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ENQUIRY INTO SUBSTANCE OVERUSE IN AUSTRALIAN COMMUNITIES

In this additional submission I would like to discuss further reasons for drug use and risk taking behaviour generally, with proposals as to how these might be managed. I will then move to a closer analysis of what is known about marijuana, where legislation is today, internationally, in relation to its use, and conclude with one ethicist's view of the debate about drug use.

REASONS FOR DRUG USE GENERALLY

Those who do not indulge in intoxicating substances or behaviours at high levels are often at a loss to understand the behaviour of those who do. I feel that this is because society generally is not paying enough attention to the distinctions between various reasons for using an intoxicating substance or behaviour.

A case can be made that there are three broad levels of use separable behaviourally and by motive. They are as a relaxant, as a painkiller, and as an expression of despair. Every intoxicating substance and behaviour, including alcohol, nicotine, cannabis, heroin, cocaine, amphetamines, prescription anti-depressants, gambling, sugar consumption, physical risk-taking and misuse of personal, emotional, financial and political power, can be seen to have a value to the user on this continuum, and society is failing to grapple with negative outcomes because we are assuming all such behaviours are undesirable and should be stopped, rather than devising different strategies for each category of motivation.

Clearly, use of a substance or behaviour as a relaxant or for leisure purposes, without damaging the interests or infringing the rights of others, is not problematic, and arguably does not require any behaviour modification or additional statutory regulation on anyone's part. We already have an adequate model for legislation for temperate and regulated intoxicant use and supply in the liquor laws, and we are becoming enculturated to strive towards prosocial use of this mood enhancing substance.

Where we lose our grip on the present problems confronting us is in failing to appreciate that substance use as a painkiller or as an expression of despair (seen as analogous to self-mutilation, where a person inflicts pain on themselves because sustained, unrequited psychological or emotional agony has driven them into a depersonalized state) cannot be addressed by attempting to impose behaviour modification on the user, but must be seen as part of a larger situation of inequity, which requires fundamental reskilling and training of all members of society in communication and human relationships, especially those individuals who occupy a position of responsibility for or power over other human beings. This includes parents, teachers, government officials, politicians, supervisors in the workplace, owners of the means of production, health and helping industry professionals, in fact anyone who does anything that affects the interests of another human being, in any capacity whatsoever.

To the extent that heavy substance use seems to cooccur with criminal behaviour, it is worth considering some expert opinion on early factors that seem to predispose individuals to antisocial activities. It would appear that certain elements of violence and abuse in one's childhood can predispose to greater likelihood of being arrested in later life.

The website of the US Dept of Justice reports research findings that people who were sexually victimized during childhood are at higher risk of arrest for committing crimes as adults, including sex crimes, than are people who did not suffer sexual or physical abuse or neglect during childhood. However, of all types of childhood maltreatment, physical abuse was the most likely to be associated with arrest for a violent crime later in life. The group next most likely to be arrested for a violent offence was those who had experienced neglect in childhood. In general, people who experience any type of maltreatment during childhood, whether sexual abuse, physical abuse, or neglect, are more likely than people who were not maltreated to be arrested later in life.

However, it is important to acknowledge official arrest statistics are just the tip of the iceberg, and do not begin to count the numbers of people whose pain and despair over childhood abuse does not spill over into overt antisocial behaviour but instead festers away in their psyche as a source of inconsolable pain and rage. These people often turn to intoxicating substances and behaviours in their endless search for pain relief, and consideration of the sources of their pain should make us ashamed to be bringing a prohibitionist approach to this social dilemma.

www.prevent-abuse-now.com reports findings that early identification of sexual abuse victims appears to be crucial to the reducing their suffering and to establishing support systems to help them achieve positive psychological development and healthy functioning as an adult. As long as young victims do not disclose the source of their pain, fear, suffering, and psychological distress will remain and likely sustain the need to use intoxicating substances as a pain killer.

Dr. William C. Holmes, of the University of Pennsylvania School of Medicine, reports that "When sexually abused boys are not treated, society must later deal with the resulting problems, including crime, suicide, drug use and more sexual abuse. He said a review of relevant studies leads him to believe 10 to 20% of all boys are sexually abused in some way.

In her book, Law Enforcement And Child Abuse (coauthored by law enforcement officer, Patricia Graves), Dr. Suzanne Sigroi notes that "Helping sexually abused children depends on the combined efforts of law enforcement, medical, social service, and prosecution personnel. It is essential for those in each field to recognize and understand the others' responsibilities in dealing with child sexual abuse. Only then can we learn how best to help each other to help the victims and their families.

At www.aifs.org.au, a site called National Child Protection Clearinghouse, run by the Australian Institute of Family Studies (Issues in Child Abuse Prevention Number 9 Autumn 1998), Paul E Mullen and Jillian Fleming report on long-term effects of child sexual abuse.

They note identifiable family risk factors, including socially deprived and disorganised family backgrounds, marital dysfunction, a step-parent in the family, and institutional or foster care. There is now an established body of knowledge clearly linking a history of child sexual abuse with higher rates in adult life of depressive symptoms, anxiety symptoms, substance use disorders, eating disorders and post-traumatic stress disorders.

At www.aifs.org.au/nch/issues8.html, Issues in Child Abuse Prevention Number 8 Spring 1997, Adam M Tomison and Joe Tucci discuss emotional abuse as the hidden form of maltreatment.

They note that the foundations for good mental health are laid down in the emotional development that occurs in infancy and later childhood, and appears to be dependent upon the quality and frequency of response to an infant or child from

a parent or primary caregiver. If a parent inadvertently or deliberately engages in a pattern of inappropriate emotional responses, the child can be said to have experienced emotional abuse.

Emotional abuse may occur as a distinct form of abuse (e.g. verbal abuse, threats to abandon a child, witnessing domestic violence), or in conjunction with other forms of maltreatment. It is increasingly considered to be the core issue in all forms of child abuse and neglect.

Not only does emotional abuse appear to be the most prevalent form of child maltreatment, but some professionals believe it to produce the most destructive consequences. It may be manifested in a sense of helplessness and worthlessness, in a sense of violation and shame, or in a lack of environmental stimulation and support for normal development.

The most recent national Australian data, produced by the Australian Institute of Health and Welfare, indicate that in 1995-96 emotional abuse cases accounted for 31% of substantiated child maltreatment cases.

However, adults or parents who emotionally abuse are frequently described as poorly equipped with the knowledge to cope effectively with children's normal demands at different developmental stages. Emotionally abusive parents showed poorer coping skills, poorer child management strategies, and more difficulty in forming and maintaining relationships.

A growing body of research also suggests that children who witness domestic violence, but who are not actually physically assaulted, may suffer social and mental health problems as a result. Using national surveys of family violence, it is estimated that between 3.3 and 10 million children are at risk of witnessing domestic violence across the United States each year.

Systems abuse has been defined as the harm done to children in the context of policies or programs being implemented by care or protection agencies, when children's welfare, development or security is undermined by the actions of individuals or by the lack of suitable policies, practices and procedures within systems or institutions, and a particular form of systems abuse is emotional abuse within educational settings. A number of studies have indicated that a proportion of teachers commonly use emotional abuse in conjunction with other punishments as a means of exerting control. While physical punishment has been banned in most educational settings, emotional abuse often passes without comment, according to researchers.

Melton and Thompson (1987) describe the current system for dealing with emotionally abused children as 'woefully inadequate'. They argue that 'when professionals cannot eliminate even the grossest forms of physical violence against
children, there is good reason to wonder about the likely success of interventions designed to change more subtle forms of maltreatment' (1987, p.206).

Suggestions to remedy these problems include a combination of alleviating socio-environmental stress, a reduction in familial dysfunction, the promotion of parenting skills and a positive self-concept, and social support, intervention for high-risk parents aimed at increasing parental understanding of children's cues, assisting their development of realistic expectations of child behaviour, and providing a detailed knowledge of child development.

Despite the growing acknowledgment of child maltreatment as a social problem, the authors point out that it is often difficult to convince those in the broader community that they, themselves, may be part of the problem. It is easier for them to think of child abusers in stereotyped ways, pathologizing them as mentally ill, abnormal or evil, enabling them to distance themselves from the problem rather

than to address the true causes of maltreatment, such as poverty, or a lack of social support.

From these findings, it is clear that a considerable amount of benefit would be derived for the community if there were greater support and education available for people in parenting situations. There is clearly a lack of community awareness of the implications of some of the negative styles of child rearing, and we are only just beginning to appreciate the great difficulties a hostile type of parenting can cause to a child's social and emotional development. When every citizen receives communication skills and parent effectiveness training as a matter of course, be it through school, through tertiary institutions or as part of community health programs, to prepare then to take their place in adult society, we may begin to find a decline in the need for substance use and risk taking behaviour as painkillers, in both current and following generations, and have a better chance of ascertaining what constitutes "normal" use, ie for leisure purposes only, of marijuana and other intoxicating substances and behaviours by members of a healthy, articulate, confident society.

EFFECTS OF MARIJUANA

I would like to turn now to the specific example of cannabis, its effects, good and bad, and some recent unusual findings.

www.norml.org describes the most commonly reported effects of smoked marijuana as a sense of well-being or euphoria and increased talkativeness and laughter alternating with periods of introspective dreaminess followed by lethargy and sleepiness A marijuana smoker typically has a sense of enhanced physical and emotional sensitivity, including a feeling of greater interpersonal closeness. A common characteristic of being under the influence of marijuana is difficulty in carrying on conversations, due to short-term memory effects.

Although euphoria is the more common reaction to smoking marijuana, adverse mood reactions can occur. Such reactions occur most frequently in inexperienced users after large doses of smoked or oral marijuana. They usually disappear within hours and respond well to reassurance and a supportive environment. Anxiety and paranoia are the most common acute adverse reactions; others include panic, depression, dysphoria, depersonalization, delusions, illusions, and hallucinations. Of regular marijuana smokers, 17% report that they have experienced at least one of the symptoms, usually early in their use of marijuana.

Tolerance, dependence, and withdrawal are often presumed to imply abuse or addiction, but this is not the case. Tolerance and dependence are normal physiological adaptations to repeated use of any drug. Commonly prescribed medications for pain, anxiety, and even high blood pressure often produce tolerance and some degree of physiological dependence. Tolerance to most of the effects of marijuana can develop rapidly after only a few doses, and it also disappears rapidly. The acute side effects of marijuana use are within the risks tolerated for many medications.

A distinctive marijuana and THC withdrawal syndrome has been identified, but it is mild and subtle compared with the profound physical syndrome of alcohol or heroin withdrawal. The symptoms of marijuana withdrawal include restlessness, irritability, mild agitation, insomnia, sleep EEG effects, nausea, and cramping. During the abstinence period at the end of one study, the study subjects were irritable and showed insomnia, runny nose, nightsweats, and decreased appetite. The withdrawal symptoms, however, were short lived, and abated in four days.

Often, drug dependence is described as cooccuring with other psychiatric disorders. Most people with a diagnosis of drug dependence disorder also have a diagnosis of a another psychiatric disorder (76% of men and 65% of women), most frequently high level alcohol use. 60% of men and 30% of women with a diagnosis of

drug dependence also use alcohol at high levels. In women who are drug dependent, phobic disorders and major depression are almost equally common (29% and 28%, respectively). High level alcohol use can be seen as just another device to block psychological pain and to deal with living in a state of learned helplessness. This learned response develops when the inability to escape causes of pain (such as abusive carers, material, emotional and educational poverty) characteristic of the powerlessness of childhood leads eventually to the individual ceasing all efforts to attempt to escape the inimical elements of their situation and sinking into a permanent state of despair and hopelessness.

A strong association between drug dependence and antisocial personality or its precursor, conduct disorder, is also widely reported in children and adults. Although the causes of the association are uncertain, researchers recently concluded that it is more likely that conduct disorders generally lead to substance use than the reverse.

Adolescent boys who smoke cigarettes daily are about 10 times as likely to have a psychiatric disorder diagnosis as those who do not smoke. This needs to be considered in the light of findings published recently in the New Scientist, suggesting that cigarette smoking itself may be predisposing people who smoke to develop depressive mood disorders.

Dependence appears to be less severe among people who use only marijuana than among those who use cocaine or those who use marijuana with other drugs (including alcohol). Marijuana users who do develop dependence appear to be less likely to do so than users of other drugs (including alcohol and nicotine), and marijuana dependence appears to be less severe than dependence on other drugs. Drug dependence is more prevalent in some sectors of the population than others, but no group has been identified as particularly vulnerable to the drug-specific effects of marijuana. Adolescents, especially troubled ones, and people with psychiatric disorders (including substance overuse) appear to be more likely than the general population to become dependent on marijuana.

Hollister (1986) suggests that, because of the varied nature of the psychotic states induced by marijuana, there is no specific "marijuana psychosis." Rather, the marijuana experience might trigger latent psychopathology of many types. Hall and Solowij (1998) concluded that "there is reasonable evidence that heavy cannabis use, and perhaps acute use in sensitive individuals, can produce an acute psychosis in which confusion, amnesia, delusions, hallucinations, anxiety, agitation and hypomanic symptoms predominate." Regardless of which of those interpretations is correct, the two reports agree that there is little evidence that marijuana alone produces a psychosis that persists after the period of intoxication.

The scientific literature indicates general agreement that heavy marijuana use can precipitate schizophrenic episodes but not that marijuana use can cause the underlying psychotic disorder.

Schizophrenics prefer the effects of marijuana to those of alcohol and cocaine, which they seem to use less often than does the general population. The reasons for this are unknown, but it raises the possibility that schizophrenics might obtain some symptomatic relief from moderate marijuana use. But overall, compared with the general population, people with schizophrenia or with a family history of schizophrenia are likely to be at greater risk for adverse psychiatric effects from the use of cannabinoids.

Human volunteers who perform auditory attention tasks before and after smoking a marijuana cigarette show impaired performance while under the influence of marijuana associated with reduced blood flow to the temporal lobe of the brain, an area sensitive to such tasks. Marijuana smoking increases blood flow in other brain regions, such as the frontal lobes and lateral cerebellum. Earlier studies

claiming to show structural changes in the brains of heavy marijuana users have not been replicated with more sophisticated techniques.

Nevertheless, recent studies have found subtle defects in cognitive tasks in heavy marijuana users after a brief period (19Ù24 hours) of m`rijuana abstinence. Longer term cognitite deficits in heavy marijuana users have also been reported. Although these studies hava attempted to match heavy marijuana users with subjects of similar cognitive abilities before exposure to marijuana use, the adaquacy of this matching has been questioned. There are complex mathodological issues involved in research in this area due to difficulty differentiating changes in brain function due to marijuana and to the illness for which marijuana is being given, for example with AIDS dementia. It is also important to determine whether repeated use of marijuana at therapeutic dosages produces any irreversible cognitive effects.

The term "amotivational syndrome" is not a medical diagnosis, but has been used to describe young people who drop out of social activities and show little interest in school, work, or other goal-directed activity. When heavy marijuana use accompanies these symptoms, the drug is often cited as the cause, but no convincing data demonstrate a causal relationship between marijuana smoking and these behavioural characteristics.

The psychological effects of cannabinoids, such as anxiety reduction, sedation, and euphoria, can influence their potential therapeutic value. Those effects are potentially undesirable in some patients and situations and beneficial in others. In addition, psychological effects can complicate the interpretation of other aspects of the drug's effect.

Despite the many claims that marijuana suppresses the human immune system, the health effects of marijuana-induced immunomodulation are still unclear. Few studies have been done with animals or humans to assess the effects of marijuana exposure on host resistance to bacteria, viruses, or tumours.

The complete effect of marijuana smoking on immune function remains unknown. It is not known whether smoking leads to increased rates of infections, tumours, allergies, or autoimmune responses.

Studies suggest people who smoke marijuana run a greater risk of respiratory disorders than people who don't. These symptoms are similar to those of tobacco smokers, and the combination of marijuana and tobacco smoking augments these effects.

There is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use. However, cellular, genetic, and human studies all suggest that marijuana smoke is an important risk factor for the development of respiratory cancer.

There is concern that legalizing the medical use of marijuana might lead to an increase in its use among the general population. No convincing data support that concern. The existing data are consistent with the idea that this would not be a problem if the medical use of marijuana were as closely regulated as the use of other medications that have abuse potential, but there is a shortage of research that directly addresses the question.

Marijuana is not a completely benign substance. It is a powerful drug with a variety of effects. However, except for the harm associated with smoking, the adverse effects of marijuana use are within the range tolerated for other medications. Thus, the safety issues associated with marijuana do not preclude some medical uses.

Present data on drug use progression neither support nor refute the suggestion that medical availability would increase drug abuse. However, this question is

beyond the issues normally considered for medical uses of drugs, and it should not be a factor in the evaluation of the therapeutic potential of marijuana or cannabinoids.

Modern research suggests that cannabis is a valuable aid in the treatment of a wide range of clinical applications, including pain relief, particularly of neuropathic pain (pain from nerve damage), nausea, spasticity, glaucoma, and movement disorders. Marijuana is also a powerful appetite stimulant, specifically for patients suffering from HIV, the AIDS wasting syndrome, or dementia. Emerging research suggests that marijuana's medicinal properties may protect the body against some types of malignant tumours and are neuroprotective.

In an article published in the Canadian Medical Association Journal in 2002, (166, (7), pp887-891), Fried, Watkinson, James and Gray discuss their findings on the effects of marijuana use on IQ, based on data from the Ottawa Prenatal Prospective Study, which began collecting data in 1978. Studying seventy 17 to 20 year olds, they found an average decrease of 4.1 points in current heavy users, compared to gains in IQ of 5.8 for light current users, 3.5 for former users and 2.6 for non-users. They concluded current marijuana use had a negative effect on global IQ only in subjects who smoked five or more joints per week. A negative effect was not observed among subjects who had previously been heavy users but were no longer smoking, that is, their IQ scores did not differ significantly form those of non users, suggesting there is no long term negative effect on global IQ resulting from heavy marijuana use. Only the quantity of current use was negatively related to change in IQ from preteen to young adult.

The authors consider that, on the distribution of IQ, which has a mean of 100 and standard deviation of 15, 2.3% of individuals will score 70 or less and 6.7% will score 77.5 or less. Introducing a factor such as heavy current marijuana use could be expected to increase these figures to 5.5% and 11% respectively. Light marijuana use, however, up to five joints a week, could be expected to have the opposite effect.

The authors note their sample is small, and that cognitive and memory effects remain to be specifically investigated.

AMERICAN GOVERNMENT RESPONSES

In relation to US Government policy on the use of marijuana, it is interesting to note that, since 1973, 12 American state legislatures, Alaska, California, Colorado, Maine, Minnesota, Mississippi, Nebraska, Nevada, New York, North Carolina,
Ohio and Oregon, have enacted versions of marijuana decriminalization, whereby marijuana users no longer face gaol sentences (nor in most cases, arrest or criminal records) for the possession or use of small amounts of marijuana. Despite the American Government's posturing on the world stage, the American populace is by no means committed to their so-called drug war, and hundreds of thousands of citizens are now mobilizing into local and national groups to fight their own Federal Government. We, as a nation proud of its creativity and independence of thought, should think very seriously before accepting any official US statements about drug reform, because they do not represent fairly or accurately the views of the American people. I refer committee members to the Drug Reform Coalition newsletter, at www.drcnet.org, and the mailing list of the November Coalition, at www.november.org.

Marijuana is the third most popular recreational drug in America (behind only alcohol and tobacco), and has been used by nearly 80 million Americans. According to government surveys, some 20 million Americans have smoked marijuana in the past year, and more than 11 million do so regularly despite harsh laws against its use.

Columnist Arianna Huffington writes that an overwhelming majority of Americans now feel that it's time for new thinking on the drug problem. According to a recent Zogby poll, 74 percent favour treatment over prison for those convicted of possession. And when given the chance to express their feelings at the ballot box, voters across the country have repeatedly shown their support for reforming drug policy. In Arizona, voters have twice approved a measure replacing mandatory incarceration with treatment.

Last year, Missouri passed a bill encouraging judges to sentence certain drug users to community service and treatment facilities rather than jail.

In November, Massachusetts and California ballots will have two new initiatives. The Massachusetts initiative requires that any properties forfeited in drug cases go to education or drug treatment rather than to police coffers, an important reform to end distorted law-enforcement priorities. In California, the Substance Abuse and Crime Prevention Act requires that nonviolent drug offenders be sent to treatment rather than prison the first two times they're arrested. Its supporters point out that the average cost of maintaining a prison inmate is $23,406 a year, while the average annual cost of a drug-treatment program is $4,300.

College students are battling against an outrageous provision in the 1998 Higher Education Act that disqualifies young people for federal aid for college if they've ever been convicted of marijuana possession but not if they've been convicted of rape, robbery or manslaughter.

In March 2002, Maine passed a bill expanding and clarifying the rights of patients and caregivers under the state's medical marijuana law, increasing the amount of usable marijuana a patient may possess from 1.25 ounces to 2.5 ounces and clarifying the legal protections for both patients and caregivers under state law. This is the first time a state legislature has expanded voter-approved protections for medical marijuana patients. The original medical marijuana law in Maine was approved by 61 percent of voters in 1999.

In early 2002, the Republican-controlled Vermont House of Representatives approved H. 645, a bill to provide legal protection under state law for medical marijuana users, by a vote of 82-59.

In April in Honolulu, the Hawaii Legislature passed a comprehensive sentencing reform bill mandating probation and drug treatment in lieu of incarceration for first-time, non-violent drug offenders.

The New England Journal of Medicine, January 30, 1997, reported that "Federal authorities should rescind their prohibition of the medical use of marijuana for seriously ill patients and allow physicians to decide which patients to treat. The government should change marijuana's status from that of a Schedule I drug ... to that of a Schedule II
drug ... and regulate it accordingly."

Enforcing marijuana prohibition costs American taxpayers an estimated $10 billion annually and results in the arrest of more than 734,000 individuals per year, far more than the total number of arrestees for all violent crimes combined, including murder, rape, robbery and aggravated assault. This policy is a tremendous waste of national and state criminal justice resources that should be focused on combating serious and violent crime. In addition, it invites government unnecessarily into areas of people's private lives, and needlessly damages the lives and careers of hundreds of thousands of otherwise law-abiding citizens

Currently, more than 60 U.S. and international health organizations, including the American Public Health Association, Health Canada and the Federation of American Scientists, support granting patients immediate legal access to medicinal marijuana under a physician's supervision. Several others, including the American

Cancer Society and the American Medical Association support the facilitation of wide-scale, clinical research trials so that physicians may better assess cannabis' medical potential.

Virtually every government-appointed commission to investigate marijuana's medical potential has issued favourable findings. These include the U.S. Institute of Medicine in 1982, the Australian National Task Force on Cannabis in 1994 and the U.S. National Institutes of Health Workshop on Medical Marijuana in 1997.

In 1999, after conducting a nearly two-year review of the medical literature, investigators at the National Academy of Sciences, Institute of Medicine affirmed: "Scientific data indicate the potential therapeutic value of cannabinoid drugs ... for pain relief, control of nausea and vomiting, and appetite stimulation. ... Except for the harms associated with smoking, the adverse effects of marijuana use are within the range tolerated for other medications."

A March 2001 Pew Research Centre poll reported that 73 percent of Americans support making marijuana legally available for doctors to prescribe, as did a 1999 Gallup poll.

OTHER INTERNATIONAL RESPONSES

Marijuana is far less dangerous than alcohol or tobacco. Around 50,000 people die each year from alcohol poisoning. Similarly, more than 400,000 deaths each year are attributed to tobacco smoking. By comparison, marijuana is nontoxic and cannot cause death by overdose. In 1995, The Lancet, one of the world's most prestigious medical journals, stated, "The smoking of cannabis, even long term, is not harmful to health," and called for decriminalization. This March, the Canadian Medical Association did the same. Almost simultaneously, the British government's scientific advisory panel on illegal drugs reported, "The high use of cannabis is not associated with major health problems for the individual or society" and recommended ending arrests for marijuana possession.

Canada has authorized more than 800 patients to legally use marijuana for medical purposes, while in the Netherlands plans are moving forward to make medical marijuana available in pharmacies.

IN the June Issue of The North Colombia Monthly, Mark Harrison reports that, in the Netherlands, where a strong public health approach is taken for drug use, the 'incarceration rate is just 11% of the United States'. Additionally, 32% of the people in the U.S. have tried marijuana, compared to only 15% of Dutch people. And while 10% in the U.S. have used cocaine, only 2% have tried it in the Netherlands, compelling evidence that the prison system doesn't work.

In 1976, the Netherlands adopted a policy of toleration for possessign of up to 30 g of marijuana. T`ere was little change in marijuana use during the seven years after the policy change. However, in 1984, when Dutch "coffee shops" that sold marijuana commercially spread throughout Amsterdam, marijuana use began to increase. Durinc the 1990s, marijuana use has continued to increase in the Netherlands at the same rate as in the United States and Norway, which strictly forbid marijuana sale and possession. Furthermore, during this period, approximately equal percentages of American and Dutch 18 year olds usdd marijuana; Norwegian 18 year olds were about half as likely to have used marijuana. There is little evidence that the Dutch marijuana depenalization policy led to increased marijuana use, although commercialization of marajuana maght have contributed to its increased use. There is little evidance that decriminalization of marijuana use necessarily leads to a substantial increase in marijuana use.

In a lighter vein, Dutch Police have been reporte` as saying that cannabis helped stop Euro 2000 becoming a battlefield for yobs. English football fans smoked so much pot at Euro 2000 that they were too intoxicated to run riot. The England fans

had been consoling themselves over their team's loss in Amsterdam's cannabis bars and cafes. Dutch police believe it is one of the reasons why English hooliganism did not surface at the tournament. There were only five arrests, three of them for ticket tout offences.

In London, a pilot scheme in which police took a more 'relaxed' attitude to possession of cannabis was consi`ered a complete success and is shortly to be extended. Britain's House of Lords Science and Technology Committee found in 1998 that the available evidence supported the legal use of medical cannabis.

In an intervaew with the London Independent fewspaper two months ago, shortly after leaving office, the cabinet minister who had been in charge of Tony Blair's drug policy called for the legalization of all drugs, saying the drug trade should be legalized and taxed. At the saee time, another Liberal Democratic MP called for the lecalization of cocaine and government-managed heroin by prescription.

The Home Affairs Select Committee of Parliament has endorsed a proposal to sharply reduce marijuana penalties. UK Home Secretary David Blunkett has proposed that marijuana be "downgraded" from Class B to Class C, the "least harmful" category of illegal drugs under British law. Class B includes drugs of "intermediate" danger, including barbiturates and amphetamines. Class C drugs include Valium and anabolic steroids. Such drugs remain illegal, but possession generally brings a warning or fine rather than arrest and jail.

In the United States, marijuana remains in Schedule I, the category reserved for substances such as haroin and LSD, which are deemed the most dangerous.

The report by the Home Affairs Select Committee of Parliament notes the damage done by excessively strict laws, and, in relation to marijuana, argues "we do not believe there is anything to be gained by exaggerating its harmfulness. On the contrary, exaggeration undermines the credibility of messages that we wish to send regarding more harmful drugs."

The parliamentary groupÌs conclusions are consistent with those of the Advisory Council, which stated, "The high use of cannabis is hot associated with major health problems for the individual or society." The council also noted that the addiction potential of marijuana is "well below nicotine and alcohol."

The director of communications for the Washington, D.C. based Marijuana Policy Project (www.mpp.org), Bruce Mirken, commented "The British government is taking a thoughtful, science-based approach to reconsidering its drug laws. In this country, policymakers regularly commission expert reports and then ignore them when they do not like the findings. From the National Commission on Marihuana and Drug Abuse in 1972 to the 1999 Institute of Medicine review of the data on medical marijuana, experts have repeatedly challenged the assumptions underlying marijuana prohibition. The British are listening to their experts. Maybe someday the U.S. will do the same."

MAPinc.org reports that bucking the American pot-prohibition orthodoxy has become a trend in advanced, industrialized nations. Portugal has moved closest to outright decriminalization, with Switzerland close behind. Only three European nations, Sweden, Finland and Norway, still adhere to the US model of strong police action against small-time drug users. "There has been a revolution in the laws throughout Europe because there is a widespread recognition that drug prohibition is not working," says British Parliament member Paul Flynn. "The most dangerous way to treat marijuana is to prohibit it and leave its marketing to a dangerous criminal. There has been a stream of misinformation from America about this."

In June 2000, the Portuguese Government voted to decriminalize the consumption of illegal drugs such as cannabis and heroin. Drug users will now be treated as sick people in need of medical help. The sale and trafficking of illegal drugs remain

crimes. Under the new law, police will report drug takers to special local authority commissions which will ensure addicts seek treatment. Portugal is the third member of the European Union, after Spain and Italy, to decriminalize the consumption and possession of small quantities of drugs.

In April, the Italian regional Legislative Council of Lombardy called on the Government and Parliament to regulate the use of medical marijuana and its derivatives. The motion was supported by a broad range of parties, including the party of the Italian Prime Minister, the Christian Democrats, the Socialists, the Greens and the Italian People's Party.

Dallas Morning News of August 29, 2001, reported that decriminalizing the production and use of drugs is winning support across Colombia, prompted in part by a US backed attack on the nationÌs illicit drug crops. The movement, favouring a reduction or elimination of criminal penalties for people involved in the drug trade, is rapidly gaining support from mainstream opinion-makers and high-powered Colombian politicians.

Under Colombian law, individuals legally can possess a "personal dosage" of cocaine, hashish and marijuana. Some legislators want to expand the law to halt the criminal prosecution of peasant farmers who cultivate less than seven acres of coca and opium plants. Enrique Santos Calderon, publisher of ColombiaÌs largest daily newspaper, El Tiempo, is quoted as saying "I believe the U.S. strategy to combat drugs is wrong-headed and inefficient. Alternate legalization and decriminalization tactics should be considered because the Ëwar against drugsÌ strategies have failed miserably."

ETHICAL CONSIDERATIONS

An extremely interesting ethical analysis of the history of substance use is provided by the Bishop of Edinburgh, Richard Holloway, in his book published in 1999, called Godless Morality: Keeping Religion out of Ethics. He notes that one of the most potent responses to post-traditional society is fundamentalism, defending tradition in the traditional way, and he describes the case of marijuana as one example of this.

He points out that observation suggest humans like using natural substances that have psychoactive properties, that may act as euphorics, or energise or tranquillise us. Religion has been prolific in providing ways of doing this. Humans always seem to have used substances to help them take a break from the necessary routines of life.

In his view, the drugs that are now illegal substances were gradually outlawed for reasons that have as much to do with politics, class and race as with the problematic qualities of the drugs themselves.

In Britain, alcohol is involved in 65% of murders, 75% of stabbings, 40% of acts of domestic violence, 30% of acts of child abuse and hundreds killed and thousands injured annually in drink-drive accidents. In the UK, there are 1,800 deaths from illegal substances each year compared with 33,000 that are related to the use of alcohol.

He describes the American experiment with prohibition as having entrenched and institutionalized crime in the USA on a scale that could not previously have been imagined. The motive behind it seemed to be a potent combination of Puritanism and racism. Opium was associated with Chinese immigrants, cocaine with southern black labourers and alcohol with the Catholic cultures of Europe. Holloway suggests the great American war on drugs started in 1919 on a wave of xenophobia. Property crimes increased 13.2 percent, homicide 16.1 percent, while robbery soared 83.3 percent. Most telling was the fact that the crime rate began a long-term decline starting in 1933 - the same year Prohibition ended.

In Holloway's view, the purely prohibitionist approach does not seem to work. In open societies, prohibitions that do not have the overwhelming consent of the populace are almost impossible to police, and can end up corrupting the very system that is there to enforce them.

He concludes that the important point is the need to protect the freedom of humanity to live life in its own way, providing it is not thereby invading the equal rights of others or damaging their freedoms or interests. He proposes we should think long and hard before prohibiting something that people want, just because we disapprove of it. We should also learn to make connections between our own customs and preferences and the customs and preferences of others of which we may disapprove for no stronger reason than that they differ from our own.

For Holloway, the positive protection of the freedom of others to live their own lives in their own way is the strongest moral argument against prohibition. The costly failure of prohibition provides a strong negative reason for thinking again.

CONCLUSION

If not by conspiracy in fact, certainly by a unity of intent, organized crime, authoritarians, and religious fundamentalists all wish to retard or prevent sensible drugs policy, for reasons which are often narrowly focused and prejudicial to individual freedom, and which have no place in the formulation of public policy that will protect the community and its members from harm while at the same time nurturing personal growth and acceptance of responsibility for one's own behaviour and its consequences.

Taking drugs clearly provokes unusual brain experiences, and for those who enjoy the exotica of the brain's potentialities, this is a relatively harmless and pleasant form of relaxation. For people who do not enjoy such experiences, drug intoxication may be frightening, and such people commonly avoid most intoxicants. However, if they also decide on the basis of their own experience that drugs are a bad thing, to be avoided by and ultimately prohibited for everyone, misunderstanding and intolerance will ensue. Most drug users just want to be left alone to enjoy their recreation. Contrary to the wild eyed, drug peddling stereotype, most users have no interest at all in encouraging others to take drugs against their will. They usually respect the life choices of the nonuser, asking only that the drug user's life choices be similarly respected, and that inappropriate value judgments be withheld, and removed from legislation they have already infiltrated.

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