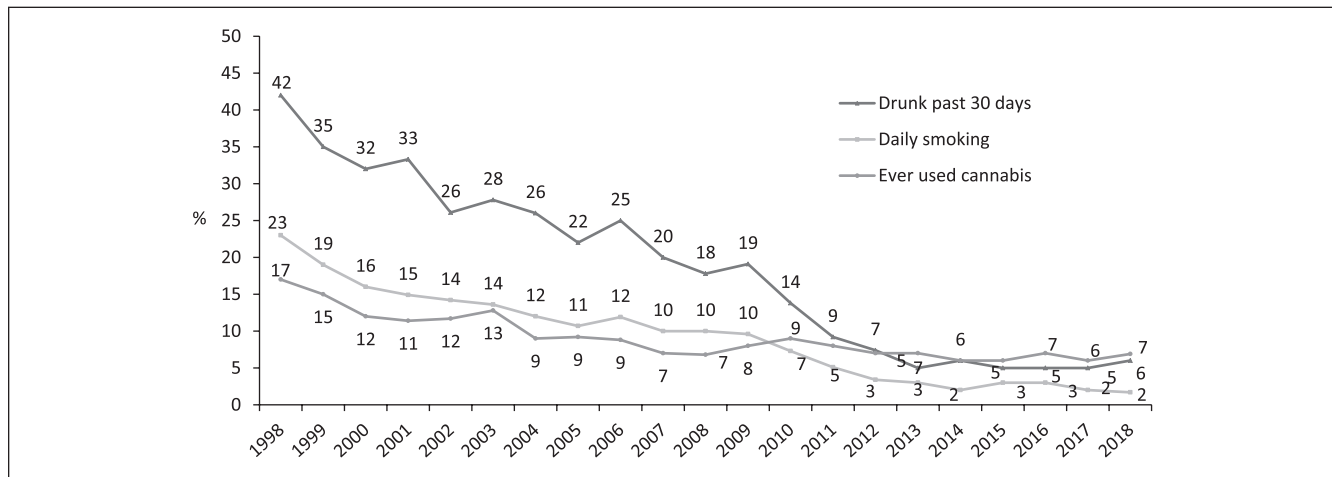


FIGURE 2 Annual Percentage of Self-Reported Substance Use Among Icelandic Adolescents, 1998-2018

SOURCE: Kristjansson et al. (2016).

TABLE 1
The Five Guiding Principles of the Icelandic Prevention Model

Guiding Principle 1	Apply a primary prevention approach that is designed to enhance the social environment.
Guiding Principle 2	Emphasize community action and embrace public schools as the natural hub of neighborhood/area efforts to support child and adolescent health, learning, and life success.
Guiding Principle 3	Engage and empower community members to make practical decisions using local, high-quality, accessible data and diagnostics.
Guiding Principle 4	Integrate researchers, policy makers, practitioners, and community members into a unified team dedicated to solving complex, real-world problems.
Guiding Principle 5	Match the scope of the solution to the scope of the problem, including emphasizing long-term intervention and efforts to marshal adequate community resources.

Guiding Principle 1: Apply a Primary Prevention Approach That Is Designed to Enhance the Social Environment

The model focuses on preventing the initiation of substance use by altering the social environment in a manner that reduces the likelihood that young people will initiate substance use. This approach therefore addresses the underlying causes of substance use initiation. By working to increase social and environmental protective factors associated with preventing or delaying substance use and decreasing corresponding risk factors, the model prevents substance use by intervening on society itself and across a broad spectrum of opportunities for community intervention. This “society is the patient” approach (Myers, 2008) prioritizes thoughtfully and intentionally altering the social, organizational, and cultural characteristics of communities as the primary means of inoculating young people against substance

use. Within this principle, accessing and/or hiring appropriate personnel to guide local team-building and bridging the use of research evidence to practical implementation will be central.

Guiding Principle 2: Emphasize Community Action and Embrace Public Schools as the Natural Hub of Neighborhood/Area Efforts to Support Child and Adolescent Health, Learning, and Life Success

The model’s primary unit of intervention is the neighborhood, which is defined as the service area assigned to a local school. The model uses an ecological approach that addresses family, school, peer, and community social influences and other opportunities within each neighborhood. Although schools are not primarily responsible for strengthening the neighborhoods and areas they serve, they do represent an essential hub for local activities designed to support the

health, well-being, and success of children and adolescents. As a result, strengthening connections between families, schools, and the community-at-large, and unifying those groups into a cohesive team devoted to preventing substance use, represents a core strategy of the IPM. Securing the collaboration and commitment of schools for the collection of data to routinely monitor trends in both substance use and risk and protective factors is therefore essential.

Guiding Principle 3: Engage and Empower Community Members to Make Practical Decisions Using Local, High-Quality, Accessible Data and Diagnostics

Local community members make all model-driven decisions based on hard data and neighborhood and school-specific diagnostics. The model thus relies on local data to (a) capture, focus, and sustain community attention on local factors essential to preventing substance use (b) guide the selection of strategies and the development of community capacity necessary to address the complex problem of substance use.

To accomplish this, the model uses data that are local, high-quality, and made accessible through quick and efficient processing and dissemination. Local data amplify community interest in what is happening with the young people living in local areas and neighborhoods, as well as motivating community action to address local problems. High-quality data strengthen opportunities to accurately describe, diagnose, and inform community decision making. Accessible and current data promote meaningful participation from the whole community by presenting information in a clear manner that is easily understood by most community members. Using local, high-quality, and accessible data allows a local prevention team to accurately describe how community characteristics relate to substance use in each specific neighborhood or school, to identify possible priorities for intervention, and to support well-informed community members as they use hard data to choose strategies most likely to be successful in their individual communities. Collaborating with community-based researchers and supporting them to collect, process, and disseminate regular data is essential to this principle.

Guiding Principle 4: Integrate Researchers, Policy Makers, Practitioners, and Community Members Into a Unified Team Dedicated to Solving Complex, Real-World Problems

In many public and community health interventions, the connections between researchers, policy

makers, practitioners, and community members are more theoretical than functional and practical. Although they may share the same goal, each group tends to function in isolation from the others and at varying proximities from the problem itself. The IPM takes a team-science-to-practice approach to prevention that integrates researchers, policy makers, practitioners, and community members into a team that works to solve real-world problems in specific areas or neighborhoods over long periods of time. Thus, each group maintains close proximity to each other and the problem itself. While working together to implement each of the 10 Core Steps of the Icelandic Prevention Model (see Kristjansson et al., 2019), each group not only offers unique skills and experiences necessary for solving local problems related to substance use but also does so in a manner that seeks to both influence and be influenced by other team members. For example, using this approach, researchers are open to ideas from policy makers, practitioners, and community members and often rely on their practice-based insights to guide future directions in data collection and interpretation of existing data. Conversely, policy makers, practitioners, and community members come to rely on researchers when collecting data, making data-driven decisions, and evaluating community progress. By establishing this kind of functional team dynamic, the model aligns the expertise and efforts of researchers, policy makers, practitioners, and community members to maximize the practical, real-world impact of their collective capacity. Clarifying and maintaining the importance of collaboration is the crux of this principle.

Guiding Principle 5: Match the Scope of the Solution to the Scope of the Problem, Including Emphasizing Long-Term Intervention and Efforts to Marshal Adequate Community Resources

The model recognizes that the social conditions that promote substance use among young people emerge from multiple, complex sources over time. For example, previously established social norms related to substance use; community economic conditions; the prevalence of depression, anxiety, and addiction among adults; and a lack of interesting and accessible structured leisure time opportunities may all contribute to a rise in the rates of substance use and abuse among adolescents. The rise of any one of these contributing factors is complex and usually occurs over long periods of time. Therefore, solutions designed to counteract, mitigate, or eliminate these social conditions must account for the scope and magnitude of those initial problems. Problems that take 10 years to develop are seldom solved in 10 weeks or

even 10 months. More often, decade-long social problems may take years to address and require long-term vision and planning, sustained attention and commitment, adherence to an iterative and repetitive approach, and long-cycle or permanently committed financial resources. Since the model is based on an ongoing effort to alter society in a manner that protects young people from substance abuse, it must also prioritize creating the community capacity and long-term commitments necessary to achieve this goal. Understanding and appreciating that primary prevention as seen through the lens of the IPM is a long-term strategy will be necessary to live up to this guiding principle.

► DISCUSSION

The IPM in many ways mirrors what Livingood et al. (2011) have called for and labelled as an applied “toolkit approach” to health promotion. Rather than relying on universal and prescriptive interventions, the toolkit approach assumes that communities vary greatly in strengths, opportunities, and resources. For health promotion practice this means that although the influence of specific risk and protective factors operates similarly across individuals (Hemphill et al., 2011), their prevalence and significance differ at the school-community level (Hawkins, Van Horn, & Arthur, 2004). This is particularly important for primary substance use prevention because it underscores the appropriateness of community-wide diagnosis of risk and protective factors, and the local tailoring of intervention activities (Livingood et al., 2011).

Instead of attributing the risks of substance use initiation among children and adolescents to individual choices, the IPM is designed to maximize the odds of healthy individual choices as default and therefore for greater population impact than typically achieved through efforts limited to individual-level programs. This aligns with the premises of the Centers for Disease Control and Prevention Health Impact Pyramid (Frieden, 2010)—the five-layer pyramid that represents a spectrum of changes from population-level socioeconomic factors at the base of the pyramid, to the individual-level counseling and education at the apex of the pyramid—and assumes an inverse relationship between the increased individual effort needed at the top and the potential population impact at the bottom. Above changes in socioeconomic factors, the fourth layer in the pyramid concerns itself with “Changing the Context to Make Individuals’ Default Choices Healthy.” In the context of the Health Impact Pyramid, this is precisely the position and focus of the IPM. However, changing community norms and culture takes time, and time is

commonly a scarce resource to planners, funders, and elected officials who seek immediate answers or solutions to community problems. Thus, mutual agreement and understanding among stakeholders that the IPM is a long-term approach is essential for success.

In reviewing the five guiding principles of the IPM, it becomes apparent that individual elements of the model are not new. The key difference between the IPM and other prevention approaches concerns its processes and reliance on collaboration between representatives from sectors that usually do not interact or engage much with one another: researchers, policy makers, practitioners, and community stakeholders. At the local level, everyone is needed at the table to work in dialogue under the realization that each of these entities represents an important function in the system, and therefore each is also limited in their scope and strengths. Thus, a central theme in the approach is community engagement and collaboration to foster an environment that is resistant to substance use, assuming that the risk of substance use initiation among children and adolescents grows out of the social environment (Akers, Krohn, Lanza-Kaduce, & Radoceovich, 1979; Hirschi, 1969; Merton, 1938; Sigfusdottir et al., 2009). Thus, instead of facilitating behavior change at the individual level through educational and/or instructional programs, as is more common in traditional prevention work, the IPM assumes that changing the environment will generate less risk-prone individuals in the long term. It is therefore not a top-down program but a bottom-up community-building collaborative approach that is organized for long-term action, change, and maintenance of change.

In conclusion, the IPM has been in development and practice-based refinement for 20 years (Palsdottir, 2003; Sigfusdottir et al., 2009) and has demonstrated strong evidence of effectiveness in reducing substance use among Icelandic adolescents. Since the initiation of the *Youth in Europe* project in 2006 (Kristjansson, Sigfusson, Sigfusdottir, & Allegrante, 2013; Sigfusdottir, Kristjansson, & Agnew, 2012), the approach has been disseminated and scaled—in part or in whole—in several other countries, cities, and municipalities (Kristjansson et al., 2013; Kristjansson et al., 2017). During this time, we have learned which challenges most commonly impede full implementation and subsequent results. These challenges include inadequate organization and poor coalition building at the local level, limited funding and personnel with protected time to devote to primary prevention, low levels of political and administrative support and/or distrust in research, poor data collection preparation with schools and/or confusion about individual roles, low participation in community meetings and failure to garner wide community support and engagement, extended time between data collection and

report dissemination, confusion about data ownership and rights to distribution, limited interest in community engagement beyond informational meetings, lack of organizational and community-based strategies to identify and work on selected priorities, limited availability for structured leisure time activities and low commitment to improve/add opportunities, and insufficient time allowed to facilitate long-term changes. Part 2 in this series will examine these challenges and the respective steps we have found necessary to take in overcoming them when implementing primary prevention of adolescent substance use.

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REFERENCES

- Akers, R. L. (1977). *Deviant behavior: A social learning approach* (2 ed.). Belmont, CA: Wadsworth.
- Akers, R. L., Krohn, M. D., Lanza-Kaduce, L., & Radocevic, M. (1979). Social learning and deviant behavior: A specific test of a general theory. *American Sociological Review*, 44, 636-655.
- Anderson-Carpenter, K. D., Watson-Thompson, J., Chaney, L., & Jones, M. (2016). Reducing binge drinking in adolescents through implementation of the Strategic Prevention Framework. *American Journal of Community Psychology*, 57(1-2), 36-46.
- Atherton, O. E., Conger, R. D., Ferrer, E., & Robins, R. W. (2016). Risk and protective factors for early substance use initiation: A longitudinal study of Mexican-origin youth. *Journal of Research on Adolescence*, 26, 864-879. doi:10.1111/jora.12235
- European School Project on Alcohol and Drugs Group. (2016). ESPAD report 2015: *Results from the European School Survey Project on Alcohol and Other Drugs*. Retrieved from Luxembourg Publications Office of the European Union website: <http://espad.org/sites/espad.org/files/TD0116475ENN.pdf>
- Frieden, T. R. (2010). A framework for public health action: The Health Impact Pyramid. *American Journal of Public Health*, 100, 590-595. doi:10.2105/ajph.2009.185652
- Glanz, K., Rimer, B. K., & Viswanath, K. (2015). *Health behavior: Theory, research and practice* (5th ed.). San Francisco, CA: Jossey-Bass.
- Hawkins, J. D., Catalano, R. F., Arthur, M. W., Egan, E., Brown, E. C., Abbott, R. D., & Murray, D. M. (2008). Testing communities that care: The rationale, design and behavioral baseline equivalence of the Community Youth Development Study. *Prevention Science*, 9, 178-190.
- Hawkins, J. D., Van Horn, M. L., & Arthur, M. W. (2004). Community variation in risk and protective factors and substance use outcomes. *Prevention Science*, 5, 213-220. doi:10.1023/b:prev.0000045355.53137.45
- Hemphill, S. A., Heerde, J. A., Herrenkohl, T. I., Patton, G. C., Toumbourou, J. W., & Catalano, R. F. (2011). Risk and protective factors for adolescent substance use in Washington State, the United States and Victoria, Australia: A longitudinal study. *Journal of Adolescent Health*, 49, 312-320. doi:10.1016/j.jadohealth.2010.12.017
- Hirchi, T. (1969). *Causes of delinquency*. Los Angeles: University of California Press.
- Hopfer, S., Davis, D., Kam, J. A., Shin, Y., Elek, E., & Hecht, M. L. (2010). A review of elementary school-based substance use prevention programs: Identifying program attributes. *Journal of Drug Education*, 40, 11-36. doi:10.2190/DE.40.1.b
- Kendler, K. S., Myers, J., Damaj, M. I., & Chen, X. G. (2013). Early smoking onset and risk for subsequent nicotine dependence: A monozygotic co-twin control study. *American Journal of Psychiatry*, 170, 408-413. doi:10.1176/appi.ajp.2012.12030321
- Kristjansson, A. L., James, J. E., Allegrante, J. P., Sigfusdottir, I. D., & Helgason, A. R. (2010). Adolescent substance use, parental monitoring, and leisure-time activities: 12-year outcomes of primary prevention in Iceland. *Preventive Medicine*, 51, 168-171. doi:10.1016/j.ypmed.2010.05.001
- Kristjansson, A. L., Mann, M. J., Sigfusson, J., Sarbu, E. A., Grubliauskiene, J., Daily, S. M., & Sigfusdottir, I. D. (2017). Prevalence of e-cigarette use among adolescents in 13 Eastern European towns and cities. *Public Health*, 147, 66-68. doi:10.1016/j.puhe.2017.02.005
- Kristjansson, A. L., Mann, M. J., Sigfusson, J., Thorisdottir, I. E., Allegrante, J. E., & Sigfusdottir, I. D. (2019). Implementing the Icelandic model for preventing adolescent substance use. *Health Promotion Practice*. Advance online publication. doi:10.1177/1524839919849033
- Kristjansson, A. L., Sigfusdottir, I. D., Thorlindsson, T., Mann, M. J., Sigfusson, J., & Allegrante, J. P. (2016). Population trends in smoking, alcohol use and primary prevention variables among adolescents in Iceland, 1997-2014. *Addiction*, 111, 645-652. doi:10.1111/add.13248
- Kristjansson, A. L., Sigfusson, J., Sigfusdottir, I. D., & Allegrante, J. P. (2013). Data collection procedures for school-based surveys among adolescents: The Youth in Europe Study. *Journal of School Health*, 83, 662-667. doi:10.1111/josh.12079
- Kumpfer, K. L., Smith, P., & Summerhays, J. F. (2008). A wakeup call to the prevention field: Are prevention programs for substance use effective for girls? *Substance Use & Misuse*, 43, 978-1001. doi:10.1080/10826080801914261
- Livingood, W. C., Allegrante, J. P., Airhihenbuwa, C. O., Clark, N. M., Windsor, R. C., Zimmerman, M. A., & Green, L. W. (2011). Applied social and behavioral science to address complex health problems. *American Journal of Preventive Medicine*, 41, 525-531.
- Merton, R. (1938). Social structure and anomie. *American Sociological Review*, 3, 672-682.
- Moss, H. B., Chen, C. M., & Yi, H.-Y. (2014). Early adolescent patterns of alcohol, cigarettes, and marijuana polysubstance use and young adult substance use outcomes in a nationally representative sample. *Drug and Alcohol Dependence*, 136, 51-62.
- Myers, D. J. (2008). Epidemiologists, our patient is society. *New Solutions*, 18, 107-109.
- Nash, S. G., McQueen, A., & Bray, J. H. (2005). Pathways to adolescent alcohol use: Family environment, peer influence, and parental expectations. *Journal of Adolescent Health*, 37, 19-28.
- Palsdottir, D. (2003). *Drug-free Iceland: 2002 final report*. Retrieved from https://www.landlaeknir.is/servlet/file/store93/item10661/IAE_final2003.pdf

Appendix D

Scholte, R. H. J., Poelen, E. A. P., Willemsen, G., Boomsma, D. I., & Engels, R. C. M. E. (2008). Relative risk of adolescent and young adult alcohol use: The role of drinking fathers, mothers, siblings, and friends. *Addictive Behaviors, 33*, 1-14.

Sigfusdottir, I. D., Kristjansson, A. L., & Agnew, R. (2012). A comparative analysis of general strain theory. *Journal of Criminal Justice, 40*, 117-127. doi:10.1016/j.jcrimjus.2012.01.001

Sigfusdottir, I. D., Kristjansson, A. L., Gudmundsdottir, M. L., & Allegrante, J. P. (2011). Substance use prevention through school and community-based health promotion: a transdisciplinary approach from Iceland. *Global Health Promotion, 18*, 23-26. doi:10.1177/1757975911412403

Sigfusdottir, I. D., Thorlindsson, T., Kristjansson, A. L., Roe, K. M., & Allegrante, J. P. (2009). Substance use prevention for adolescents: The Icelandic model. *Health Promotion International, 24*, 16-25. doi:10.1093/heapro/dan038

Watkins, J. A., Howard-Barr, E. M., Moore, M. J., & Werch, C. C. (2006). The mediating role of adolescent self-efficacy in the relationship between parental practices and adolescent alcohol use. *Journal of Adolescent Health, 38*, 448-450.

Windle, M., & Zucker, R. A. (2010). Reducing underage and young adult drinking: How to address critical drinking problems during this developmental period. *Alcohol Research & Health, 33*, 29-44.

FACTUALLY INCORRECT STATEMENTS

Uniting Church statements	Drug Free Australia response
“The (Uniting Church) campaign calls for society to question whether our drug laws reflect the essential worth and rights of every person.” (p 4)	1. There is not a single human right that Australia has ever denied any Illicit drug user. But neither has there ever been a UN-sanctioned right to use drugs, something Uniting needs to be told 2. Further, there is no UN-sanctioned right to inflict harm on partners, children, parents, siblings, friends, other vehicle drivers and passengers, other workplace colleagues or the larger community. But this is a reality of drug use that drove a 110 year international consensus that illicit drugs are unacceptably harmful 3. Further, ‘HARM REDUCTION’ is the <u>centre-piece of Australia’s drug policy</u> precisely because illicit drugs cause unacceptable harms, but Uniting has to tacitly deny the many harms caused by drugs to support their extremely narrow compassion focus 4. Inflicting harm on others lessens the self-worth of drug users in their own eyes, let alone in those of their society. They know it is their voluntary choice to use drugs with the harms they inflict on others even if they feel that addiction coerces ongoing bad choices
“The campaign is proudly a partnership approach in recognition of the mutuality and interdependence between all people.” (p4)	1. Uniting’s policy statements specifically IGNORE the interdependence between all people by pretending drug use is an individualist phenomenon, downplayed as essentially affecting nobody, hardly even the user. Uniting specifically denies the Judeo-Christian notion that no man is an island
“The campaign also seeks to promote the active participation of those affected by the injustice of our drug laws, by giving voice to those with lived experience.” (p 4)	1. Uniting narrowly focuses on the self-inflicted misery of the drug user (their choice), elevating it above the broader misery inflicted on a whole constellation of people – partners, children, parents, siblings, friends and the community (not their choice). This is misplaced compassion

	2. Drug Free Australia's concern is for the impact on families when drugs become part of their lives. Because of over 35 years of Harm Minimisation, where Prevention and Demand Reduction has largely been ignored, intergenerational drug use is now common in families. This leads, in turn, to unprecedented levels of child abuse and neglect, young people unable to reach their full potential and poor role models in parents and significant others.
"Uniting believes in a fair go for everyone, but especially for those that are vulnerable." (p 4)	1. The UN's Convention on the <u>Rights of the Child</u> contains the right to be free from illicit drugs precisely because there are many who are more vulnerable to the harms wrought by drug use and users 2. On every available metric, decriminalising drugs predominantly increases drug use in under 25 year olds, whose developing brains are more vulnerable to long-term damage 3. FAIR? Is it fair that drugs cause road accidents which harm more than the occupants of a drug users vehicle? Is it fair that drugs in the workplace cause harms to more workers than the individual drug user? Is it fair that a user inflict harms on a whole constellation of people close to them?
"The stigma that has too long attached to people who live with drug dependency has discouraged many from having the open and honest conversation about their drug use that might have pointed them towards treatment."	1. Uniting appears to <u>support the LGBTQI+ movement</u> which seeks to stigmatise or even cancel those not supporting its aims, while condemning those not supporting the harms (where harm reduction is an industry) of drug use
"Yet the word 'decriminalisation' remains a misunderstood term, often conflated with the concept of legalisation, and often used by some of our media to drive an agenda based on fear, not facts" (p 4)	1. It is the drug users themselves that think decriminalisation allows them to legally use drugs recreationally – 43% of users in ACT thought <u>cannabis was now legal</u> when the ACT decriminalised cannabis. If users and media make the same mistake the problem is with decriminalisation as a policy simply because it invites misinterpretation

	2. Uniting's approach to decriminalisation is, practically-speaking, drug legalisation by another name (despite their protestations otherwise) in that any laws around illicit drug use will have no meaningful limits or deterrent value. It will give all appearances of sanctioning drug use
"We ask questions like: What should happen when someone is found with small quantities of psychoactive substances? Should the same thing happen to everyone? What about the person supplying these substances?" (p 4)	1. It is a fact that drug users often fund their own habit by lower level dealing, where the law already distinguished between higher level and lower level drug dealers. Both low and high-level dealers are part of the same problem 2. Small quantities are carried by drug user/dealers precisely because there are larger penalties for higher level dealing, successfully limiting the number of people that can be harmed by low level dealing
"The 2019 National Drug Strategy Household Survey showed that there continues to be strong public support among Australians for measures amounting to the removal of criminal sanctions for possession for personal use of all prohibited drugs" (p 6)	1. The cited Survey asks only about support for the decriminalisation of cannabis, not of heroin, amphetamines, cocaine or ecstasy. Uniting seeks to position "referral to treatment or education" as support for decriminalisation when the question does not stipulate 'with a conviction' or 'with no conviction'
"Only a small proportion of people who use drugs experience drug dependency (i.e. use that causes social, financial, psychological or physical problems)." (p 7)	1. Possibly Australia's most prolific researcher on heroin use, Prof. Shane Darke, said in The Conversation in 2014, "The typical picture of an active heroin user is a dependent, long-term unemployed person, with a long history of treatment and relapse, and a history of imprisonment. Heroin is simply not the sort of drug that could be termed recreational because very few people use it in non-dependent, non-compulsive fashion." 61% of of Sydney injecting room clients are on social security (see p 70) and 10% involved in sex work (see p 15), dispelling the myth of the functional drug user 2. Drug dependency is not the only vexing issue with drug use - for instance, 29% of ecstasy deaths within Australia are from car accidents

	which endanger the lives of the driver, occupants and those in other vehicles 3. Using United's logic, those drivers who speed on our roads without causing loss of life should not be penalised for their speeding. The law does not work that way with speeding or with drug use
"Existing drug laws create unnecessary barriers, stopping people getting into treatment, increasing social stigma and heightening the isolation among those who need support." (p 7)	1. To the contrary, Australia has a government-sanctioned Australian Injecting and Illicit Drug Users League (AIVL) which has reach into most drug user networks. Syringe programs also boast an extensive reach.
"By responding with law and order rather than treatment and support, society is punishing people rather than trying to help." (p 7)	1. Uniting's false dichotomy between 'law and order' and 'treatment and support' is contradicted by the success of Sweden which had Europe's highest drug use in the 1960s but the lowest by the 1990s using mandatory rehab, which coalesces treatment with court inducement
"Treatment works. By refocusing the system on helping people, lives can be saved, money can be saved, and law enforcement resources can be redirected." (p 7) "... because the act of removing currently-existing sanctions could send a signal that drug use is now permissible. The experience of countries that have decriminalised use/possession is that this does not occur (see, for example, the discussion of Portugal in section 3 ahead)." (p 12)	1. Uniting is referencing here the failed Portugal model where law enforcement funds were redirected into treatment. Portugal's drug use rose 59% in 16 years, drug deaths increased by 59% and use by high school minors increased 60%. Australia's Tough on Drugs prevention approach between 1998 and 2007 saw a 42% decrease in drug use (p 8) and a 75% decrease in overdose deaths (p 8). 2. Increased drug use means more treatment, more mental health issues, more school drop outs, more workplace accidents, more abuse and neglect of children, as well as increased family violence and dysfunction.
"...many schemes only withhold criminal sanctions for the first few occasions a person is found in possession. This is presumably on the grounds that if a person is repeatedly found in possession, after having been provided with an alternative and a more lenient response, then it is appropriate for the full force of the criminal law to operate." (p 11)	1. Uniting's assertion that repeated violations of drug laws should not eventually attract a criminal penalty wrongly assumes that addiction is a disease, like leukemia, which may or may not be reversed. Rather addiction is clearly a psycho-social issue where the choices of a drug user, albeit at times psychologically constrained by their

Uniting calls for: • No limit on the number of referrals (to treatment or education) a person may receive • No civil sanctions for non-compliance.” (p 13)	addiction, are paramount 2. Stripping meaningful consequences for repeated illicit drug use entails a quasi-legalisation drug policy model simply because Uniting argues against even coerced treatment or rehab. In this regime, the drug user controls Australian drug policy 3. The 2019 NDSH Survey indicates 99% of Australians do not give their approval to the use of heroin, speed and ice, with cocaine (97%), ecstasy (96%) and cannabis (80%) indicating that Australians would rather live without drug use. Australians clearly want LESS drug use, not more, whereas Uniting’s approach will only create more drug use, as has happened with decriminalisation regimes before
“A second rationale appears to be that removing criminal sanctions itself has risks. This may be either because criminal sanctions are presumed to be an effective and appropriate deterrent, or because the act of removing currently-existing sanctions could send a signal that drug use is now permissible.” (p 12)	1. According to the 2019 NDS Household Survey 73% of Australians say they have no interest in ever trying drugs. 32% of Australians say they will not try drugs because of their illegality – that means that drug laws are working nicely. 10% of Australians who have never used cannabis would try it for the first time if made legal, while another 3% of users would have it more often. Illegality as deterrence is demonstrably evidenced
“Given the fact that 43.2% of people over the age of 14 have used drugs in their lifetime (with 16.4% in the past year), taking no action is a credible option, at least for the vast majority of people who use drugs and are not dependent.” (p 13)	1. The statistics do not support Uniting’s assertion. The very same 2019 survey they cite shows that 96-99% of Australians do not give their approval to the regular use of heroin, ice, speed, cocaine or ecstasy, with 80% not giving their approval to regular cannabis use. This means that 62%, the majority of past illicit drug users, agree on their futility and harm and no longer use them. Australian disapproval of drugs indicates they would prefer users not use drugs
“There has been no major increase in drug use in Portugal in the nearly two decades since criminal penalties were removed, while rates of problematic use and use by adolescents has fallen, as have rates of drug-related deaths. Outcomes have also	1. Who has misled Uniting with these egregiously false statements about Portugal? Portugal surveys their drug use every 5 years

improved, with fewer people appearing before the courts, increased rates of people receiving drug treatment, and reduced social costs of drug misuse.” (p 16)	- use increased between 2001 and 2017 by 59%, an alarming increase - overdose deaths increased 59% - use by high school minors rose 60% - overdose deaths increasing by 59% indicates opiate use has increased by roughly the same percentage – so problematic use demonstrably increased - when drug use is no longer a crime there is no need for courts or appearances - but that doesn’t stop the increased harm from increased drug use - social costs of drug use obviously rose with increased use and deaths - see Drug Free Australia’s document on Portugal with all the official data 2. If Uniting is trying to infer decriminalisation does not increase drug use elsewhere, here are Australia’s own statistics of huge initial increases for SA (1987) and the ACT (1992) from a level of negligible baseline use (p 53), finally settling at the same levels as NSW and Victoria, which already had entrenched criminal networks selling cannabis. Use marijuana monthly or more often for four jurisdictions, 1988–1996 <table><thead><tr><th>Year</th><th>SA</th><th>ACT</th><th>NSW</th><th>Vic</th></tr></thead><tbody><tr><td>1988</td><td>25%</td><td>25%</td><td>25%</td><td>15%</td></tr><tr><td>1991</td><td>38%</td><td>25%</td><td>22%</td><td>18%</td></tr><tr><td>1993</td><td>32%</td><td>32%</td><td>25%</td><td>20%</td></tr><tr><td>1995</td><td>25%</td><td>25%</td><td>25%</td><td>20%</td></tr></tbody></table> Source: NDS 1988, 1991, 1993, 1995; those who have never tried marijuana are excluded The same happened in all US States that decriminalised as well as the Netherlands where virtual decriminalisation was pursued. WA decriminalised cannabis and then recriminalised recognising the damage cannabis was doing	Year	SA	ACT	NSW	Vic	1988	25%	25%	25%	15%	1991	38%	25%	22%	18%	1993	32%	32%	25%	20%	1995	25%	25%	25%	20%
Year	SA	ACT	NSW	Vic																						
1988	25%	25%	25%	15%																						
1991	38%	25%	22%	18%																						
1993	32%	32%	25%	20%																						
1995	25%	25%	25%	20%																						
“However, we would hope and expect that decriminalisation would mean better access to help for parents whose drug dependency is impacting their parenting.” (p 17)	3. The evidence is in, and Uniting is ignoring that the diversion of policing resources to ‘treatment’ in Portugal only led to increased use of the most dangerous drugs along with																									

	increases in overdose deaths. Australia's Tough on Drugs prevention approach 1998-2007 saw a 42% decrease in drug use (p 8) and a 75% decrease in overdose deaths (p 8). Children were the winners with these positive impacts.
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MISGUIDED ASSERTIONS

Uniting Church statements	Drug Free Australia response
"For those who do not develop drug dependency, the current reliance on criminal sanctions puts at risk careers and opportunities." (p 7)	1. Uniting ignores the fact that drug users who don't develop a debilitating dependency are often the agents promoting their drug use to others who will develop a debilitating dependency. They are part of the problem and have historically been treated as such
"We believe that, among other things, good laws generally display the following characteristics: transparency, equity, focus and proportionality. Uniting proposes these principles should be applied to the legislation governing the possession and personal use of illegal drugs in NSW and the ACT. In fact, to not do so would, in our view, be an abrogation of good public policy making." (p 8)	1. <u>These 'principles' are based on the misleading premise that 'drugs will always be here,</u> so laws should be focused on reducing harm, rather than reducing and preventing initial use'. A more balanced approach is the alternative as laid out by Drug Policy Futures. Of particular note are principles 4 and 5 of their listed Principles
"The principle of equity supports the decriminalisation of the personal use of all prohibited drugs" (p 12)	1. And unfortunately for Uniting, the same principle of Equity historically led to all illicit drug use being criminalised. They cannot therefore complain if cannabis use was treated as severely as heroin use
"Drug dependency generally is a symptom of underlying vulnerability and disadvantage, and therefore sanctions like fines and community service are likely to exacerbate that disadvantage." (p 15)	1. This is a naïve statement and omits the fact that many who possess small quantities of drugs are actually in a network of people selling drugs to make money, only keeping small amounts in possession to pretend its for personal use. Taking away the ability to

	confiscate and the deterrent of possible civil sanctions will allow these business-people to flourish and increase in numbers.
"The question is, in a decriminalised system where there are no criminal sanctions for possession/use on its own, should possession/use remain an aggravating factor when other crimes are charged?" (p 17)	1. In cases where drug induced violence, particularly due to cannabis or ice is concerned, the causality of an addiction should not go without penalty or coerced rehab.
"The more serious a person's drug dependency, the more likely it will be that their use does not exist in isolation, but is a symptom of deeper social and psychological issues or part of a reinforcing complex of structural vulnerabilities. Therefore, people with drug dependency may have difficulty making good decisions about their own long-term best interests and compounding this by adding fines or orders for non-compliance helps no one." (p 15)	1. This kind of thinking comes from the same George Soros-funded irrationality that seeks to empty prisons of people doing real crimes. The fact is that the harms done by drug use to families and community are a crime, and must be treated as such with penalties and coerced rehab.
"A staged approach would probably be required, starting with the removal of criminal sanctions for possession/use under the threshold quantity, and the gradual replacement of threshold quantities with other criteria for determining supply/trafficking in due course."	1. Uniting again ignores the fact that traffickers of large quantities of drugs use syndicates of individual 'pushers or mules' so that, if caught, they claim 'possession for personal use'.

The Truth on Portugal

Countering false claims by activists concerning Portugal's decriminalisation using its own official statistics

**DRUG
FREE**
AUSTRALIA



EXECUTIVE SUMMARY

Portugal's drug policy needs to be compared to what has successfully worked in Australia - our Tough on Drugs policy from 1998 to 2007.

Australia's **Tough on Drugs reduced the use of all illicit drugs by 39%** between 1998 and 2007. **It reduced opiate overdose deaths by 67%.**

Portugal decriminalised all drugs in July 2001. By 2007, use of any illicit drug had risen by 9%. This was followed by decreases in drug use by 2012, in line with decreases in other European countries. By 2017 though, drug use was **59% HIGHER** than in 2001. This represents a failure in Portugal's drug policy.

Use of any drug by high-school students aged 16 and over was **36% HIGHER** in 2011 than it was in 2001, despite initial decreases up to 2006. According to a separate ESPAD survey, use of cannabis by 16 year old high-school students was **59% HIGHER** in 2015 than before decriminalisation.

Claims that decriminalisation in Portugal was responsible for reduced opiate use fail to recognise that opiate use was already falling **BEFORE July 2001, from 0.9% in 1998 to 0.7% in 2000**. A successful opiate reduction strategy was already in place before decriminalisation.

Claims that Portugal's drug use fell below European averages likewise fails to note that Portugal has always, other than for heroin use, been below European averages. In 2001, Portugal's drug use per capita was **one-fifth** that of Australia's.

Those overdose deaths in Portugal which are directly comparable to Australian overdoses have **INCREASED 59%** since 2001.

Reductions in HIV in Portugal are constantly attributed to the 'success' of decriminalisation. However, **HIV notifications reduced from their 1999 high by 23% BEFORE decriminalisation** even commenced, demonstrating that successful reduction policies were already in place before July 2001.

Portugal, with no complaint from those who promote its drug policies, coerces rehabilitation. Australia would well do the same.

Iceland has shown that its resilience-based education for school children can significantly lower drug use, as did our own Tough on Drugs.

Portugal's decriminalisation has produced increased drug use and increased deaths. Tough on Drugs markedly reduced both. Extensive surveys of Australians show that they do not approve the use of illicit drugs, indicating that Australians want less drug use, not more. Portugal's drug policy has produced more drug use, not less.

A GLOSSARY OF TERMS CAN BE FOUND AT APPENDIX B ON PAGE 31

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The Truth on Portugal

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', selectively using data with no context rather than giving the full picture.

But here is the reality, using Portugal's own official data 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.



http://www.emcdda.europa.eu/publications/national-reports/portugal-2014_en
<http://www.emcdda.europa.eu/html.cfm/index86763EN.html>

Drug Free Australia researchers have also used the most current information from as late as June 2018, available at:

<https://drugfree.org.au/index.php/resources/library/9-drug-information/182-portugal.html> - select [Integrated Drug Policy Manuel Cardoso SICAD \(zip file\)](#)

and

https://www.qmhc.qld.gov.au/sites/default/files/downloads/the_portuguese_experience_0.pdf

First, Australia's superior Tough on Drugs results

Compare the results of Australia's 'Tough on Drugs' strategy between 1998 and 2007 to those of Portugal in this document (Tough on Drugs was scrapped by the new Federal government of late-2007). The Tough on Drugs approach worked within an environment of States and Territories maintaining criminal penalties for use of all illicit drugs other than cannabis.

USE OF ALL ILLICIT DRUGS DECLINED BY 39% BETWEEN 1998 AND 2007.

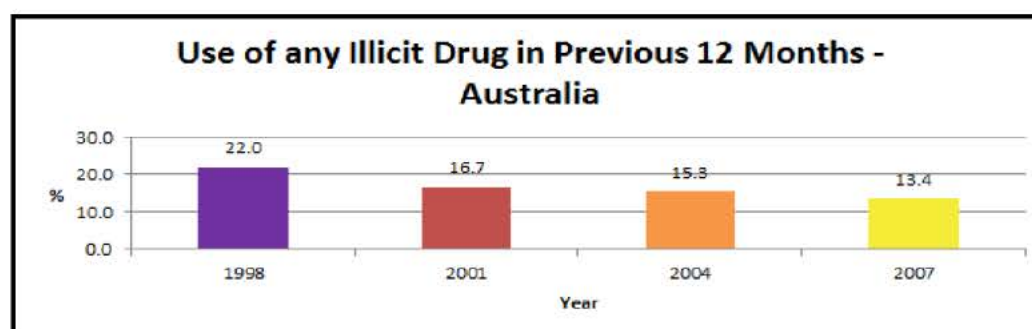
View the actual drug use statistics for Portugal, then return here to compare them to the superior success of our Tough on Drugs approach.

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

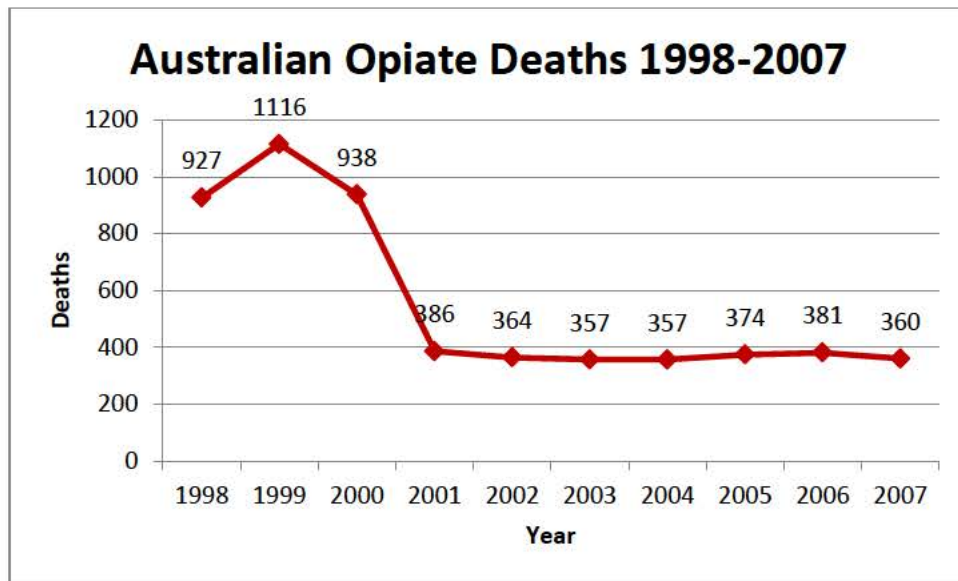
Drug/behaviour	1993	1995	1998	2001	2004	2007	2010
Illicit drugs (excluding pharmaceuticals)							
Cannabis	12.7	13.1	17.9	12.9	11.3	9.1	10.3
Ecstasy ^(b)	1.2	0.9	2.4	2.9	3.4	3.5	3.0
Meth/amphetamines ^(c)	2.0	2.1	3.7	3.4	3.2	2.3	2.1
Cocaine	0.5	1.0	1.4	1.3	1.0	1.6	2.1
Hallucinogens	1.3	1.9	3.0	1.1	0.7	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)	14.0	16.7	22.0	16.7	15.3	13.4	14.7

<https://www.aihw.gov.au/getmedia/85831350-afb6-4524-8d8d-764fa5d2d1f8/12668-20120123.pdf.aspx>

p 8



During Tough on Drugs Australian opiate deaths plummeted.

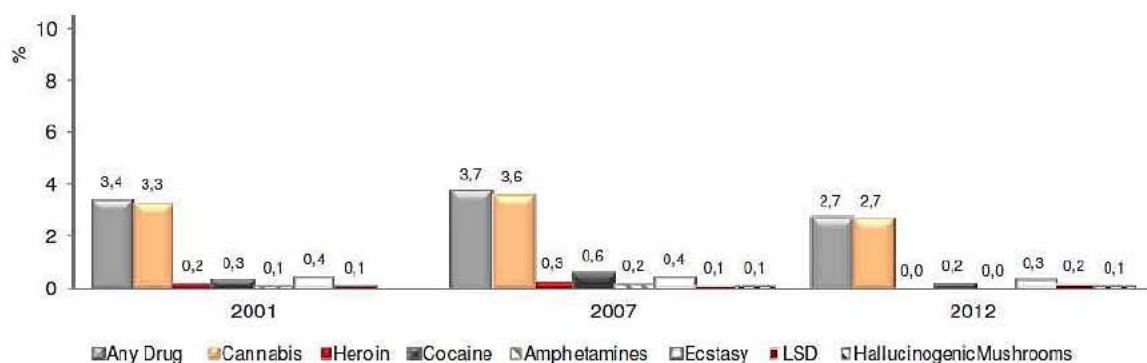


Portugal – overall drug use ROSE after decriminalisation

Since the implementation of decriminalisation in 2001 drug use for all age-groups in Portugal rose through to 2007 - compare the grey bars in Portugal's official REITOX 2014 annual report (page 26) to the European Monitoring Centre graphed below. While cannabis use increased marginally for all aged groups, cocaine use doubled as did use of speed and ice.

AGED 15-64

Any drug	Up 9%
Cannabis	Up 9%
Heroin	Up 50%
Cocaine	Doubled
Speed/Ice	Doubled
Ecstasy	No change
LSD	No change
Magic Mushrooms	Up from negligible to 0.1%

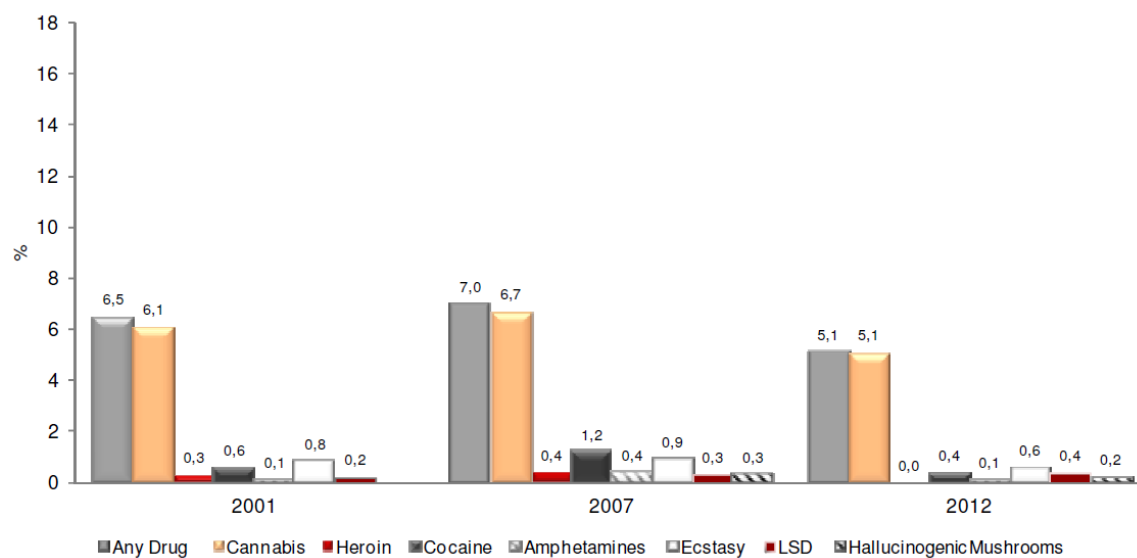


Graph 3 – General Population, Portugal – Total (15-64), last 12 months prevalence, by type of drug (%) (SICAD2013)

Drug use by young people aged 15-34, as graphed by the REITOX report (below), saw greater increases.

AGED 15-34

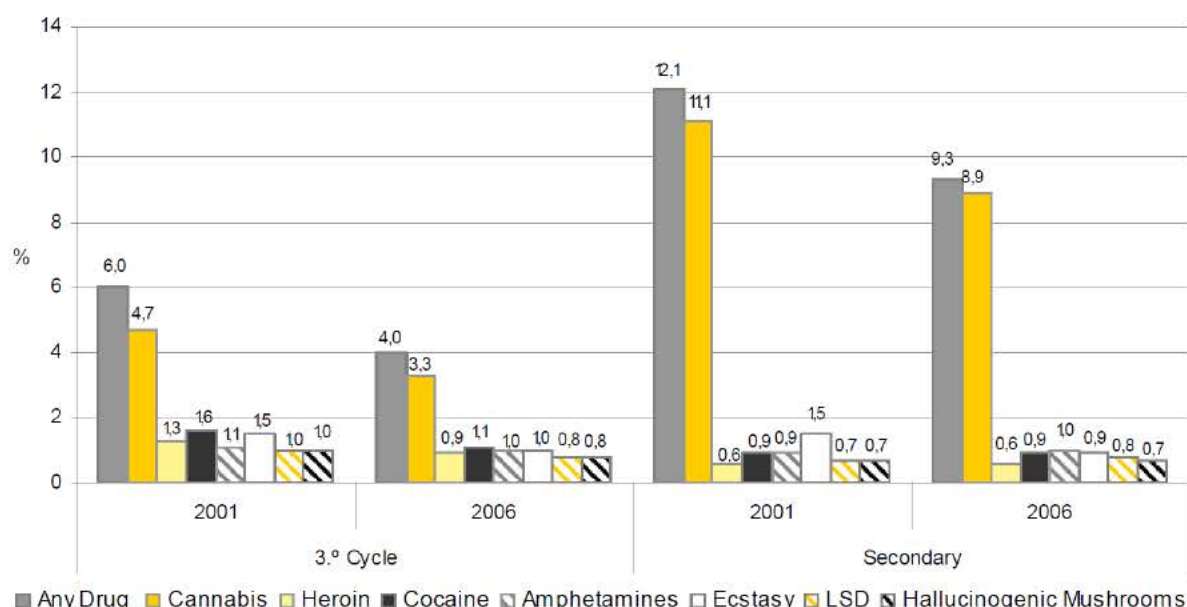
Any drug	Up 8%
Cannabis	Up 10%
Heroin	Up 33%
Cocaine	Doubled
Speed/Ice	Quadrupled
Ecstasy	Up 13%
LSD	Up 50%
Magic Mushrooms	Up from negligible to 0.3%



Graph 4 – General Population, Portugal – Young Adult Population (15-34 years), last 12 months prevalence, by type of drug (%) (SICAD2013)

Although high-school student use fell from 2001 to 2007

The dominant message given by activists about Portugal is that decriminalisation did not cause increases in drug use. Only high-school student use did fall - by 33% for 3rd Cycle students (typically aged 13-15) and by 23% for secondary students (aged 16-18) as per graphs copied below from the 2008 REITOX National Report for Portugal (page 23). A Cato Institute report promoting the "success" of decriminalisation made much of these decreases while downplaying the increases for the greater part of the population already seen in the graphs above.



Graph 7 - School Population – 3rd Cycle and Secondary: Last Month Prevalence, by type of Drug

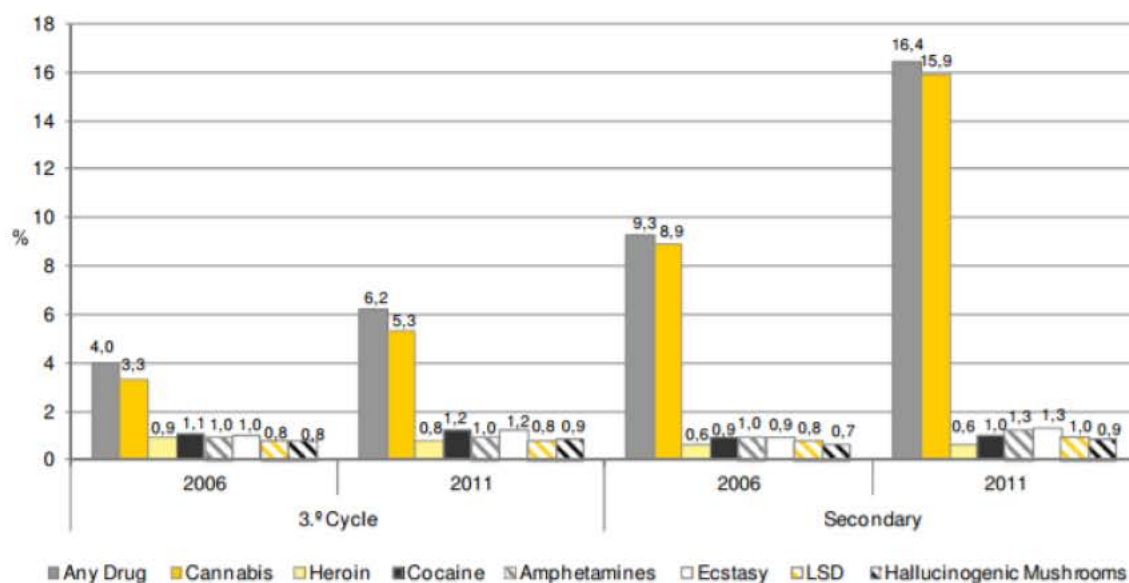
Overall drug use fell from 2007 to 2012

Between 2007 and 2012 drug use in Portugal for all age groups declined in line with general decreases across various European countries.

Italy - Opiates	0.8% (2005)	0.48% (2011)
Spain - Opiates	0.6% (2000)	0.29% (2012)
Switzerland - Opiates	0.61% (2000)	0.1% (2011)
Italy - Cocaine	1.1% (2001)	0.6% (2012)
Italy - Speed/Ice	0.4% (2005)	0.09% (2012)
Austria - Speed/Ice	0.8% (2004)	0.5% (2012)

Yet high school use rose sharply from 2006 to 2011

Use of any illicit drug by high-school students rose markedly between 2006 and 2011. The graph below is again copied directly from page 37 of the 2014 REITOX report to the EMCDDA. From 2001, when decriminalisation commenced, Secondary School drug use in 2011 was 36% higher than 2001 and 76% higher than in 2006.



Graph 15 – School Population – INME (3º Cycle and Secondary): Last 30 Days Prevalence of use, by type of drug (IDT, I.P. 2012)

By 2017 drug use was 59% higher than in 2001

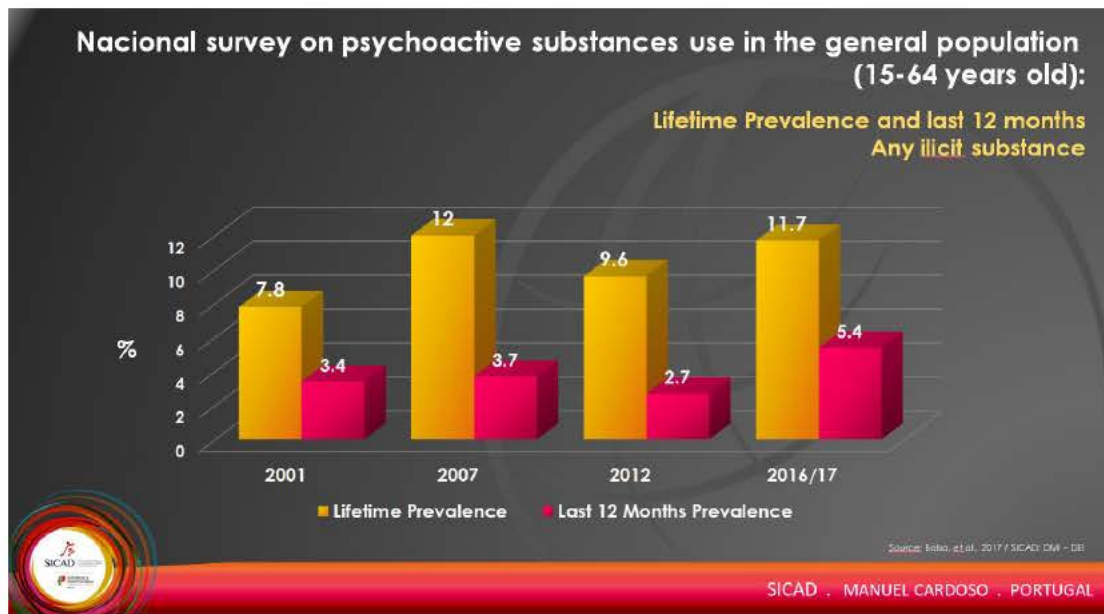
While Portugal has not yet reproduced the results of its 2016-17 survey in the usual REITOX National Report which would give a breakdown of use for each drug type, the figures for overall illicit drug use are available from a presentation by Manuel Cardoso, the Deputy General-Director of SICAD, Portugal's 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

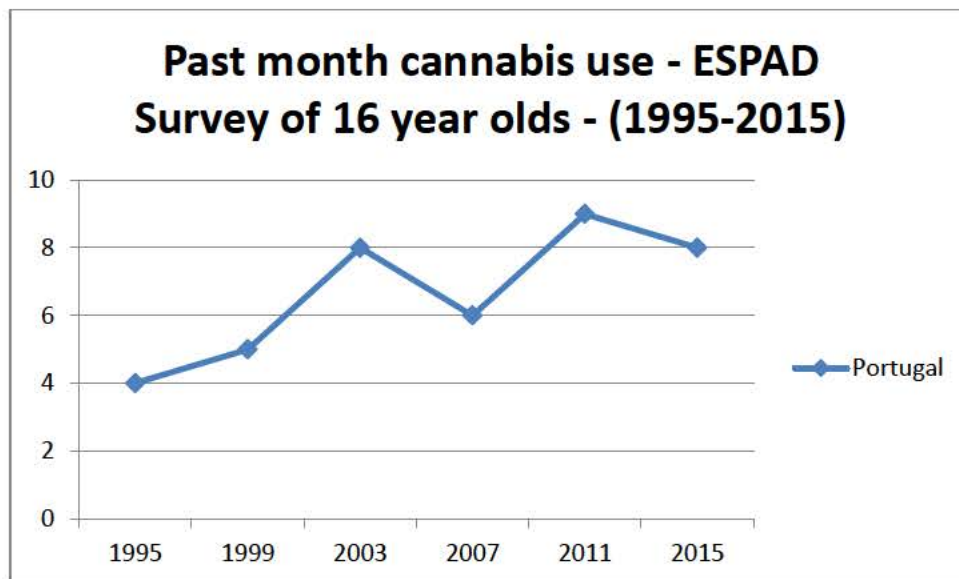
2001	3.4
2007	3.7
2012	2.7
2017	5.4



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 1999

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.



Implications of a failed drug policy

Because drug use has such a profoundly negative effect on those within the relational orbit of any drug user, there is a multiplication of harm to friends, family and community as additional new users are inducted into use.

The drug which predominates in drug use percentages in Portugal is cannabis. As cannabis use increases so does its harms, which from the tens of thousands of peer reviewed studies on cannabis are as follows:

- Cannabis users are 50% more likely to develop alcohol use disorder
- Cannabis use is associated with a 2 times greater risk of psychosis
- Cannabis use is associated with a 4 times greater risk 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

Appendix F

- Newborns are adversely affected with appearance, weight, size, hormonal function, cognition and motor function adversely affected through to adulthood and it is now established that cannabis literally shatters chromosomes, which when recombined cause deleterious conditions for the unborn
- Cannabis use causes COPD & bronchitis
- Cancers of the respiratory tract, lung and breast are associated with cannabis use, with the chances of lung cancer doubling even when tobacco use is excluded
- Cannabis is also associated with cardio-vascular stroke and heart attack, with risk of myocardial infarction 5 times higher after one joint

Taking as an example just one single cannabis harm of all those listed above, psychosis affects many others beyond the individual user, dispelling the misguided notion that drug use is fine because it affects none other than those that choose to use drugs. But users of high THC cannabis preparations have a 5 times elevated risk of suffering psychoses, [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(14\)00117-5/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(14)00117-5/fulltext) with the UK's Professor Robin Murray estimating that one in every six cases of psychosis in the UK is caused by high potency cannabis with one in every four in London being likewise caused by cannabis use. <http://www.dailymail.co.uk/sciencetech/article-5881123/Psychiatric-expert-claims-one-six-people-psychosis-linked-cannabis-use.html>

Those arguing for the legalisation and decriminalisation of illicit drugs state that drug use is a civil right because drugs only harm the individual who uses them. But continuing to take cannabis-induced psychosis as an example, it is clear that it negatively affects:

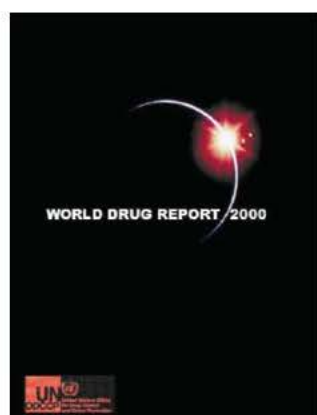
The user's partner
The user's children
The user's parents and siblings
The user's friends
The user's employer and workmates
The community's mental health facilities
The community's hospitals

Though the list is incomplete, it is abundantly clear that the only way to reduce such harms is to institute a national drug policy which fully rehabilitates drug users and works to prevent the recruitment of new users. This is where Portugal's drug policy is failing.

In 2001, 3.3% of the 3.4% using any illicit drug, (343,000 of Portugal's population of 10,395,000), were using cannabis. In 2017, it is highly likely that 5.2% of the 5.4% using any illicit drug were using cannabis, (535,000 of Portugal's 10,291,000), giving an increase of close to 200,000 users now additionally susceptible to the cannabis harms listed above, including the aforementioned cannabis-induced psychosis. These are very significant increases in use and associated harms.

Opiate use was already falling before decriminalisation

Much has been made of the decreases in heroin use in Portugal after decriminalisation. But Portugal's opiate use, which had topped OECD countries in 1998 at a staggering 0.9% according to the United Nation's World Drug Report for 2000, halved to 0.46% by 2005.



ANNEX 2 | ANNUAL PREVALENCE OF ABUSE OF ILLICIT DRUGS

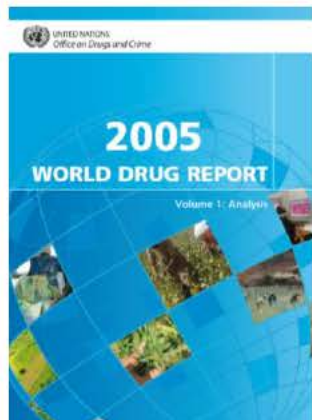
EUROPE	Cannabis		Opiates		Cocaine*		Amphetamines		Ecstasy	
	%	Year	%	Year	%	Year	%	Year	%	Year
Western Europe										
Austria	3.0	1996*	0.2	1998	0.5	1996*	0.2	1996*	0.8	*
Belgium (18-65)	5.0	*	0.2	**	0.5	**	0.5	**	0.7	1998*
Denmark (18-69)	4.0	1995*	0.3	1995	0.3	1995	0.9	1995*	0.7	*
Finland	2.5	1998*	0.05	1997*	0.2	1998	0.1	1998*	0.2	1998*
France (18-69)	4.7	1995	0.3	1997*	0.2	1995	0.3	1995*	0.3	*
Germany (18-59)	4.1	1997	0.2	1998	0.6	1997	0.4	**	0.8	1997**
Greece (12-64)	4.4	1998*	0.4	*	0.5	**	0.06	1998*	0.01	1998*
Ireland	7.9	1995*	0.3	1997*	0.6	**	0.6	**	1.0	**
Italy	4.6	**	0.5	1997*	0.6	1996*	0.5	**	0.5	*
Liechtenstein	0.8	1996	0.1	1998	0.4	1998	0.02	1997	0.2	1998
Luxembourg	4.0	1998*	0.5	1997*	0.4	**	0.3	1998	0.2	*
Malta	2.2	**	0.2	1998	0.1	1996	0.01	1997	0.2	*
Monaco	0.4	1996	0.1	1995	0.01	1994	0.01	1993	0.4	*
Netherlands (12 and above)	5.2	1998	0.2	1998	0.7	1998*	0.4	1997*	0.8	1998*
Norway	3.8	1998*	0.2	1997*	0.3	1997*	0.5	1997*	0.1	**
Portugal	3.7	**	0.9	1998	0.5	1998*	0.2	**	0.1	*
San Marino	4.0	1997*	0.02	1997*	0.04	1994	0.3	1994	0.3	*
Spain	7.6	1997*	0.6	1999	1.7	1997	0.8	*	1.0	1997*
Sweden (15-75)	0.1	1998	0.1	1997	0.2	1998*	0.2	1997	0.1	1998*
Switzerland (18-45)	8.5	1998*	0.5	1998	0.5	1998*	0.7	**		
Turkey			0.01	1998						
United Kingdom	9.0	1998*	0.5	**	1.0	1998*	1.3	**	1.0	1998*
OCEANIA										
		Cannabis		Opiates		Cocaine*		ATS (1)		
		%	Year	%	Year	%	Year	%	Year	
Australia (14 and above)		17.9	1998	0.7	1998	1.4	1998	3.6(2.4)	1998	
Fiji		0.2	1996							
Micronesia Fed.State.		29.1	1995							
New Caledonia		1.9	**							
New Zealand		15.0	1998	0.6	1998	0.04	1998	2.0	1998	
Papua New Guinea (6-45)		29.5	1995			0.01	1995			
Vanuatu		0.1	1997							

* UNDCP estimate
** Tentative estimate for the late 1990s
* Includes abuse
(1) Where available Ecstasy prevalence in brackets
Source: Global Illicit Drug Trends 2000

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However roughly half of that decreased use predated decriminalisation, with 0.7% recorded in the UN World Drug Report for the year 2000 as reproduced on the next page. It is not clear what dynamic was in play for the 22% decrease in heroin use by 2000, the year prior to decriminalisation. However it may well have continued to be the dynamic at play without decriminalisation being a factor – we simply do not know.

Appendix F



World Drug Report 2005 Volume 2: Statistics

OPIATES	
Annual prevalence of abuse as percentage of the population aged 15-64 (unless otherwise indicated)	
EUROPE	
East Europe	
Russian Federation, 2001	2.1
Ukraine*, 2002	0.8
Belarus*, 2003	0.4
Moldova, Rep., 2000	0.07
Southeast Europe	
Croatia, 1999	0.7
Bulgaria, 2001	0.5
Albania*, 2000	0.5
FYR of Macedonia, 1998	0.4
Romania*, 2002	0.3
Turkey, 2002	0.05
Western and Central Europe	
Latvia, 2001	1.7
Estonia, 2001	1.2
United Kingdom, 2001	0.9
Luxembourg, 2000	0.9
Italy, 2002	0.8
Denmark, 2001	0.7
Portugal, 2000	0.7
Spain, 2000	0.6
Switzerland, 2000	0.6
Ireland, 2001	0.6
Lithuania, 2002	0.6
Slovenia, 2001	0.5

It appears that heroin use is simply not recorded for 2012 in the REITOX report graphs on pages 7 & 8 of this document, and it is not at all clear why. Other data on page 71 of the same 2014 REITOX report (facsimile below) show that presentations for heroin use scored higher for outpatients and for detox units than any other type of illicit drug. Heroin also made up 42% of residential rehab admissions.

Regarding the characterization of users' consumption that went in 2013 to the different structures of drug treatment³⁰ can be seen that, in outpatient, heroin remains the main substance more reported by patients in treatment in the year (82%). At the level of those who started treatment in 2013, this also occurred in the case of users readmitted (77%), but not in the case of new users, where cannabis has emerged as the main substance most referred (49%).

Also among patients of DU's, heroin was the main drug most often reported (66% public and 69% in the licensed), but in TC's this occurred at licensed (42%) level but not at the public, where main drug most reported was cocaine (61%).

Portugal's drug use was initially below European averages

Activist claims that Portugal's drug use is below European averages ignores the fact that Portugal, before decriminalisation, initially had drug use below European averages other than for heroin, as can be seen in the Annex 2 Table copied onto page 14 of this document. Compared to Australia in 2001, Portugal had overall drug use one-fifth of Australian levels.

From 2001 to 2017 decriminalisation, despite being coupled with coerced rehabilitation and treatment, has failed to decrease the burden of drug use in Portugal, despite concerted efforts to target problem drug users with what they title "dissuasion". The diversion of funding from law enforcement to dissuasion and treatment has not ultimately succeeded.

Rising drug deaths in Portugal

Claims that there were significant decreases in drug-related deaths in Portugal immediately following decriminalisation are based on two errors.

First, 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'

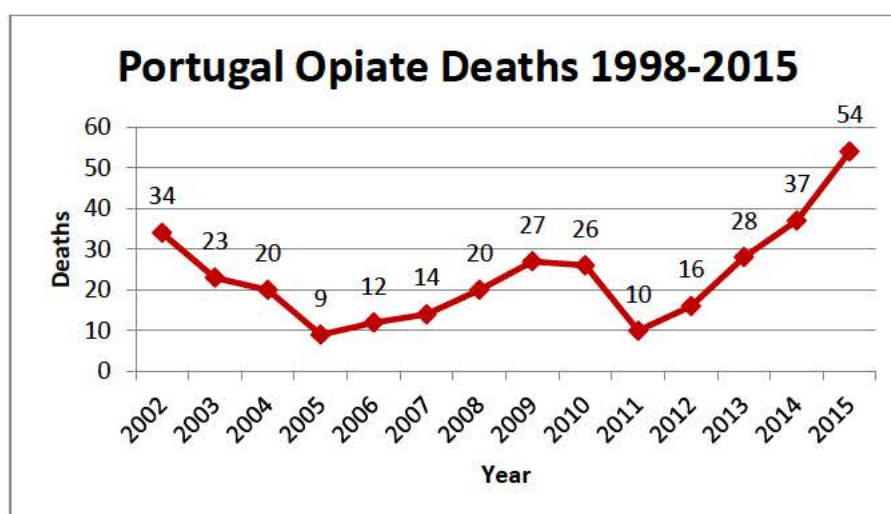
[Download as Excel file \(.xlsx\)](#)

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, (see Appendix for definitions) 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 on pages 14-15, which predated decriminalisation with reductions from 0.9% in

Appendix F

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 on page 6. 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.

One of the claims for Portugal that is in fact correct is that they have lower overdose deaths per million population than Australia. Below are the statistics for both countries to 2007 when Australia's Tough on Drugs ceased.

Year	PORTUGAL		AUSTRALIA	
	Deaths	Per Million	Deaths	Per Million
2002	34	3.3	364	18.5
2003	23	2.2	357	18.1
2004	20	1.9	357	17.9
2005	9	0.9	374	18.4
2006	12	1.1	381	18.5
2007	14	1.3	360	17.2

The most obvious factor for the much lower rate of overdose deaths per million population is that only 18% of heroin users inject heroin (*see circled datum on the EMCDDA Table copied on the next page*) whereas most heroin users in Australia inject. Users who smoke or snort their opiates do not run the same risks of overdose as injectors.

Appendix F

Country	High-risk opioid use estimate		Entrants into treatment during the year						Clients in substitution treatment
			Opioids clients as % of treatment entrants			% opioids clients injecting (main route of administration)			
			All entrants	First-time entrants	Previously treated entrants	All entrants	First-time entrants	Previously treated entrants	
Year of estimate	cases per 1 000	% (count)	% (count)	% (count)	% (count)	% (count)	% (count)	count	
Latvia	2014	3.4–7.5	46.2 (382)	24.7 (102)	67.8 (280)	91 (343)	87.1 (88)	92.4 (255)	518
Lithuania	2007	2.3–2.4	88.2 (1 905)	66.6 (227)	92.6 (1 665)	84.4 (1 607)	84.6 (192)	84.3 (1 402)	585
Luxembourg	2007	5–7.6	53.9 (146)	46.4 (13)	51 (100)	50.3 (72)	15.4 (2)	52 (51)	1 121
Hungary	2010–11	0.4–0.5	4.2 (196)	1.6 (51)	9.5 (118)	60.2 (109)	55.1 (27)	63.5 (73)	745
Malta	2014	5.3–6.2	72.8 (1 277)	27.5 (58)	79 (1 219)	63.4 (786)	47.3 (26)	64.1 (760)	1 013
Netherlands	2012	1.1–1.5	10.5 (1 113)	5.7 (346)	16.9 (767)	6.5 (44)	9.3 (18)	5.4 (26)	7 569
Austria	2013	4.9–5.1	50.8 (1 737)	29.2 (435)	67.3 (1 302)	35.9 (479)	23.1 (79)	40.3 (400)	17 272
Poland	2009	0.4–0.7	44.8 (1 061)	4.7 (162)	25 (877)	61.3 (632)	39.1 (61)	65.1 (555)	2 586
Portugal	2012	4.2–5.5	53.8 (1 538)	26.3 (357)	78.8 (1 180)	18.3 (255)	12.5 (39)	19.9 (216)	16 587
Romania	–	–	41.8 (1 094)	15.1 (211)	74 (852)	93.4 (1 007)	85.7 (180)	94 (799)	593

http://www.emcdda.europa.eu/edr2016_en p 71

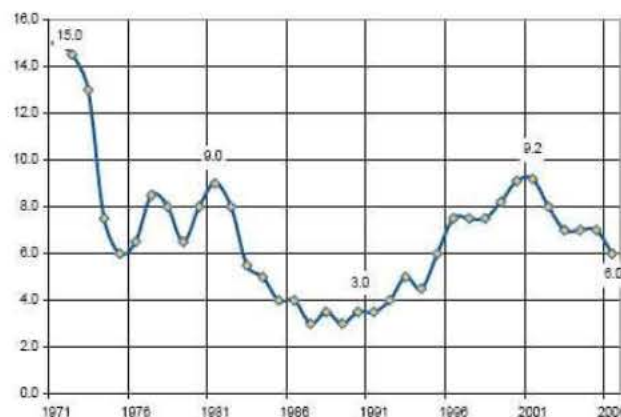
If Australia wants to replicate the low death rates from opiates, health authorities will have to convince Australians of the switch from injecting to smoking or snorting. It is unlikely that Australians will change.

However, smoked heroin is a harm reduction measure that is manifestly not the logical birth-child of decriminalisation. Netherlands has long promoted smoked heroin while drug use in that country is still technically criminalised.

Portugal uses coerced rehab and treatment

Portugal's policy coerces treatment and rehab, as does Sweden's which reduced its drug use from the late 1970s from the highest levels in Europe to the lowest in the developed world by the early 1990s with coerced rehabilitation central to its drug policy. In the graph below from the United Nation's https://css.unodc.org/pdf/research/Swedish_drug_control.pdf decreases align with Swedish spending on rehab, which decreased between 1990 and 2001 due to Sweden's economic recession, but which was reinstated after 2001.

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



Source: C&N

Coerced rehabilitation has successfully reduced drug use in Sweden, and is not cited as an impingement on users' rights in Portugal by those who claim that everything Portugal is good. There is therefore no excuse for politicians to be discouraged from using the success of Sweden's coerced rehab policies within Australia, given its acceptability in Portugal.

HIV decreases not due to decriminalisation

Drug legalisation/decriminalisation activists falsely claim that sharp decreases in Portugal's HIV incidence year on year are the result of decriminalisation.

Both HIV and Hepatitis C (HCV) are transmitted by sharing used needles. While Australia has some of the lowest HIV rates despite a sizeable injecting user population it has an HCV prevalence of 65% (<https://catalogue.nla.gov.au/Record/3301382> p25) which is no different to any other drug-using country (ie typically 60-70% <http://www.ifngo.org/main/pmwiki.php?n=Policy.DrugAbuse>). While Australia's Needle & Syringe Programs (NSPs), the envy of every other country worldwide, took credit for our low HIV rates, our high HCV prevalence makes it clear that a majority of our injectors still often share needles despite provision of clean needles by our state-of-the-art NSPs. The failure of

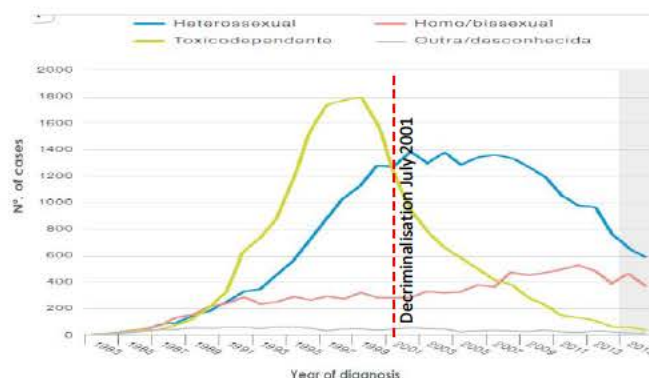
NSPs to control HCV has been confirmed by the world's most authoritative review of NSPs (<https://www.nap.edu/catalog/11731/preventing-hiv-infection-among-injecting-drug-users-in-high-risk-countries> p 145). If so many users are sharing needles as witnessed by high HCV rates, then Australia's low HIV rates are logically due to something other than NSPs.

The founder of Australian NSPs, Dr Alex Wodak, expressed alarm in a 1997 Medical Journal of Australia article (<https://www.ncbi.nlm.nih.gov/pubmed/9087180>) titled "Hepatitis C: Waiting for the Grim Reaper" where the apparent ineffectiveness of NSPs in preventing HCV led him to propose a new Grim Reaper campaign to target its spread. This of course suggests that Australia's Grim Reaper television advertising campaign targeting HIV was the likely reason for low HIV levels in Australia, not NSPs. Australia's higher levels of HIV testing than other countries also contributes.

While Australia's HIV interventions effectively stopped any growth in contracted HIV from an initially low base of infected persons, Portugal has had to initially contend with the highest HIV levels in Europe with 45% of Portugal's intravenous users having contracted HIV in the late 1990s. However, the identified interventions which have reduced HIV notifications in 2016 to less than 1 in 10 of their intravenous users (see http://www.emcdda.europa.eu/countries/drug-reports/2018/portugal/drug-harms_en) are not at all unique to decriminalisation.

First, from the graph below it is clear that the greatest reductions in HIV transmissions were already being achieved BEFORE the introduction of decriminalisation in mid-2001 (decreases from January to June 2001 can reasonably be expected to match the proportional magnitude of those in the year 2000). The significant decreases in opiate use, also before 2001 as discussed on pages 14-15, would be a contributor.

Diagnose of HIV infection by characteristics of sampled population, Portugal 1983-2015



Source: INSA, IP (2015). Infecção VIH/SIDA: in Portugal a 31 de dezembro de 2014. Lisboa: Instituto Nacional de saúde Doutor Ricardo Jorge, IP

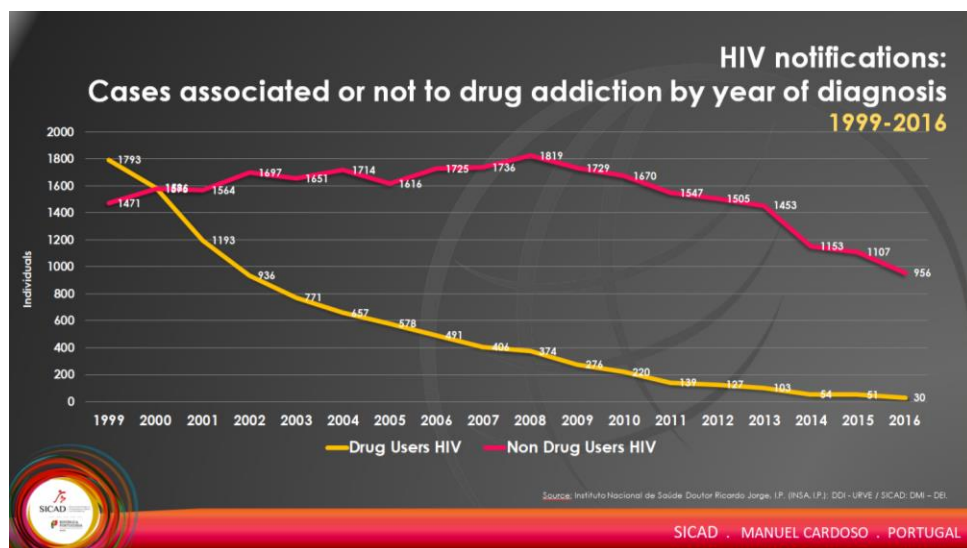


Interventions on Addictive Behaviour and Dependencies | João Castel-Branco Goulão 07/04/18

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https://www.qmhc.qld.gov.au/sites/default/files/downloads/the_portuguese_experience_0.pdf

Greater detail in Manuel Cardoso's graph of HIV reductions copied below, allows a more exact estimate of HIV reductions before decriminalisation. In 1999 there were 1793 notifications, reducing to 1586 by the year 2000. This then reduced to 1193 by the end of 2001. Given that decriminalisation commenced in July that year, it is reasonable to attribute half of the reductions for 2001 to pre-decriminalisation drug interventions, giving a 23% reduction in HIV notifications from 1999 to June 2001, the month before decriminalisation. This indicates that whatever interventions were in place in a criminalised drug policy regime were likely to have worked as successfully in a decriminalisation drug policy regime.



Second, the success in decreasing heterosexual HIV transmissions evident from 2007 onwards also demonstrates that factors other than the decriminalisation of drug use were causal for decreases in HIV.

Third, while the move by Portuguese opiate users from intravenous drug use to smoked or snorted opiate use will have been somewhat responsible for the decreased transmissions of HIV, these changes are not the result of decriminalisation because they are not unique to decriminalisation. Smoked and snorted opiate use also happens within drug policy regimes that still maintain criminal penalties for drug use.

Fourth, one important factor has been the provision of free and readily available HIV screening, the very same factor that has led to low HIV transmissions in Sweden and Norway <https://www.ncbi.nlm.nih.gov/pubmed/14533729>. Yet freely available HIV testing and counseling in Sweden and Norway succeeds in a CRIMINALISED context, therefore free HIV testing is not synonymous with decriminalisation, given that it works successfully in either context.

While Portugal's success with HIV must be applauded, there is nothing to suggest that decriminalisation has in any way been causal. And overblown activist claims about HIV reductions need to be publicly corrected.

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 2016, and Table 9.17 from its statistical data

<https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/data> indicates Australian approval or disapproval of the regular use of various illicit drugs.

97-99% of all Australians do not give their approval to the use of heroin, cocaine, speed/ice and ecstasy, and 86% do not give their approval to the regular use of cannabis.

Table 9.7: Personal approval of the regular use by an adult of selected drugs, people aged 14 years or older, 2007 to 2016 (per cent)												
Drug	Males				Females				Persons			
	2007	2010	2013	2016	2007	2010	2013	2016	2007	2010	2013	2016
Tobacco	15.8	17.4	17.3	18.1	12.9	13.3	12.2	13.2	14.4	15.3	14.7	15.7#
Alcohol	51.7	51.5	51.7	52.4	39.0	38.9	38.6	39.8	45.3	45.1	45.1	46.0
Cannabis	8.7	11.0	12.6	17.8#	4.6	5.3	7.0	11.2#	6.7	8.1	9.8	14.6#
Ecstasy	2.6	3.0	3.3	3.9	1.5	1.7	1.6	1.8	2.0	2.3	2.4	2.9#
Meth/amphetamine ^(a)	1.5	1.5	1.6	1.6	0.9	0.9	1.1	0.8	1.2	1.2	1.4	1.2
Cocaine/crack	1.8	2.2	1.9	2.0	1.0	1.2	1.3	1.4	1.4	1.7	1.6	1.7
Hallucinogens	2.1	3.2	4.5	5.1	1.2	1.6	1.7	2.4#	1.7	2.4	3.1	3.7#
Inhalants	1.0	1.3	0.9	0.9	0.7	0.8	1.0	1.0	0.8	1.0	0.9	1.0
Heroin	1.3	1.5	1.3	1.3	0.7	1.0	1.1	1.0	1.0	1.2	1.2	1.1
Pharmaceuticals ^(a)	15.5	23.3	24.5	28.7#	11.9	21.4	21.9	26.9#	13.7	22.4	23.2	27.8#
Prescription pain-killers/analgesics ^(a)	n.a.	13.4	13.0	13.2	n.a.	12.6	12.2	12.1	n.a.	13.0	12.6	12.7
Over-the-counter pain-killers/analgesics ^(a)	n.a.	14.4	14.8	19.5#	n.a.	14.3	14.2	18.7#	n.a.	14.3	14.5	19.1#
Tranquilisers, sleeping pills ^(a)	4.8	7.2	9.5	10.1	3.4	5.7	6.8	8.5#	4.1	6.4	8.2	9.3#
Steroids ^(a)	2.5	3.0	3.0	3.0	1.0	1.4	1.5	1.8	1.7	2.2	2.2	2.4
Methadone, or buprenorphine ^(a)	1.1	1.5	1.3	1.6	1.0	1.0	1.2	1.1	1.0	1.2	1.3	1.3

Statistically significant change between 2010 and 2016.
(a) For non-medical purposes.
Note: The list of response options changed across survey waves. Comparisons should be interpreted with caution.
Source: NDSHS 2016.

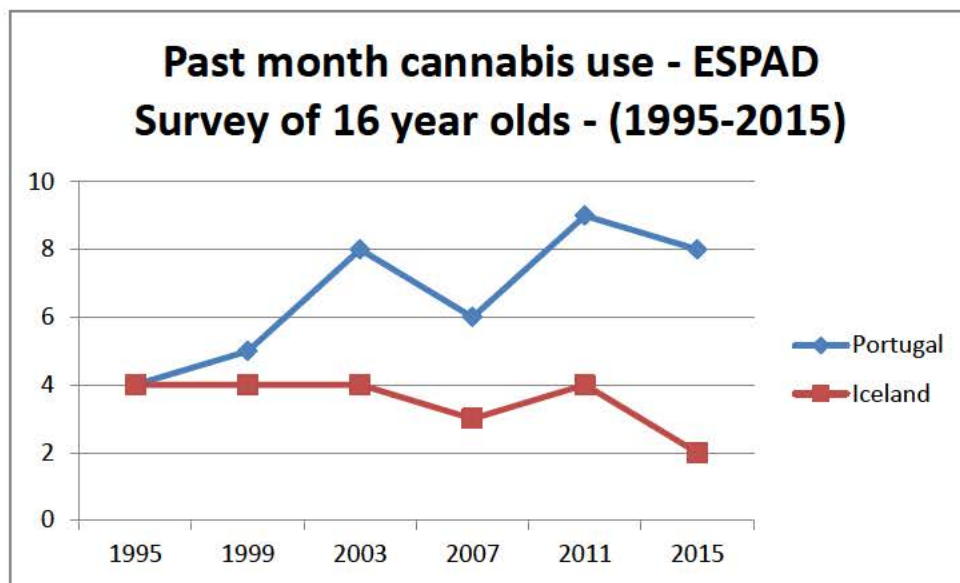
Australians want less drugs, not more

With 97-99% of all Australians not giving their approval to the use of heroin, cocaine, speed/ice and ecstasy, and 86% 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. Decriminalisation of drugs has been associated worldwide with increased drug use. (see <https://drugfree.org.au/images/13Books-FP/pdf/Decriminalisation.pdf>) Australians need to be educated about the real results of decriminalisation, and the misleading portrayals of Portugal's drug policy need public correction.

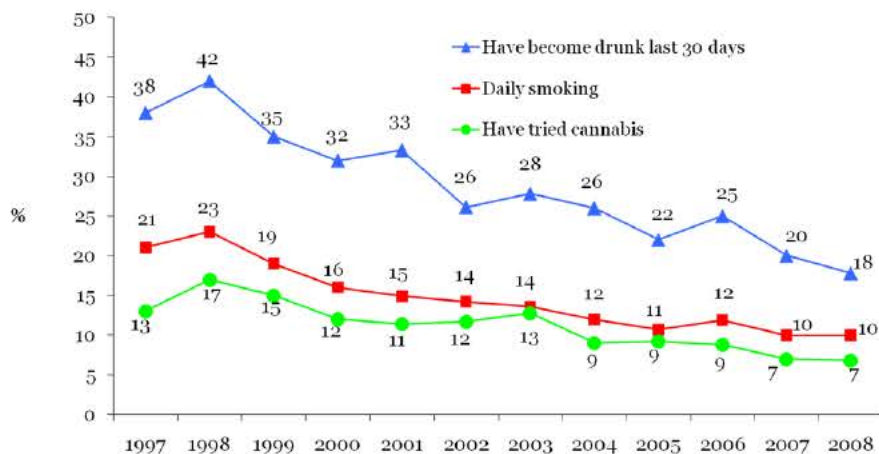
And some governments haven't failed their citizens

In contrast to the increased drug use by high-school age young people under Portugal's decriminalised regime, Iceland instituted a resilience-based education program for their high-school age young people, with good success. Resilience-based programming puts an emphasis on a whole of community approach, where older people are more intentionally connected with young people, passing on values learnt from experience. Iceland has put an additional emphasis on sports programs, seeking high levels of involvement by their school-age children.

The results:



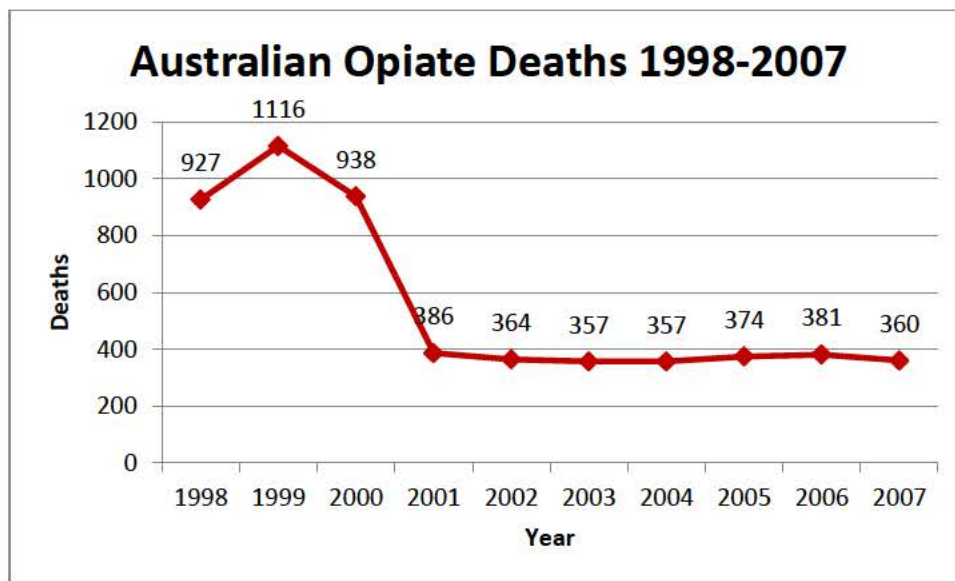
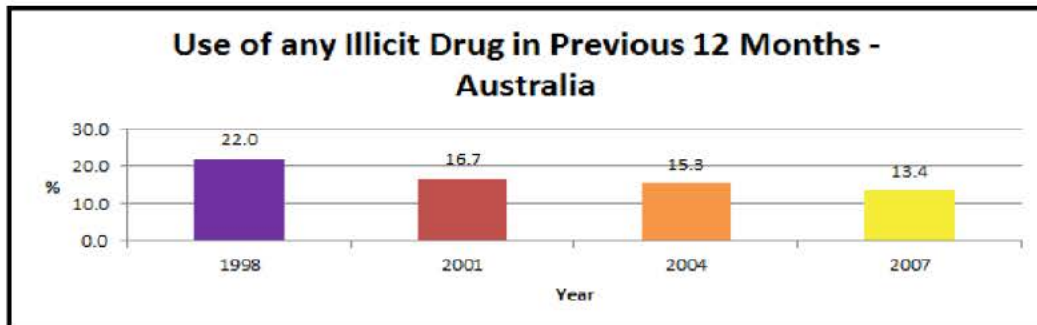
Substance use amongst 10th graders (16 years) in
Iceland from 1997 to 2008



Iceland demonstrates that rates of teen drug use are reversible, and that national approaches can be highly successful.

For those who say that approaches from Sweden and Iceland can never work within our Australian culture (which is just groundless excuse-making), then all that is needed are the Tough on Drugs graphs from the first pages of this document.

All Australia lacks is political courage and political will.



Conclusions

Most of the claims being made for the 'success of Portugal's decriminalisation of all types of drug use are false claims.

- Decriminalisation has increased drug use for all age-groups
- Decriminalisation has seen sharp increases amongst high-school students
- Portugal's drug use, other than for heroin, was initially lower than European averages
- It is not clear what caused major decreases in opiate use before decriminalisation, but opiate use was in fact declining before decriminalisation
- While drug deaths in Portugal are much lower in Portugal due to heroin being smoked or snorted rather than injected, drug overdose mortality is currently increasing
- HIV decreases are mostly not due to decriminalisation
- Other countries have proven interventions which have markedly reduced drug use, with coerced or mandatory rehab acceptable to their populations
- Australia's Tough on Drugs shows a far superior success to Portugal

Recommendations

Australian politicians and media need to acquaint themselves with the real statistical picture for Portugal rather than accepting the false claims of activists at face-value

Australian politicians and media need to be aware that Portugal coerces treatment and rehab and therefore should reject the notion that coerced treatment could never be accepted by drug users or a country's voters

Australian politicians and media need to seek every opportunity to advance the truth and not the false claims made about Portugal

Australian politicians need to recognise that Australians want less drugs, not more, and legislate those strategies which reduce drug use - Tough on Drugs was one such strategy

APPENDIX A – drug death definitions

In 2012, the journal *Drug and Alcohol Review* reproduced an attempt by Caitlin Hughes and Alex Stevens to reconcile conflicting views of Portugal's drug statistics.



HARM REDUCTION DIGEST—44

A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs

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In this Harm Reduction Digest two observers and scholars of the 2001 Portuguese drug policy reform consider divergent accounts of the reform which viewed it as a 'resounding success' or a 'disastrous failure'. Acknowledging from their own experience the inherent difficulties in studying drug law reform, Caitlin Hughes and Alex Stevens take the central competing claims of the protagonists and consider them against the available data. They remind us of the way all sides of the drug policy debates call upon and alternatively use or misuse 'evidence' to feed into discussions of the worth, efficacy and desirability of different illicit drug policies. In doing so they provide pause for thought for those of us who operate as drug policy researchers and drug policy advocates.

SIMON LENTON
Co-editor, Harm Reduction Digest

Introduction

In July 2001 as part of a comprehensive new policy Portugal decriminalised use, acquisition and possession of all illicit drugs when conducted for personal use. Sales of all illicit drugs remained as criminal offences. Ten years on, the reform has attracted considerable

about drug use and related harms, is often implied to be the tested, trustworthy tool for generating policies 'devoid of dogma' [7], this case study provides a much needed opportunity to examine the way *all* sides of the drug policy debate can call upon and alternatively use or misuse evidence to feed into discussions of the worth, efficacy and desirability of different illicit drug

This document has already described Portugal's definition of drug-related deaths through to 2009 when this data was reanalysed, creating new statistics for drug-induced deaths (EMCDDA's Selection B for Portugal) versus other drug-related deaths. On the following pages we have reproduced the discussion by Hughes and Stevens which confirms that only Appendix B deaths are comparable to Australian overdose data. We note that some activists make comparisons between Australia's and Portugal's mortality data, making conclusions about the lower mortality per million population in Portugal, while illegitimately using Selection D deaths to affirm decreasing deaths up to 2016. This of course is not legitimate.

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A resounding success or a disastrous failure 107

if not more importantly, the accounts had differential appreciations of the weaknesses of the adopted indicator for reporting on deaths attributable to illicit drug use.

Unlike much of the Western world, Portugal has not historically collected or reported information on deaths that are directly attributable to drug intoxication. Indeed, information on 'overdose' only became available in November 2010 (following calls by the EMCDDA and Instituto da Droga e da Toxicodependência (IDT) for harmonisation and improvement of indicators of drug-related deaths) [12]. Until recently the primary indicator 'drug-related deaths' has been produced by the INML and defined as the number of deaths that involve a positive post-mortem toxicological test for the presence of illicit substances [12]. It is the only data available before and after the reform, but it has two major limitations. First, as noted by Greenwald, it is responsive to changes in recording practices, such as the number of toxicological autopsies. Second, it is only an indirect indicator of attribut-

able death; many people are found to have traces of a drug in their body when they die, but this does not mean that the drug caused the death. This is why the standard international classification of drug-related death relies on reports by physicians on their assessment of the cause of death, *not* positive toxicological tests [41].

The data weaknesses and a substantial rise in toxicological autopsies from 2005 to 2009 give merit for suggesting that as argued by both Greenwald and our own account [8], the rise in 'positive post-mortem toxicological tests' may have been largely spurious. Yet neither the possibility of a spurious change nor substantial changes in recording practices were mentioned in the Pinto accounts.

Data from the National Statistics Institute (INE) has recently been made available and backdated from 2001 onwards. This provides a more accurate indicator of drug-attributable death as it refers to the number of people that have been determined by doctors according to International Classification of Diseases protocols

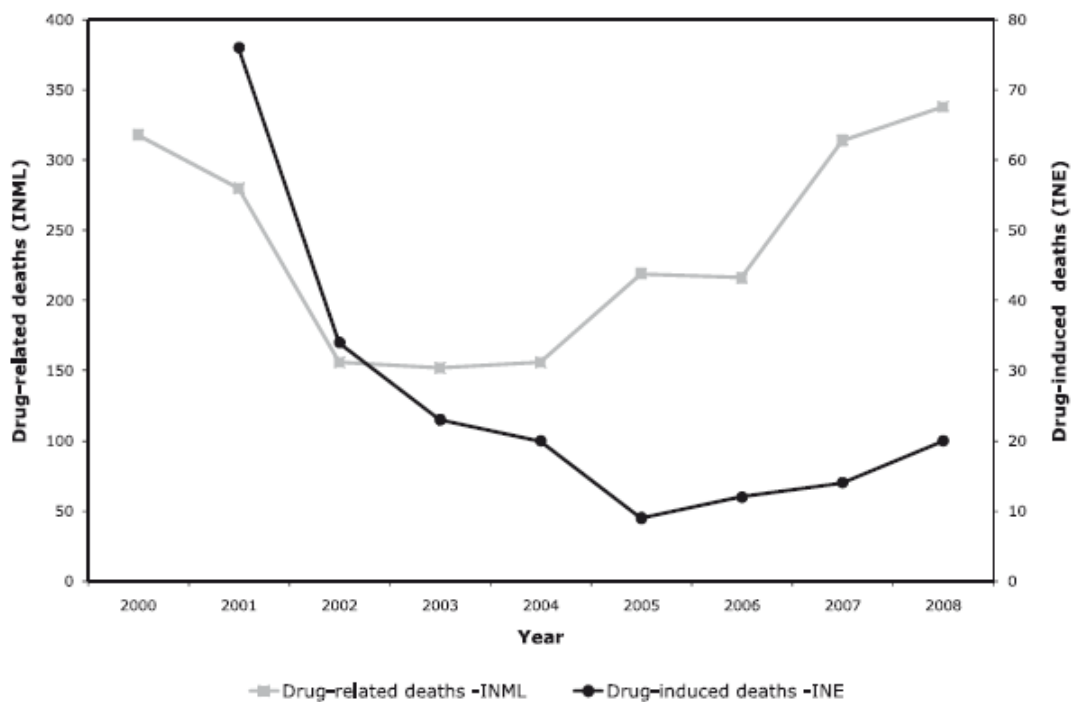


Figure 4. Drug-related deaths in Portugal between 2000 and 2008 using National Institute of Forensic Medicine (INML) definition (positive post-mortem toxicological test for drugs) and National Statistics Institute (INE) definition (determination by physician according to International Classification of Diseases criteria that death was attributable to drugs). Source: Instituto da Droga e da Toxicodependência (2009, 2010) [12,42].

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to have died due to drugs [12]. INE data support the hypothesis that the reported rise in the INML data was spurious as the number of people determined by physicians to have died due to drug use decreased from 2001, with a slight increase from 2005 to 2008/9 (to levels that remain much lower than at the time of decriminalisation) [12,42] (see Figure 4). This is not to say that decreases are attributable solely to the reform, with the expanded services a more plausible explanation, but a key goal of the reform had been to reduce social stigma and thereby facilitate access to Portuguese drug treatment and harm reduction services. As shown in Hughes and Stevens [8] drug treatment access in Portugal expanded considerably post-reform. This provides partial evidence that the reform may have contributed to the observed declines.

Examining the other assertion by Pinto of a 40% rise in 'drug-related homicides' in post-reform Portugal, it is clear that this was based on a false attribution to the World Drug Report. The data referred to all homicides, that is, any intentional killing of a person, including murder, manslaughter, euthanasia and infanticide [43]. The 2009 World Drug Report [44] merely speculated that the rise 'might be related' to drug trafficking activity:

While cocaine seizures in a number of European countries increased sharply during that period, in 2006, Portugal suddenly had the sixth-highest cocaine seizure total in the world. The number of murders increased 40% during this same period of time, a fact that might be related to the trafficking activity. Although the rate remains low and Lisbon is one of Europe's safest cities, Portugal was the only European country to show a significant increase in murder during this period.

There is no way of grounding or assessing whether the rise in homicides was drug-related or, if they were, whether they were attributable to the reform. Indeed, a striking omission from the Pinto assertions has been attention to the proposed causal mechanism (and its validity or lack thereof). For example, is it reasonable to assume that decriminalisation of penalties for minor drug use offences, in the absence of any legislative change for traffickers, would have a detectable effect on drug-related homicide? A much more plausible hypothesis is that this association is an artefact of increased European demand for cocaine and geography: namely that Portugal is one of two main gateways through which cocaine flows into Europe [40]. This leads us to conclude that assertions of a rise in drug-related homicide have questionable validity. They also run counter to our earlier reported trend that drug-related crime reduced, rather than increased post-reform [8].

Appendix F

Overdose deaths > Trends > EMCDDA 'Selection B'

Country	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995
Austria *	122	150	139	194	221	237	207	223	221	186	202	196	185	192	84	153	167	135	119			
Belgium			61	74	72	94	106	155	146	118	86	105	74	97				113	48	123	137	132
Bulgaria *	22	17	15	21	24	25	41	38	74	52	29	40	26	15	13	24	41	28	21	16	11	19
Croatia	56	54	59	48	48	59	73	61	87	115	72	84	88	57	52	64	51	48	34	36	33	47
Cyprus																						
Czech Republic	41	53	35	39	32	22	29	33	24	19	19	19	14	18	13	31	23	24				
Denmark		201	250	247	249	301	254	277	267	246	227	207				258	247	239	243	256	242	214
Estonia	114	88	98	111	170	123	101	133	67	81	68	57	98	36	86	45	31	22	7	4		
Finland	194	166	176	201	213	197	156	175	169	143	138	126	135	101	97	110	134	119	84	98	107	
France			370	349	264	340	392	365	374	333	305	301	267	231	242	272	247	118	143	228	393	465
Germany		1306	1195	1179	1079	1076	1205	1276	1326	1284	1169	1223	1104	1161	1139	1239	1487	1337	1280	1088	1305	1227
Greece																						
Hungary	32	56	42	39	44	17	20	33	30	38	36	19	23									
Ireland													112									
Italy			263	244	288	254	270	358	391	473	443			415	530	698	851	950	1068	1097	1369	1231
Latvia	18	18	15	11	17	11	7	19	24	20	17	14	14	12	35	36	42	32	3	5	1	
Lithuania	109	115	87	54	70	45	51	68	61	76	62	32	38	40	33	35	45	37	32	34	23	9
Luxembourg	5	12	8	11	8	6	12	14	10	27	19	8	13	10	12	16	21	14	22			
Malta	5	8	2	3	7	5	5	8	8	11	7	8	6	5	8	7	6	5	5	5	2	1
Netherlands	235	197	123	144	118	103	94	139	129	99	112	122	127	104	103	144	131	115	110	108	108	70
Norway *		289	266	234	246	262	248	285	263	275	251	234	303	255	307	405	374	256	282	194	204	
Poland																						
Portugal		54	37	28	16	10	26	27	20	14	12	9	20	23	34							
Romania *																						
Slovakia																						
Slovenia	40		28	28	26	24	25	28	36	42	26	36	25	22	26	21	19	23	19	13		
Spain *		105	117	114	144	150	163	160	165	217	204	316	480	579	536		604	609				
Sweden *	590	661	628	476	427	371	369	350	320	310	235	245	225	258	203	204	194	157	138	133	122	70
Turkey																						
United Kingdom		3070	2717	2529	2178	2197	2058	2432	2382	2397	2139	2122	2103									

(1) National definitions usually refer to acute deaths directly related to drug consumption ("overdoses", "poisonings" or "drug-induced"). Note that, in a few countries, the figures might include also a limited number of cases of death.

(2) Comparisons between countries must be made with caution, because mortality rates and trends are influenced by factors such as practices of reporting, recording information and coding overdose cases that may vary across countries.

(3) General notes about interpreting the data are shown first, followed by notes which are specific to data in the table (these latter notes are indicated within the table with an asterisk (*)).

(4) Austria: Since 2008, the official number of drug related deaths includes cases where no autopsy was performed.

(5) Bulgaria: From 2013 onwards data refers to EMCDDA "Selection B".

(6) Spain: data refers to selection B with no X44 ICD10 code.

(7) Norway: Until 2002 the national definition did not include "intentional poisoning" (ICD codes: X61,X62). From 2003 "Selection B" has become the national definition.

(8) Sweden: In 2016 Sweden updated data since 2001 in order to include T40.4 cases.

(9) United Kingdom: The UK has made several changes for 2015 reporting for Selection B: Reporting for England & Wales changed to report by the year deaths occurred rather than the year of registration. This is to give internal consistency.

(10) United Kingdom: From 2013 onwards data refers to EMCDDA "Selection B" whereas before data based on the Drug Strategy Definition (DSD) was used.

(11) Romania: sub-national coverage.

Appendix F

Overdose deaths > Trends > EMCDDA 'Selection D'

Country	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996	1995
Austria *	165	153	122	138	161	201	187	206	201	175	197	191	185	163	139	139	167	128	109	136	191	170
Belgium																						
Bulgaria *			32	25	32	25	21	33	32	47	18	36	36	56	33	79						
Croatia																						
Cyprus	6	9	6	3	5	8	9	12	11	12	7	9	14									
Czech Republic	32	44			38	28	55	49	44	40	42	62	57	55	44	84	80	79	61			
Denmark	207	167	191	164	166	218	204	206	195	205	221	206	214	198	198	201				216		
Estonia																						
Finland		141	137	162	155	165	130	105	112	92	88	72	74	67	66	60	96	87	51	42	31	30
France															82	101	98	85	113	184	351	
Germany																						
Greece *	73	78	64	68	73	107	151	229	208	242	253	325	255	217	259	321	304	265	245	232	222	176
Hungary	29	25	23	31	24	14	17	31	27	25	25	28	34	32		40	38	42	31	47	52	
Ireland		224	223	225	185	227	174	214	215	208	187	164	127	105	127	109	113	115	104			
Italy	266	308	313	349	393	365	374	484	517	606	551	653	653	517	520	825	1016	1002	1080	1160	1566	1195
Latvia	41	25	23	20	36	26	29	43	46	53	47	25	39	45	54	51	52	115				
Lithuania														31	19	23	23	23				
Luxembourg													13	14	11	18	26	17	16	9	17	22
Malta								7			5	7	7	5	5	8	5	4	6	5	3	2
Netherlands																						
Norway *								184	179	200	195	184	223	172	210	338	327	220	270	177	184	132
Poland																						
Portugal	27	40	33	22	29	19	52	56	94													
Romania *	19	21	33	30	28	15	34	32	33	32	21	6	7	7	3	12	0					
Slovakia	20	27	13	27	26	16	20	22	25	17	20	17	23									
Slovenia																						
Spain *		171	172	196	195	181	182	181	139	188	218	237	212	274	204	240	254	258	271	321	381	371
Sweden																						
Turkey	920	590	497	232	162	105	126	153	147	136	51	26										
United Kingdom																						

- (1) National definitions usually refer to acute deaths directly related to drug consumption ("overdoses", "poisonings" or "drug-induced"). Note that, in a few countries, the figures might include also a limited number of cases of death.
- (2) Comparisons between countries must be made with caution, because mortality rates and trends are influenced by factors such as practices of reporting, recording information and coding overdose cases that may vary across countries.
- (3) General notes about interpreting the data are shown first, followed by notes which are specific to data in the table (these latter notes are indicated within the table with an asterisk (*)).
- (4) Austria: Since 2008, the official number of drug related deaths includes cases where no autopsy was performed.
- (5) Bulgaria: From 2013 onwards data refers to EMCDDA "Selection B".
- (6) Spain: data refers to Madrid, Barcelona, Valencia, Zaragoza, Seville and Bilbao.
- (7) Greece: From 2014 onwards the numbers used refer to the reported number of deaths (confirmed and pending cases).
- (8) Norway: Until 2002 the national definition did not include "intentional poisoning" (ICD codes: X61,X62). From 2003 "Selection B" has become the national definition.
- (9) United Kingdom: The UK has made several changes for 2015 reporting for Selection B: Reporting for England & Wales changed to report by the year deaths occurred rather than the year of registration. This is to give internal consistency.
- (10) United Kingdom: From 2013 onwards data refers to EMCDDA "Selection B" whereas before data based on the Drug Strategy Definition (DSD) was used.
- (11) Romania: sub-national coverage.

APPENDIX B – Glossary of Terms

Amphetamines - a synthetic, addictive, mood-altering drug (such as Speed or Ice) used illegally as a stimulant

Decriminalisation – while the use of illicit drugs remains illegal, there is the lessening of criminal penalties such that there is no criminal conviction, most often paying fines instead

Drug-induced death – acute deaths such as overdoses or poisonings related to drug use

Drug-induced psychosis - substance-induced psychosis is a form of psychosis brought on by alcohol or other drug use

Drug-related death – in Portugal this referred to deaths where toxicological analysis found an illicit drug in the body at time of death even though that drug was not likely the cause of death

EMCDDA - The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is an agency of the European Union located in Lisbon, Portugal. Established in 1993, the EMCDDA strives to be the "reference point" on drug usage for the European Union's member states, and to deliver "factual, objective, reliable and comparable information" about drug usage, drug addiction and related health complications

ESPAD – European School Survey Project for Alcohol and Other Drugs – standardised survey of school children's drug use originating in Sweden in the early 90s

HCV – Hepatitis C is a virus that causes inflammation and damage to the liver, usually spread via unclean injecting equipment

HIV – sexually transmitted disease spread mostly through sexual contact, blood transfusion and use of unclean injecting equipment

HIV notification – identification of a new HIV diagnosis in a given year

Legalisation – drug policy where a once-illicit drug can be used legally with no threat of conviction, usually in a regulated environment as with alcohol or tobacco

National Drug Strategy Household Survey – survey every three years of around 25,000 Australians by the Australian Institute of Health and Welfare, monitoring drug use and attitudes to drug policy

NSP – Needle and Syringe Programs provide free needles and other injecting equipment to drug users

Opiates – a drug derived from, or related to, opium – eg heroin, morphine, oxycontin, endone

REITOX - for more than 20 years, the European information network on drugs and drug addiction has been the cornerstone of the European drug monitoring and reporting system

Tough on Drugs - introduced in 1998 the Australian Federal approach that aimed to reduce drug supply, trafficking, and demand as well as the harm caused by drugs. Tough on Drugs was led by Drug Free Australia's President, Major Brian Watters

APPENDIX C – ESPAD statistics

Appendix F
ESPAD 1995

Table 28 c. **Frequency of the use of marijuana or hashish during the last 12 months and the last 30 days. All students*.**

	Number of occasions							
	Last 12 months					Last 30 days		
	0	1-2	3-5	6-9	10+	1-2	3-5	6+
Croatia	94	4	1	0	1	1	1	1
Cyprus	97	1	0	—	1	1	0	1
Czech Republic	84	9	3	2	3	5	1	1
Denmark	86	7	3	1	3	4	1	1
Estonia	..	..	..	..	..	..	..	..
Faroe Islands	91	6	1	1	2	2	0	0
Finland	96	3	1	0	0	1	0	0
Hungary	97	2	0	0	0	1	0	0
Iceland	92	4	2	1	2	2	1	1
Ireland	67	12	6	4	7	8	4	7
Italy	82	6	3	2	7	5	3	5
Lithuania	99	0	0	0	0	0	0	0
Malta	94	3	1	1	1	1	0	1
Norway	95	2	1	1	1	2	0	1
Poland	94	3	1	1	1	2	1	0
Portugal	94	2	1	1	2	2	1	1
Slovak Republic	94	4	1	1	1	2	0	1
Slovenia	90	5	2	2	2	3	1	1
Sweden	96	3	1	0	0	1	0	0
Turkey (Istanbul)	97	2	1	1	0	1	0	1
Ukraine	92	5	1	1	1	3	1	1
United Kingdom	65	10	6	5	14	10	5	9
Latvia	97	3	0	0	0	1	0	0
France	89	5	—	3	3	..	..	..
Greece	98	1	0	0	0	1	0	0
Spain**	87	—	—	13	—	5	2	2
USA	71	8	5	4	12	6	3	7
England	66	10	6	5	14	9	5	9
Northern Ireland	80	8	4	3	5	6	3	3
Scotland	54	12	6	7	21	12	7	13
Wales	69	10	5	4	11	10	3	6

* Percentages are based on students answering the question.

** Data by sex not available.

Appendix F
ESPAD 1999

Table 29c. Frequency of use of marijuana or hashish during the last 12 months and the last 30 days. Percentages among all students.

	Number of occasions									
	Last 12 months					Last 30 days				
	0	1-2	3-5	6-9	10+	0	1-2	3-5	6+	
Bulgaria	92	4	1	1	2	96	2	1	1	
Croatia	88	5	2	1	4	94	3	1	2	
Cyprus	98	1	0	0	0	99	0	0	0	
Czech Republic	73	10	4	4	9	84	8	4	5	
Denmark	81	8	4	3	5	92	5	2	1	
Estonia	91	5	1	1	2	95	2	1	1	
the Netherlands	95	3	1	0	0	99	1	0	0	
Finland	92	4	1	1	2	98	2	0	1	
France	69	9	6	4	12	78	9	4	9	
FYROM	94	3	1	0	1	97	2	0	1	
Greece	93	3	1	1	3	96	2	1	2	
Greenland	84	7	4	2	4	90	7	1	2	
Hungary	92	4	2	0	2	96	3	0	1	
Iceland	89	5	2	2	2	96	3	1	1	
Ireland	74	10	5	4	8	85	7	3	5	
Italy	80	7	3	3	7	86	6	4	4	
Latvia	89	6	2	1	2	95	4	1	1	
Lithuania	90	7	2	1	1	96	3	1	1	
Malta	95	3	1	1	1	97	2	0	0	
Norway	91	4	2	1	3	96	2	1	1	
Poland	88	5	3	1	2	93	3	2	2	
Portugal	91	4	2	1	2	95	3	1	2	
Romania	99	1	0	..	0	99	1	0	0	
Russia	86	8	3	2	2	95	3	1	0	
Slovak Republic	85	7	4	2	2	94	4	1	1	
Slovenia	79	8	4	2	7	87	6	2	4	
Sweden	94	4	1	1	1	98	2	0	0	
Ukraine	87	6	3	2	2	95	3	1	1	
United Kingdom	71	10	5	4	10	84	7	3	6	
The Netherlands	77	8	4	2	9	86	6	3	5	
USA	68	9	5	4	14	81	7	4	9	

ESPAD Appendix F 2003

Table 29c. Frequency of use of marijuana or hashish during the last 12 months and the last 30 days. Percentages among all students.

	Number of occasions									
	Last 12 months					Last 30 days				
	0	1-2	3-5	6-9	10+	0	1-2	3-5	6+	
Austria	83	7	4	2	5	90	5	2	3	
Belgium	73	10	5	3	10	83	6	3	7	
Bulgaria	84	7	3	2	4	92	4	2	3	
Croatia	84	7	3	3	4	92	3	2	3	
Cyprus	97	1	0	0	0	98	1	0	0	
Czech Rep.	64	13	6	5	12	81	9	4	7	
Denmark	83	8	4	2	3	92	5	1	2	
Estonia	86	7	2	2	4	94	3	1	2	
Faroe Isl.	96	2	1	1	1	99	1	0	1	
Finland	92	5	2	1	1	97	2	0	0	
France	69	10	5	4	13	78	8	5	9	
Germany	79	8	4	3	7	88	6	2	4	
Greece	95	3	1	1	1	98	1	1	1	
Greenland	75	8	6	5	5	89	7	2	2	
Hungary	89	6	2	1	2	94	3	1	2	
Iceland	90	4	2	1	3	96	2	1	1	
Ireland 31	69	13	5	4	10	17 83	7	3	6	
Isle of Man	66	11	7	4	12	79	9	5	7	
Italy	78	8	3	3	8	85	6	3	6	
Latvia	91	5	2	1	2	96	2	1	1	
Lithuania	89	6	3	1	1	94	4	1	1	
Malta	91	4	2	1	2	96	2	1	1	
Netherlands	77	9	3	3	8	87	5	2	6	
Norway	94	3	1	0	2	97	1	1	1	
Poland	86	6	3	2	4	92	4	1	2	
Portugal 13	87	6	3	1	4	8 92	4	1	3	
Romania	98	1	0	0	0	100	0	0	0	
Russia	84	9	4	1	3	93	5	1	1	
Slovak Rep.	80	9	4	2	5	90	5	2	2	
Slovenia	77	8	5	2	8	86	6	3	5	
Sweden	95	3	1	1	0	99	1	0	0	
Switzerland	69	9	5	4	13	80	7	3	10	
Turkey	97	2	1	0	1	98	1	0	1	
Ukraine	88	6	2	1	3	95	2	1	2	
United Kingdom	69	10	5	4	13	80	7	4	8	
Average	84	7	3	2	5	91	4	2	3	
Spain	68	32				78	23			
USA	72	9	5	3	12	83	6	3	8	

Appendix F

Appendix III – Tables

ESPAD 2007

Question 24b-c

Table 32a. Frequency of use of marijuana or hashish during the last 12 months and last 30 days. All students. 2007.
Percentages.

	Number of occasions										No response	
	Last 12 months					Last 30 days						
Country	0	1-2	3-5	6-9	10+	0	1-2	3-5	6+	Last 12 months	Last 30 days	
Armenia	98	1	0	0	0	99	1	0	0	0	0	
Austria	87	6	3	1	3	94	3	1	2	1	1	
Belgium (Flanders)	81	7	3	2	7	88	7	2	4	1	1	
Bulgaria	83	8	3	2	4	93	3	1	3	1	1	
Croatia	87	6	2	2	3	94	3	1	2	1	1	
Cyprus	96	2	1	1	1	97	1	1	2	1	1	
Czech Republic	65	13	7	5	10	82	9	4	6	2	2	
Estonia	81	10	3	2	3	94	4	1	1	1	1	
Faroe Islands	96	3	0	1	0	99	1	0	0	1	1	
Finland	94	4	1	0	1	98	1	0	0	0	0	
France	76	9	4	3	8	85	6	3	6	1	1	
Germany (7 Bundesl.)	85	7	3	2	3	93	4	1	2	1	1	
Greece	95	3	1	0	1	97	2	0	1	0	0	
Hungary	90	5	2	1	2	95	3	1	1	1	1	
Iceland	94	3	1	1	2	97	2	0	1	1	1	
Ireland	85	6	2	1	5	91	4	1	4	2	2	
Isle of Man	74	9	5	3	10	84	6	3	7	1	1	
Italy	81	6	3	2	7	87	5	2	6	1	1	
Latvia	89	7	2	1	2	96	2	1	1	1	1	
Lithuania	88	8	2	1	1	95	3	1	1	1	1	
Malta	89	5	2	1	2	95	3	1	1	0	0	
Monaco	79	8	4	2	6	90	4	1	5	1	1	
Netherlands	75	9	5	2	9	85	7	2	6	1	1	
Norway	96	2	1	1	1	98	1	0	1	1	1	
Poland	88	7	2	2	2	94	4	1	1	0	0	
Portugal	90	4	2	1	2	94	4	1	2	1	1	
Romania	98	2	0	0	0	99	0	0	0	1	1	
Russia	88	7	2	1	2	96	2	1	1	2	2	
Slovak Republic	76	11	4	4	6	89	6	2	3	2	2	
Slovenia	82	7	3	2	5	91	5	2	3	0	0	
Sweden	95	3	1	1	1	98	1	0	0	1	1	
Switzerland	73	10	5	3	9	85	7	2	6	1	1	
Ukraine	93	5	1	1	1	97	1	0	1	2	2	
United Kingdom	78	9	5	3	5	89	5	2	4	1	1	
Average (unw.)	86	6	3	2	4	93	4	1	2	1	1	
Denmark	79	9	5	3	4	90	6	2	2	2	2	
Spain	70	9	6	3	13	80	7	5	8	..	..	
USA	75	8	4	3	10	86	6	3	6	..	..	

Appendix F

Appendix III – Tables

ESPAD 2011

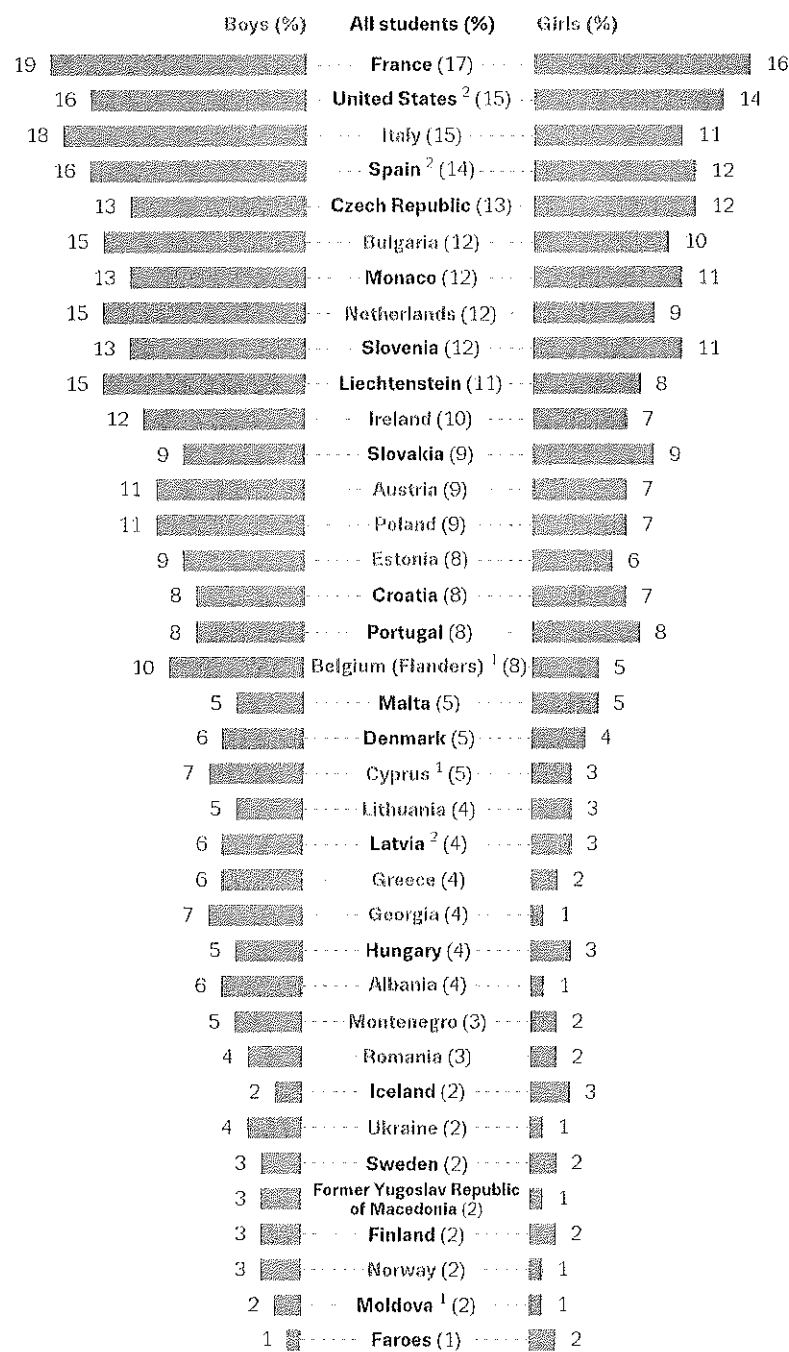
Question C25c

Table 31a. Frequency of use of marijuana or hashish during the last 30 days. All students. 2011. Percentages.

COUNTRY	Number of occasions						Once or more	No response
	0	1-2	3-5	6-9	10-19	20+		
Albania	98	1	0	0	0	0	2	1
Belgium (Flanders)	89	6	2	1	1	1	11	1
Bosnia and Herz. (RS)	99	1	0	0	0	0	1	0
Bulgaria	90	5	2	1	1	1	10	1
Croatia	93	3	1	1	1	1	7	1
Cyprus	95	2	1	1	1	1	5	1
Czech Republic	85	7	3	1	1	2	15	1
Denmark	94	3	1	1	0	0	6	2
Estonia	94	4	1	0	0	0	6	1
Faroe Islands	99	1	0	0	0	1	1	1
Finland	97	2	1	0	0	0	3	0
France	76	9	5	4	2	3	24	1
Germany (5 Bundesl.)	93	4	1	1	0	1	7	1
Greece	96	2	1	0	0	0	4	1
Hungary	92	5	1	1	1	1	8	1
Iceland	96	2	1	0	0	0	4	1
Ireland	93	3	2	1	1	1	7	1
Italy	88	5	2	2	2	2	12	1
Latvia	94	4	1	0	1	0	6	2
Liechtenstein	92	6	1	1	0	1	8	0
Lithuania	95	3	1	0	0	0	5	2
Malta	96	2	1	1	0	0	4	0
Moldova, Rep.of	99	1	0	0	0	0	1	1
Monaco	79	11	2	4	2	2	21	0
Montenegro	97	1	0	1	0	0	3	0
Norway	98	1	0	0	0	0	2	1
Poland	90	5	2	1	1	1	10	1
Portugal	91	4	2	1	1	1	9	1
Romania	98	1	0	0	0	0	2	1
Russian Fed. (Moscow)	96	3	1	0	0	1	4	2
Serbia	97	1	0	0	0	0	3	1
Slovak Republic	91	5	1	1	1	1	9	3
Slovenia	90	5	2	1	1	1	10	1
Sweden	97	2	0	0	0	0	3	1
Ukraine	97	2	0	0	0	0	3	1
AVERAGE	93	3	1	1	1	1	7	1
United Kingdom	87	6	3	1	1	2	13	1
Spain	85	6	3	1	1	2	15	2
USA	82	7	3	2	2	4	18	3

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Figure 6b. Prevalence of cannabis use in the last 30 days by gender (percentage)



↑
Colour indicates significant
difference between boys and girls
(not tested for Spain and United States).

¹ Belgium (Flanders), Cyprus and Moldova: limited geographical coverage.

² Latvia, Spain and United States: limited comparability.