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MODERNISING AUSTRALIA'S ILLICIT DRUG POLICY

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MODERNISING AUSTRALIA'S ILLICIT DRUG POLIC

Prohibition

Prohibition is an awful flop.

We like it.

It can't stop what it is meant to stop. We like it.

It's left a trail of graft and slime,

It don't prohibit worth a dime,

It's filled our land with vice and crime,

Nevertheless, we're for it.

Popular song in the United States, 1920s-1930s

It is 23 years since the landmark Senate Standing Committee on Social Welfare report was issued with the provocative title: "Drug problems in Australia-an intoxicated society?" In that time, deaths from alcohol and deaths from tobacco and consumption of these substances have declined. Other outcomes related to legal drugs have also improved. But deaths, disease, crime, corruption related to illicit drugs and consumption of illicit drugs have all increased exponentially. This submission, refers only to illicit drugs.

Prohibition - an expensive way of making a bad problem worse.

"Over the past two decades in Australia we have devoted increased resources to drug law enforcement, we have increased the penalties for drug trafficking and we have accepted increasing inroads on our civil liberties as part of the battle to curb the drug trade. All the evidence shows, however, not only that our law enforcement agencies have not succeeded in preventing the supply of illegal drugs to Australian markets but that it is unrealistic to expect them to do so". (Parliamentary Joint Committee on the National Crime Authority, 1989).

This realistic conclusion about the impact of attempts to restrict the supply of illicit drugs was made a decade ago. Three of the authors of this document are today senior members of Federal Cabinet. The evidence to support the conclusion reached by the Parliamentary Joint Committee on the National Crime Authority is even greater today than it was when the members of the committee deliberated. Royal Commissioner Justice James Wood came to the same conclusion noting that "it is fanciful to think that drug addicts can be prevented from obtaining and using prohibited drugs" (Wood, 1997). Yet most of the daily discussion about drugs in the media and in our parliaments is based on the supposition that this trade could easily be suppressed, if only sufficiently strict policies were implemented. This is denial on a breathtaking scale. It would be easier to drain the Pacific Ocean than prevent illicit drugs entering Australia.

Communism and international prohibition were among the major movements to emerge during the course of the twentieth century. In retrospect the collapse of the central command economies in the Soviet Union and her eastern European satellites a decade ago was an inevitable result of trying to defy powerful market forces. As the twenty-first century begins, arguments now rages about how best to regulate free markets rather than whether to have them. Ignoring powerful market forces over a

long period is a certain recipe for achieving truly dreadful social and economic outcomes.

International prohibition is doomed for the very same reason that communism fell. The major response to increasing demand for mood altering drugs like cannabis, heroin, amphetamine and cocaine, in almost all countries during the twentieth century has been the criminal law. Prohibition attempts to defy economic gravity. Prohibition attempts to stop a kilogram of heroin costing \$1 in Burma reaching the streets of Kings Cross or St Kilda where it may now fetch \$200,000. Following many a political crisis stemming from illicit drugs, police drug squads have been expanded and penalties for offenders made more severe. Consequently, the price of a kilogram of heroin has been pushed even higher to compensate for the increased risks borne by the traffickers. For more than half a century in Australia, drug policy has been developed ignoring the effect of lucrative profits on the market for illicit drugs. Profits are the oxygen of any industry. When severe penalties have frequently proved to be an inadequate deterrent and have merely increased the harm resulting from illicit drugs, penalties have been made even stricter. Attempts to defy the inexorable law of supply and demand for illegal drugs have proved to be as unsuccessful as were attempts by international communism to defy economic gravity. Many have now concluded that 'prohibition has not worked'. Reliance on law enforcement has unfortunately proved to be expensive, ineffective and often counter-productive.

Drugs are bad, prohibition is worse

"Anecdotal information suggests that law enforcement is having only a limited effect on the amount of heroin offered at street level" ... "It is obvious that current policies are not working" (Australian Bureau of Criminal Intelligence, 1997).

The comment that "prohibition does not work" is heard very often these days. A recent paper produced under the auspices of the UN International Drug Control Program (UNDCP) concluded "present levels of enforcement will have little deterrent or preventive impact on drug trafficking to Europe". The authors argued that the implications of their analysis for increasing the effectiveness of European law enforcement were "not encouraging. The balance of evidence suggests increasing enforcement will impact only marginally upon prices due to rapidly diminishing marginal returns" (Farrell, 1996).

In calling for more stringent enforcement of drug laws, prohibition supporters fail to answer why allocation of 84% of commonwealth and state government expenditure on illicit drugs to law enforcement has not been enough. Despite 84,000 drug related arrests in 1997-8 and at least 8,000 inmates serving sentences for drug related offences, drug deaths have kept soaring, the cost of street drugs has been falling and the concentration and availability of street drugs has been increasing. If we are unable to keep illicit drugs out of our prisons, how do zero tolerance supporters expect to keep illicit drugs from entering our 37,000-kilometre coastline? How do they expect authorities to detect more than a fraction of imported illegal drugs entering with the 7 million air passengers and 2 million containers arriving each year? If Australian authorities are unable to create a drug free environment in our prisons, how can a drug free community be created in our streets?

The law of supply and demand predicts that supply increases to meet demand. This means that if demand exists and is not met by a legal source, other sources will emerge. Several decades of zealous effort to depress demand for illegal drugs have demonstrated the inability of governments to significantly depress the desire of young people for illicit drugs. Government policies on illicit drugs can only be effective if they are based on an acknowledgment of the power of market forces in the demand and supply of illicit drugs. A third way must be found to meet the demand for currently illegal drugs between a totally unregulated free market and a totally unregulated illegal market. A regulated legal market, which will never completely suppress an illegal element, is a more realistic and sustainable way of responding to illicit drugs. Access Economics has estimated that the annual turnover for mood altering drugs in Australia was \$ 12 billion for alcohol, \$7 billion for illicit drugs (of which cannabis accounted for \$ 5 billion), \$ 6 billion for tobacco, and \$ 4 billion for pharmaceutical drugs.

During the last quarter of the twentieth century, a new style of modern government emerged and spread far and wide within the developed and developing world. Achieving acceptable outcomes for modest expenditure is one of the hallmarks of this modern style of government. Many of the shibboleths of previous eras have been questioned. The ‘tax and spend’ approach of many previous governments is now widely derided. One of the few areas quarantined from the modern style of government has been illegal drugs. The ‘tax and spend’ approach to government still thrives in the response of almost all governments to illegal drugs. Expenditure of billions of taxpayers’ dollars continues without convincing evidence of benefit and despite compelling evidence of major harms such as corruption. The ever increasing cost of imprisoning growing numbers of drug users are ignored. Royal Commissions that find police corruption to be rampant and linked to unsuccessful attempts to enforce unenforceable drug policies are soon forgotten. The sacred cow of prohibition lives on.

Dreadful and worsening outcomes despite substantial and increasing government expenditure has prompted an almost endless series of major official inquiries into illicit drugs in Australia in recent years. For the last quarter century, a major official enquiry or Royal Commission has been held somewhere around Australia. Surely this speaks volumes of the failure of current policy. A similar debate rages in most western countries.

Why do policy makers continue with failed drug policies?

The best way to get a bad law repealed is to enforce it strictly.
Abraham Lincoln

Despite the resounding failure of punitive drug policies, politicians have clung to prohibition for many reasons. Almost all members of the community fear and loathe illicit drugs. By acting tough on drugs and using a “no-nonsense” rhetorical style, politicians of most political parties have been able to respond to the community’s fear of drugs and contempt of drug users. After the fall of communism deprived the community of a long running favourite fall guy, drug users became a very useful scapegoat for governments. The powerful web of international treaties and network of international drug agencies has also created a powerful illusion that current drug

policy was irrevocable. Critics of prohibition concentrated on detailing the failings of current policy and were slow to suggest realistic alternatives. Those who questioned prohibition could always be easily dismissed as covert drug users, while those who defended prohibition were able to claim a morally superior drug free status.

One of the major sustaining factors for policies widely considered to have failed resoundingly, has been the perception that political support for drug law reform was suicidal. It is now clear that this perception is no longer true. There still is a very significant political problem of introducing reforms that can achieve sufficient benefits within an electoral cycle. But politicians who rely on draconian drug policies to provide continuing strong electoral and community support for are no longer assured of a long career while other politicians who cautiously introduce moderate reforms are, these days, often politically rewarded by a grateful community.

Community support for changing drug policy

Community polling for the ACT heroin prescription trial showed almost equal support for and against the trial. The Victorian ALP Opposition went to the 1999 State election with a policy supporting the establishment of five injecting rooms and still won office. the NSW Government holds a commanding lead while cautiously implementing modest reforms. In contrast, while supporting a zero tolerance drug policy in 2000, the NSW Opposition scrapes along the bottom in opinion polls.

In September 1997, Swiss voters responded to a "Youth without drugs" referendum initiative that proposed the elimination of the "harm reduction" pillar of national drug policy and the end of substitution treatments and, more particularly, heroin prescription. The initiative was rejected by 71 % of voters with majorities in all 26 cantons (Suisse Office Fédéral de la Santé Publique, 1999).

Even in the United States, citizen initiated referenda held in the last two years on a variety of drug reform issues in conjunction with Congressional elections in seven states and the District of Columbia saw a majority support reform in each election (<http://www.csdp.org/ads/endwar.htm>). The 1996 votes were: California 56%: 44%; Arizona 65%:35 %. The medical marijuana initiatives and related results in 1998 were: Alaska Yes: 58 %, No: 42 %; Arizona Proposition 300 ('No' vote endorses medical use of illegal drugs) Yes: 42 %, No: 58 %; Arizona Proposition 301 ('No' vote endorses drug treatment instead of prison for drug possession) Yes: 49 %, No: 51 %; Colorado (Amendment 19) Yes: 60 %, No: 40 % ; District of Columbia (Initiative 59) Yes: 69 %, No: 31 %; Nevada (Question 9) Yes:58 % No: 42 %; Oregon (Measure 67-Medical Marijuana) Yes: 55 %, No: 45 %: Oregon (Measure 57 - Criminalize possession of marijuana) Yes:33 % No: 67 %; Washington State (Initiative 692) Yes: 59 % No: 41%; Arizona (Proposition 105 - Voter Protection Act) Yes:52 %, No:48 %. Maine passed Medical Marijuana by 61%:39% in November 1999 (personal communication: Mr David Fratello).

Overcoming the failings of current policy is similar to the problems of overcoming drug dependence. In both cases, the costs are borne up front while the benefits are delayed. But drug dependent individuals often get to the point where continued drug use is so unpleasant that the travails of withdrawal and entering the unknown arena of drug treatment becomes preferable to continued drug taking.

Does drug law reform lead to increased drug use?

One of the myths sustaining prohibition is the fear that any modernisation of drug policy will risk increasing drug consumption because of falling prices. There is no convincing evidence that liberalisation of drug policy has led to an increase in drug consumption although this has been examined for cannabis (Single, 1989). It is inherently plausible that falling drug prices could result in increasing consumption. After all, an inverse relationship between price and consumption is one of the fundamentals of micro-economic theory. But the number of people consuming cocaine in the United States fell sharply during the 1980s at a time when cocaine prices dropped sharply. The price paid for drugs is but one factor affecting consumption. Perhaps price affects consumption less than other commodities because the cost of drugs is passed on to non-drug users through property crime.

Policy makers also have to question whether decreasing drug consumption should be, as advocated by zero tolerance supporters, the paramount goal of our national drug policy. Since Australia adopted an official national drug policy of harm minimisation in 1985, it is the consequences of drug use – deaths, disease, crime and corruption – which have rightly been the paramount goal of policy and not drug consumption *per se*. If, for example, deaths, disease, crime and corruption were to fall by 10% but drug consumption to rise by 5%, would this not be an outcome to be welcomed? The number of acute drug related deaths in the Netherlands (population 15.6 million) fluctuated between 23 and 67 between 1985 and 1997 with no discernible increase or decrease (European Monitoring Centre for Drugs and Drug Addiction, 1999). In Sweden (population 8.8 million), where a zero tolerance policy prevails, deaths in the same period fluctuated between 113 and 250, doubling between 1989 and 1996 (European Monitoring Centre for Drugs and Drug Addiction, 1999). Surely a more preferable policy is one that reduces deaths of young Australians even if this is accompanied by increased drug use.

Reducing drug consumption should be regarded as a means to an end and not an end in itself. Reducing alcohol and tobacco consumption is an effective way of achieving better outcomes because the amount of harm is closely correlated with the quantity of alcohol or tobacco consumed. The relationship between illicit drug consumption and related harm is unknown but unlikely to be closely correlated because most of the harms are related to the mode of administration rather than a direct and predictable pharmacological property of the drugs themselves.

The effect of prohibition is like smoking cannabis: a sense of euphoria and a distorted sense of reality

“The current policies are not working. We seize more drugs, we arrest more people, but when you look at the availability of drugs, the use of drugs, the crime committed because of and through people who use drugs, the violence associated with drugs, it's on the increase. It can't be working”.

Keith Hellowell. The Guardian, 23 May, 1994. Chief Constable, West Yorkshire (at present Drug Czar, United Kingdom).

Some Australian states began to ban cannabis in the late 1920s. In response to international pressure, the Commonwealth prohibited heroin production and importation in 1953. When cannabis and heroin laws were introduced in Australia, demand for these drugs was almost non-existent. Demand for illicit drugs in Australia grew steadily after the Vietnam War. Governments responded to the growing demand for cannabis and heroin by expanding customs and police resources to cut drug supplies and introducing increasingly severe penalties for those convicted of using or selling drugs. The market responded to the increasing risk of detection and more severe penalties by providing greater compensation in the form of higher prices for illicit drugs. Higher prices and more lucrative profits attracted a growing number of individuals prepared to traffic in illicit drugs. Higher prices of illicit drugs may have also triggered increasing property crime used to generate income to pay for drugs. Inadvertently, government policies have increased the profits of drug trafficking while the market has continued to grow in response to the price signals. Governments of all political persuasion in Australia have been reluctant to deprive the traffickers of the oxygen of profits. As we learnt from alcohol prohibition in the United States, the most effective way of defeating Al Capone and the other traffickers of bootleg liquor was to permit a legal source for a drug that could not be eradicated.

When Australian governments have been pressed recently about the dreadful outcomes resulting from illicit drug policy, a stock response has been to argue that any change in direction “sends the wrong message”. The creation of a drug free Australia still appeals to a community that does not understand the impossibility of achieving this objective. However, the pursuit of an unachievable objective threatens the attainment of important and achievable objectives.

US Congress decreed in 1988 that the United States would become drug free by 1995. Not only has the US failed to achieve this objective, zero tolerance has set back the achievable objective of controlling HIV infection among injecting drug users. “To date, nearly 40% of the 652,000 cases of AIDS in the US have been linked to injecting drug use. More than 75% of babies diagnosed with HIV/AIDS were infected as a direct or indirect result of injection drug use by a parent” (Department of Health and Human Services, 1998)

Almost half the estimated 40,000 new HIV infections in the United States each year have been directly or indirectly attributed to injecting drug use and the sharing of injection equipment. Surely Australia was better served controlling HIV infection whatever message policies at the time “sent” than the zero tolerance policies of the US which failed to reduce drug consumption and failed to contain HIV infection. Even the US Secretary of Health and Human Services has acknowledged that “a meticulous review of the scientific evidence has proven that needle exchange can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs.” (Shalala, 1998) Ms Shalala’s statement followed six reviews conducted by or on behalf of the US government (which is no friend of harm minimisation).

The Serenity prayer of Alcoholics Anonymous recommends that we find the courage to change what we can, develop the serenity to accept what cannot be changed, and acquire the wisdom to know the difference. A modern Australian drug policy would be based on an acceptance that drugs like cannabis and heroin are here to stay. We have to accept that efforts to reduce demand and supply have unfortunately been

largely ineffective. Policy must be based on the pursuit of achievable goals such as a substantial and sustainable reduction in deaths, disease, crime and corruption. And policy must be based on the wisdom of distinguishing between what we are able to do well and what we have only been able to do badly. We have to distinguish between the world as it really is and the world as we would like it to be.

Making choices

“We have a failed social policy and it has to be re-evaluated.”

General Barry McCaffrey. (US Drug Czar). International Herald Tribune. 15.3.1999. page 10.

Drug policy is a matter of choosing between options. Having reduced consumption of drugs such as cannabis, heroin, amphetamine and cocaine to their irreducible minimum, the options we have to choose between are those that will meet existing demand. Under current policy, demand is supplied (by default) by criminals and corrupt police. Other options include a totally unregulated illegal market or some kind of regulated legal market. The community would not, rightly, accept an unregulated legal market. For the last half century, the demand for currently illicit drugs has been met through a totally unregulated illegal market. Australians know the benefits and costs of this approach by now very well. Benefits have been difficult to identify while the health, social and economic costs have been immense.

Australians would prefer to see less rather than more consumption of cannabis, heroin, amphetamine and cocaine. Unfortunately, and contrary to conventional wisdom, attempts to reduce demand for these drugs through education of the community or young people in particular, has had only a very limited effect. A review of youth drug education showed that 73% of youth drug education interventions demonstrated no effect on drug consumption. In the remaining 27%, some benefit was shown but the average reduction was only 3.7% and even this reduction dissipated over time (White, 1998). Drug education has an important role to play the primary prevention of drug use. But, it does not help to be unrealistic about the small impact of efforts to persuade young people not to experiment with or keep using drugs. We have to be equally realistic about the effectiveness of efforts to reduce the cultivation of drugs like cannabis, opium and coca, the refinement of drugs like heroin, amphetamine and cocaine, their transport from producer to consumer country, their entry into Australia, and their distribution and sale within Australia. Once demand has been decreased to the lowest level possible, we then need to choose between which kind of market we are prepared to tolerate to supply this demand.

A totally unregulated legal market for currently illicit drugs is inconceivable. Even if a good technical case could be made for this option, it is very doubtful that the community could be persuaded that “crack cocaine should be made available from supermarket check out counters”. Community support for this legalisation option is understandably barely measurable. This is unlikely to change in the foreseeable future. Even if community support for this legalisation option was somehow obtained, the process of gaining necessary political support would be insurmountable. Australia is also most unlikely to defy the international system of treaties and conventions that would condemn such a totally unregulated legal market for drugs like heroin and cocaine.

How Does Australia Respond to Illicit Drugs Like Heroin and Cocaine?

In financial terms, Commonwealth and state government expenditure in response to illicit drugs in 1992 was estimated at \$US 393 million (\$A 620 million) (United

Nations International Drug Control Programme, 1997). Of this not inconsiderable sum, 84 percent was allocated to law enforcement, 6 percent to treatment and 10 percent to prevention and research. Although these figures are somewhat imprecise, they represent the best indication available of the uneven proportions of government expenditure allocated to supply reduction and demand reduction. Commonwealth and state expenditure on Methadone programs has been estimated at \$30 million per year (Commonwealth Department of Human Services and Health, 1995). In 1991, Australian expenditure on needle syringe programs was estimated at \$10 million (Feachem, 1995). Expenditure on harm reduction programmes amounts to a tiny fraction of government outlays on supply reduction.

The rationale behind current policies is 'harm minimisation'. Australia officially adopted a national policy of 'harm minimisation' at the Special Premiers' Conference held in Canberra on 2 April 1985. The meeting was convened by the then Prime Minister and attended by all State Premiers and both Chief Ministers. The term 'harm minimisation' was not defined at that time. A national commitment to harm minimisation has been endorsed on several subsequent occasions by the Ministerial Council on Drug Strategy (MCDS), Australia's paramount drug policy making body.

During the 1990s, it was common practice for Australian government officials to refer to national drug policy as 'the balanced approach'. In 1998, however, Prime Minister John Howard strongly endorsed a 'zero tolerance' approach and commended this policy on several occasions. He borrowed this unfamiliar rhetoric and philosophy, with all its connotations of intolerance, from the United States of America. Zero tolerance in the United States has provided a philosophical base for a drug policy which has yielded appalling outcomes.

Following the evaluation of the third national drug strategy in 1998, the Ministerial Council on Drug Strategy (MCDS) again endorsed a national policy of harm minimisation but this was defined to include the three goals of *supply reduction*, *demand reduction* and *harm reduction*. By this time, a harm reduction approach to illicit drug problems had become well entrenched among health department and law enforcement officials across the nation. The primary focus taken by health department and law enforcement officials was to reduce the health, social and economic adverse consequences of illicit drugs without necessarily reducing consumption. Harm reduction interventions such as needle syringe programs and methadone treatment programs have been strongly supported in community opinion polls. Nonetheless, the vociferous opposition of a critical minority attracts considerable attention.

How can Australia's response to illicit drugs best be understood at the beginning of the twenty first century? The allocation of substantial resources to illicit drug law enforcement and minimal resources to treatment, prevention, research and harm reduction indicates that the solid core of the national drug policy is supply reduction, while demand reduction and harm reduction are but a thin veneer.

How Did Australia Develop Its Drug Policy?

In the 1890s, prior to federation, several Australian states prohibited the smoking of opium. At the time, the practices of smoking opium was confined to Chinese, many of whom were working on Australia's gold fields (Manderson, 1993). The drug laws

were expanded in the first decade after federation although the Commonwealth Comptroller-General of Customs, H.N.P. Wollaston, stated in his report to the Commonwealth Parliament in 1908 that 'it is very doubtful if such prohibition has lessened to an extent the amount which is brought in to Australia' (Manderson, 1993). Wollaston added:

owing to total prohibition, the price of opium has risen enormously ... the Commonwealth gladly gave up about £ 60,000 revenue with a view to a suppression of the evil, but the result has not been what has been hoped for. What now appears to be the effect of total prohibition is that, while we have lost the duty, the opium is still imported pretty freely (Manderson, 1993).

At the 1925 Geneva Convention, Australia agreed to enact laws to 'limit exclusively to medical and scientific purposes the manufacture, import, sale, distribution, export and use of 'medicinal opium, cocaine, morphine, Indian hemp and heroin.' Although the use of 'Indian hemp' (or cannabis) was virtually unheard of in Australia at that time, authorities responded to the call for conformity to the new international legal framework. Nevertheless, the Under-Secretary of the Colonial Secretaries Department concluded that 'the omission of that drug from the operation of the Act would possibly be of small moment, but having been considered by the conference as requiring to be included, it might perhaps be as well, if practicable, to bring it within the purview of the dangerous drugs laws.' (Manderson, 1993). On this shaky foundation, the mighty edifice of cannabis prohibition was constructed.

During the first half of the twentieth century in Australia, the occasional cases of heroin dependence were managed by the medical profession under the supervision of state or territory health departments (Manderson, 1993) much as similar cases of dependence to other opioids such as morphine are managed today. Doctors would try to encourage their heroin dependant patients to become abstinent. After several unsuccessful attempts, the doctors would contact their state (or territory) health department. Further prescription was authorised if all were agreed that every possible, reasonable attempt had been exhausted. Australia was required by international treaty obligations to report per capita legal heroin consumption. Heroin consumption in Australia in 1951 was reported to be the highest in the world and appeared to be increasing. Australia came under increasing international pressure to prohibit the use of heroin even though problems consequent on consumption of the drug were not evident. The Director-General of Health in New South Wales said, for example, that 'heroin ... is quite effectively controlled in this state and ... I see no justification to enforce absolute prohibition'. The Australian Federal Council of the British Medical Association (BMA), later to become the Australian Medical Association, argued that there 'should be no curtailment of availability'. Although the Royal Australasian College of Physicians and the Royal College of Obstetricians and Gynaecologists both declared in 1953 that 'the use of heroin should not be prohibited', the Commonwealth advised State Premiers in May 1953 that the importation of heroin was to be absolutely prohibited. Prohibition of importation and production of heroin was gazetted on 25 June 1953.

In the following years, the states exhausted their stocks of heroin. Thereafter, doctors prescribed other drugs than heroin when managing painful conditions. Initially, there was little evidence that the prohibition of heroin production or importation in 1953

had resulted in significant negative consequences. This assessment began to change in the late 1960s when US servicemen on rest and recreation leave from the Vietnam war began visiting capital cities in Australia. Some US Servicemen brought heroin with them and introduced young Australian men and women to the drug and the practice of injection. The Bourbon and Beefsteak bar in Sydney's Kings Cross became the first centre of Australia's heroin trade. Over the following years, heroin injecting spread to all Australian states and territories. The number of young men and women injecting heroin appeared to increase inexorably. New illicit drugs appeared on the scene with monotonous regularity.

What Have Been the Outcomes of Australia's Illicit Drug Policy?

"So when I now say 'let us legalise drugs', I hope I will not be accused of being tolerant of the evils that drugs cause, or soft on the thugs and violent criminals who push drugs, wreck lives, and are imperilling our society". Edward Ellison, Former Head of Scotland Yard Anti-drugs Squad. The Daily Mail 10.3.1998.

A diverse group of clinicians, researchers, law enforcement officers, government officials and drug users recently estimated (Law, 1999) that there were in Australia in 1997 100,000 regular injecting drug users with an additional 175,000 occasional injecting drug users. This group estimated that the number of injecting drug users had increased at a rate of seven percent per annum from the 1960s. This rate represents a doubling time of just 10 years.

There are a number of indications, however, that the rate of increase of injecting drug use in Australia during the last years of the twentieth century was occurring at an even faster pace. This perception is based on an increase in the number of drug seizures, the amounts of drugs seized, deaths from drug overdose, demand for drug treatment and a rapid increase in the demand for sterile needles and syringes. In addition, there was a steady decrease in the age of persons arrested for drug related offences; age of persons presenting on the first occasion for drug treatment; age of persons attending needle syringe programs; and the reported age of initiation. This suggests a long-term increase in illicit drug use with a particularly rapid growth phase during the closing years of the twentieth century.

Drug overdose deaths in Australia have also increased significantly during the last twenty years. Where 70 people died (10.7 per million) in 1979, there were 550 deaths (67 per million) in 1995 (Hall, 1999). Between 1991 and 1997, the number of overdose deaths in Australia doubled. The number of drug overdose deaths in Australia at the end of the twentieth century was running at half the number of deaths from youth suicide, widely recognised for some time to have become a major public health concern.

Although attempts to attribute criminal offences to illicit drug use has its difficulties, there can be little doubt that drug related property crime in Australia was exceedingly common and growing rapidly at the end of the twentieth century. The Australian Institute of Criminology reported that 53 percent of property offenders said that they were using heroin at the time of committing the offence. In New South Wales, heroin dependence was considered responsible for a 33.4 percent increase in robberies committed with a fire arm, a 76.8 percent increase in robberies with a knife

and a 29.5 percent increase in robberies without a weapon. A survey of Sydney heroin users from 1995 to 1997, found that 70 percent had committed a property crime in the month prior to interview whilst 9 percent had committed a fraud and 4 percent a violent crime. Interviews with inmates convicted of burglary offences in New South Wales indicated a higher median rate of burglary (13.7 per month) among heroin users than among burglars who did not use heroin (8.7 per month). Median weekly burglary income for heroin users (\$3,000) was far greater than for non users of heroin (\$1,000). Although a substantial proportion of heroin users commit crime before commencing illicit drug use, there can be little doubt that drug use prolongs and exacerbates criminal behaviour.

High levels of official corruption has also been linked to illicit drugs. This connection was confirmed in a number of official inquiries and royal commissions. For example, both the Fitzgerald Report (Royal Commission into Possible Illegal Activities and Associated Police Misconduct (Qld) 1989) and the Woods Report (Royal Commission into the New South Wales Police Service 1997) concluded that official corruption was widespread and linked to the enforcement of laws relating to illicit drugs.

It was widely assumed during the second half of the twentieth century in Australia, that support for 'tough on drugs' policies inevitably results in growing political popularity. Nevertheless, there is now increasing national and international evidence for the view that support for Draconian drug policies is becoming a political liability rather than an asset. In 1998, two thirds of respondents in a public opinion poll expressed disapproval of the Commonwealth Government's handling of illicit drug issues. This poll was held after the Prime Minister had aligned himself with a 'zero tolerance' approach.

Australia did not adopt its current drug policies following a careful and thorough assessment of the effectiveness of previous policies and a rigorous evaluation of policy options. The prohibition of cannabis and the prohibition of heroin were both historical accidents. Once adopted, however, they have been automatically defended whenever questioned. The commitment to these policies has become increasingly entrenched, at the same time as community support for them appears to be eroding.

Have Australia's Drug Policies been Effective?

"It is not the function of our Government to keep the citizen from falling into error, it is the function of the citizen to keep the Government from falling into error".
US Supreme Court. *American Communications v. Douds*.

During the 1990s, an increasing number of community leaders began to express anxiety about the relative ineffectiveness of Australia's drug policy. Police Commissioners at a national meeting in 1998 expressed the need to 'almost wipe the slate clean' by moving from 'punishment to rehabilitation'. In 1998, capital city mayors unanimously supported drug law reform and a scientific evaluation of heroin prescription. The West Australian branch of the National Party supported cannabis reform and a heroin trial. The growth and support for drug law reform followed the collapse in confidence in the effectiveness of a drug policy based on law enforcement.

If our national drug policy has been designed fundamentally to decrease drug use, decrease deaths, decrease crime and decrease corruption, Australia's drug policy in

the latter decades of the twentieth century was clearly not achieving these objectives. It is important to recognise not only the failure of drug policy, but the magnitude of this failure. Failure to this extent in the corporate world would inevitably result in bankruptcy. Military failure on this scale would almost certainly result in the court martial of those responsible. Corrections may also occur in politics, but more slowly. Governments are often very concerned to emphasise the importance of drug users accepting responsibility for their own individual actions. But governments seem less inclined to accept direct responsibility for the consequences of their own policies.

Despite the comprehensive and resounding failure of a law enforcement based drug policy in relation to drug use, deaths, crime and corruption, some significant public health gains were achieved. Establishing and maintaining control of HIV infection among and from injecting drug users in Australia has been a major public health achievement. Similarly, there is growing evidence to suggest substantial reduction in new infections of Hepatitis C among injecting drug users. These achievements were gained despite, and not because of, supply control. In fact, these achievements only took place because law enforcement officials had the wisdom to identify correctly the importance of these public health threats to the community. Discretion was indeed the better part of valour. Following recognition of the magnitude of the HIV threat to Australia in the early 1980s, law enforcement officials have generally been very discriminating when policing in the vicinity of needle exchange and methadone programs.

One of the supposed indicators of the effectiveness of the law enforcement approach are levels of drug seizures. From time to time, State and Commonwealth Ministers and even the Prime Minister have expressed great pride in announcements of successful major seizures. These announcements were accompanied by overly optimistic estimates of the impact of major seizures on the availability of illicit drugs. Alas, subsequent data indicated that these major seizures were not followed by detectable changes in the price and availability of illicit drugs. Even Australia's most senior law enforcement officers reported that (Australian Bureau of Criminal Intelligence, 1998) 'heroin is a serious concern and it is obvious that current policies are not working'. They also noted that 'heroin remains generally available in Australia and anecdotal information suggests that law enforcement efforts are having only a limited effect on the amount of heroin offered at street level.' (Australian Bureau of Criminal Intelligence, 1998).

Have Any Other Countries Made Better Progress on Illicit Drugs?

"Seek the truth from the facts".

Mao Tse Tung

Faced with the poor outcomes from Australia's drug policy in recent decades, it would not be surprising if some concluded that illicit drug policy was too difficult and achieving progress was impossible. Nevertheless, it is now clear that a number of European countries have made substantial progress recently even though most other developed countries have reported unacceptable and deteriorating outcomes during the same period. In Switzerland, health problems, public nuisance, and crime related to drugs all increased steadily during the 1980s and early 1990. HIV was poorly controlled among injecting drug users. Authorities in many cities appeared to have

lost control of public order due to widespread drug injecting in public places. Following a vigorous national debate, Swiss policy changed in the early 1990s and improvement soon followed. Drug overdose deaths in Switzerland halved from four hundred and nineteen in 1992 to two hundred and nine in 1998 and one hundred and eighty one in 1999. Public nuisance related to drug injecting in public places declined steadily during the 1990s. Drug related crime has also been declining in Switzerland during the 1990s (Swiss Federal Office of Public Health 1999).

Estimated government expenditure in response to illicit drugs in Switzerland in 1994 was 1,011 million SFr of which 500 million SFr was allocated to law enforcement, 260 million SFr to care, treatment, therapy and rehabilitation, 200 million SFr to harm reduction, 35 million SFr to prevention and 16 million SFr to research and training (Swiss Federal Office of Public Health 1999). These financial commitments had a number of positive outcomes. The capacity of the methadone treatment programs throughout the country expanded from 728 in 1979 to 15,382 in 1997. The number of admissions to residential abstinence programs grew from 1,900 in 1993 to 2,100 in 1996. Heroin programs were established on a research base between 1994 and 1997 and by 1998, 1,056 patients were receiving treatment in the form of heroin prescription provided with considerable psychosocial assistance. The capacity of detoxification and rehabilitation residential centres increased from 1,250 in 1993 to 1,750 in 1997. The first injecting room in Switzerland was established in the city of Bern in 1986. By 1999, there were fourteen injecting rooms spread across the German speaking part of Switzerland. In these facilities, drug injecting takes place under supervision with immediate assistance provided in the event of an overdose. No deaths have been reported from any Swiss injecting room to date (Swiss Federal Office of Public Health 1999). Although the heroin prescription trial and injecting rooms have captured a great deal of national attention in Australia, less emphasis has been placed on the fact that strenuous efforts have been made to expand the range, increase the capacity and improve the quality of drug treatment in Switzerland. The important point is that approximately ten times as much funding per person is allocated to health interventions in Switzerland compared to Australia.

In the Netherlands, drug overdose deaths have been maintained at a low and stable rate of about 50 per year in a population of fifteen million. The number of sterile needles and syringes exchanged with injecting drug users in the city of Amsterdam has halved during a five year period in the 1990s without a change in policy. This coincided with a steady increase in the mean age of injecting drug users suggesting that the population of injecting drug users was declining because of a decline in the number of new recruits.

The encouraging results in Switzerland and the Netherlands during the 1990s suggests that pragmatic approaches based on solid evidence can improve public health outcomes. Consequently, there has been a growing interest in Western Europe in more public health oriented approaches, especially as countries with a historical commitment to belief-based moralistic approaches reported unacceptable and deteriorating outcomes.

How can Australia Achieve Better Outcomes from Its Illicit Drugs Policy?

“It is hard to notice something that is too big to be seen”.
G.K.Chesterton.

The following strategies, the Australian Drug Law Reform Foundation's 10 Point Plan, are a framework for achieving better outcomes from illicit drug policy.

- (1) Illicit drugs are primarily a health and social issue although drug law enforcement should always have an important role in a community's response.
- (2) Penalties are required for the unauthorised, large-scale production and sale of all mood-altering drugs. Threshold levels and the nature and extent of the penalties will differ for different drugs.
- (3) Health and social interventions for illicit drugs should receive funding equivalent to that allocated for drug law enforcement.
- (4) Well funded, research based drug education for schools and communities forms an important part of a community's response to mood altering drugs although benefits are modest and not sustained.
- (5) Criminal sanctions are inappropriate for the personal consumption of mood altering drugs.
- (6) Cannabis production and sale should be regulated and taxed with a proportion of the tax reserved to fund drug education, treatment and law enforcement.
- (7) Drug treatment should be attractive, effective, diverse and meet demand. Needle syringe programmes should also meet demand. Supervised injecting facilities should be provided where required near large drug markets.
- (8) Non custodial sentencing options should be expanded and, where possible, preferred to incarceration.
- (9) Promising new treatment options, including heroin prescription, should be evaluated according to standard scientific processes.
- (10) Harm minimisation, a standard public health approach for complex problems, must remain Australia's official drug policy while harm minimisation programmes should be expanded.

This framework is discussed in more detail.

Redefining the Problem of Illicit Drugs

The most important step is to redefine illicit drug use as primarily a health and social issue rather than a criminal justice problem. Law enforcement will always be needed to complement health and social interventions but should no longer be allowed to dominate policy, funding allocation or public rhetoric. It should also be recalled that there are many precedents for such a reclassification. In most Australian states, the high cost, ineffectiveness, and substantial unintended negative consequences of a law enforcement approach to public drunkenness resulted in a similar re-classification. Following two decades of experience with a primarily health and social response to

public drunkenness, there have been few calls for a review of this approach.

Setting Appropriate Penalties

Unauthorised, large scale cultivation, production, transport, distribution, sale or possession of all mood altering drugs should continue to attract penalties including, where appropriate, criminal charges. The magnitude of the penalties, however, should be in proportion to the quantity and type of drugs seized. It is logical that unauthorised *trade* in mood altering drugs should attract different penalties for different drugs. It is also logical that the precise *quantities* of mood altering drugs which attract a penalty will need to be defined separately for different drugs.

More emphasis on non custodial sentencing options is required to divert selected offenders from the criminal justice system to drug treatment. The cost of incarceration is 4 to 8 times higher than residential abstinence promotion treatment and 25 to 50 times the cost of Methadone treatment. Incarceration is undoubtedly unavoidable for some drug users with deeply entrenched criminal behaviour, especially if the offences involve violence. Diversion is available in most Australian jurisdictions at present but rarely occurs because of inadequate resources. The NSW Drug Court established in 1999 was allocated \$12 million to manage 300 participants over two years.

Cultivation, production, transport, distribution, sale or possession of small quantities of illicit drugs consistent with personal use should not attract criminal sanctions. Quantities considered to be consistent with personal use will need to be defined for each type of drug. A system of accountable police discretion will be required to minimise the risk of corruption.

Cannabis: Decriminalisation, Regulation and Taxation

“Penalties against the use of a drug should not be more damaging to an individual than the use of a drug itself; and where they are they should be changed. Nowhere is this more clear than in the laws against the possession of marijuana ... Therefore I support legislation to eliminate all federal penalties for the possession of up to one ounce of marijuana”.

President Jimmy Carter

The regulation and taxation of cannabis production and sale is inevitable in the long term. It is likely that Australia will adopt a policy of regulated production and sale after proceeding through a phase where consumption is legal but production is illegal. However, a market where production is illegal and consumption is legal is not sustainable. Zero tolerance supporters argue that cannabis is a highly dangerous drug. The more dangerous the drug is assumed to be, the less sense it makes to leave distribution to criminals. At present, the \$A 5 billion per annum estimated annual turnover Australian of the cannabis industry generates negligible taxation revenue. Hypothecation of cannabis tax revenues for the purposes of illicit drug law enforcement, prevention of drug use and treatment of illicit drug users is likely to be a popular policy.

Expiation of cannabis charges on payment of a fine was first introduced in South Australia in 1986 and was then introduced in other states and the ACT. Although this

approach appears to reduce expenditure on cannabis law enforcement, it has resulted in an increasing number of offenders (net-widening), many of whom are socially and economically disadvantaged.

Balanced Allocation of Funding

Effective drug policy cannot be developed without a fundamental change in allocation of funding. Under current policy, the majority of government expenditure on illicit drugs is allocated to programs with a poor return on investment. Conversely, treatment interventions, which provide a very favourable return on investment, are poorly funded. *Equal funding for law enforcement on the one hand, and for prevention and treatment on the other would provide a far better return to the community than the current allocation.* The limited resources provided to health and social interventions also condemn law enforcement to unacceptable outcomes.

Adequately Funded, Research-Based Drug Education

Adequately funded, research-based drug education is required for schools and the community. Nevertheless, there are limits to this strategy. Experience with drug education suggests that modest, long-term gains are far more likely than the heroic, short term gains assumed by many politicians and community members.

Drug Treatment: Improving the Range, Capacity and Quality

Expanding the range, increasing the capacity and improving the quality of drug treatment is a fundamental requirement of any effective drug policy. Improvement in drug treatment is the most important component of a comprehensive approach designed to reduce the unacceptable number of drug overdose deaths in Australia. Expansion of drug treatment facilities and options will also decrease drug-related crime, especially if emphasis is given to attracting the most severely entrenched drug users in to treatment. *As long as drug users in Australia continue to find it more difficult to enter drug treatment than to obtain illicit drugs from the trafficking industry, poor outcomes are inevitable.* In order to recruit and retain the majority of drug users in drug treatment, the target populations must be offered drug treatments that they find attractive and accessible. Therefore, drug treatment will need to be expanded to meet demand. Needle syringe programs must also meet demand because of the high health, social and economic costs of an uncontrolled HIV epidemic among injecting drug users.

Evaluation of New Treatment Options

New treatment options must be evaluated, as the current range of treatments is too limited. Selection of new interventions for research evaluation should be based on strong theoretical rationales, impressive empirical data or both. Cost effectiveness should also be a consideration. Rigorous research evaluation of heroin prescription was recommended by a committee of the ACT legislative assembly in 1991 and finally approved by a six: three majority of health and police ministers at the Ministerial Council on Drug Strategy on 31 July 1997. Federal Cabinet, however, declined to act on this decision less than three weeks later. Following the impressive health, social and economic gains of the 1994-97 Swiss Heroin trial, a number of

European countries have now commenced, committed themselves, or are strongly considering beginning a heroin trial. Injecting rooms have been established in Switzerland, Germany and the Netherlands. These facilities are more difficult to evaluate but appear to have reduced deaths from drug overdose, reduced the number of new infections of blood born viruses (including HIV, Hepatitis B and Hepatitis C), reduced injection of illicit drugs in public places and may also have reduced corruption of public officials.

Renewed Commitment to Harm Reduction

Australia's commitment to harm reduction needs further clarification following the calls for zero tolerance in 1998 and 1999 by the Prime Minister. It is now clear that attempts to *reduce* the adverse consequences of illicit drug use are almost always successful, while attempts to *eliminate* harm are often inadvertently counterproductive. The paramount focus of National Drug Policy must be a reduction in adverse health, social and economic consequences of mood altering drugs. Reducing consumption may be a means to achieving this end, but use reduction should not be the primary goal of drug policy. The injection of street drugs of unknown concentration, possibly adulterated with unknown substances or microbial agents, is inherently unsafe. Consumption of the same drugs by non-injecting routes of administration is less hazardous.

Attempts to reduce the supply and demand of illicit drugs in Australia over the last quarter century have been unsuccessful. While a reduction in the number of persons who inject illicit drugs would be highly desirable, whether this is achievable given the increasing global production of illicit drugs and the relative ineffectiveness of drug education is another question. It may well be that the undermining of the illicit drug trafficking industry by recruiting and retaining drug users into a more attractive and effective drug treatment system will substantially reduce demand and new recruits to drug use.

Australia's drug policies were originally adopted for cannabis on an almost arbitrary basis, and those for heroin following international pressure. More than seven decades of cannabis prohibition and almost five decades of heroin prohibition has been an expensive, ineffective and counterproductive exercise. 'Fine tuning' of these policies or 'more of the same', is unlikely to achieve acceptable outcomes. A fundamental review of drug policies is required that redefines the problem of illicit drugs as primarily a health and social issue. Unless such a redefinition is accompanied by a major re-allocation of funding for expanded and improved drug treatment, progress will not occur. Although, the vast bulk of government funding has been allocated to law enforcement, the major success of Australia's drug policy has been control of HIV infection among injecting drug users. This was due to harm reduction programs and not to supply reduction.

Australia now has the example of other more successful countries to emulate. Attracting drug users from the illicit supply system into drug treatment will improve the lives of drug users and their families as well as reducing crime for the entire community. Reform of Australia's drug policies is now more a question of 'when' than 'whether'.

How should drug markets be managed?

“The people's right to change what does not work is one of the greatest principles in our system of government”.

Richard M. Nixon.

Regulated cultivation and sale of cannabis following the lines of tobacco control offers the opportunity to reduce negative consequences of cannabis consumption as well as the considerable costs and harms resulting from cannabis control. Regulated cultivation and sale of cannabis occurs in some cantons of Switzerland. Regulated sale now occurs in some countries including the Netherlands. There is disagreement among legal experts about whether or not regulated cultivation and sale breaches international conventions to which Australia is a signatory. Regulated production and sale of drugs such as heroin, cocaine and amphetamine is not now and probably never will be a desirable, feasible, political or legal option. But availability of heroin, amphetamine and cocaine controlled by medical prescription has previously been an option in Australia for managing dependence, is currently an option in some overseas countries and is fully consistent with Australia's treaty commitments. Costs and benefits of medical prescription of heroin and amphetamine should be carefully evaluated by rigorous scientific research. Such research is under way in several countries. Crude, dilute preparations of opium and cocaine are available in some countries. This requires more documentation and consideration. Sildenafil, a drug with legitimate medicinal application but also often used for recreational purposes, is already available through medical prescription in Australia. It is difficult to consider how drugs like ecstasy could fit into any existing system but ecstasy and similar drugs represent a very small public health problem.

For the last fifteen years, I have participated in the regulation of prescribed drugs in NSW (as a member and currently the chair of the Medical Committee under the NSW 1966 Poisons Act). This committee makes recommendations about applications from doctors who wish to prescribe drugs of dependence to people in New South Wales for periods longer than two months. I therefore have some experience in regulating the prescription of drugs of dependence for a population of six million over more than 15 years. The results achieved by regulation of prescription drugs are certainly not perfect, but they are clearly acceptable. Steady improvement is occurring. Computerisation of medical prescriptions, which will further improve surveillance effectiveness, is likely in the next decade provided that risks to privacy can be overcome.

The severity of health and social problems resulting from illegal drugs distributed through criminal networks contrasts starkly with the very acceptable outcomes from provision of the same drugs supplied under prescription. Heroin is metabolised to morphine within 60 seconds of entering the human body. Morphine is prescribed in vast quantities in Australia. Problems from prescribed morphine occur but are distinctly uncommon. Problems resulting from heroin dispensed through criminal networks began to increase rapidly a little more than a decade after importation and production of the drug was banned in Australia in 1953 (Manderson, 1993). Problems resulting from lawfully prescribed dexamphetamine occur but are minor and

uncommon while problems abound from street amphetamine, now Australia's most commonly injected illegal drug.

The inexorable law of supply and demand and regulation of drugs

The law of supply and demand predicts that the supply of a commodity increases to meet demand. Where demand is strong and legal supply proves inadequate, other supply sources emerge. Prohibition can be an effective way of controlling dangerous substances if demand is weak, controls are difficult to subvert, and substitute commodities are less harmful. Barbiturate prohibition was very effective in Australia because demand was weak, controls enforceable and benzodiazepines proved far less harmful than the barbiturates they substituted for. The prohibition of compound analgesics in Australia was a triumph for similar reasons. Drug prohibitions have to be selected with great care. They are very usually ineffective because of strong demand and unenforceable controls. They are also often inadvertently counter-productive. Supply control all too often redistributes the illicit drug problem geographically (to different neighbourhoods), pharmacologically (more dangerous substances and routes of administration) and demographically (different populations or ethnic groups).

Controlling tobacco and alcohol

In most countries, production and sale of alcohol and tobacco is legal but highly regulated. The nature and extent of regulation varies considerably from country to country and also changes considerably over time within the one country. In the beginning of the twentieth century, tobacco production and consumption was minimal. Advances in manufacturing, marketing and advertising then transformed the industry with production and sales increasing exponentially. Rapidly increasing cigarette smoking over the last century was accompanied by a spectacular rise in tobacco-related deaths and diseases. By the 1950s, about 70% of Australian males smoked cigarettes.

An awareness of the potential health risks of cigarette smoking began in the 1920s but was not confirmed until the 1950s and 1960s when the cigarette industry was still virtually unregulated. The appearance of several seminal reports provoked governments to progressively introduce controls on the tobacco industry.

Increasing price by raising taxes, decreasing availability through various means, restricting cigarette advertising and reducing the opportunities to smoke in public places has resulted in a steady decline in the proportion of Australian men and women who smoke cigarettes. The decline in smoking was followed by a substantial decline in tobacco-related deaths. Although public health practitioners would have wished to see more vigorous implementation of controls and steeper declines in consumption and tobacco related deaths, it is beyond debate that tobacco smoking controls have been effective in Australia. Within the national or international public health movement, there are no serious advocates for tobacco prohibition. Although tax concessions to the tobacco industry and tobacco industry funded political conventions are rank hypocrisy in a supposedly "tough on drugs" government, what matters is that tobacco related deaths have been falling for years. Recent small increases in smoking

prevalence among teenagers are unfortunate but must be seen in the context of generally very acceptable long-term declines in smoking and adverse outcomes resulting from tobacco.

Similar remarks apply to alcohol. Alcohol-caused deaths in Australia declined between 1990 and 1997 by 20% for males and 24% for females at a time when per capita alcohol consumption declined 11% from 8.4 litres to 7.6 litres (Chikritzhs, et al., 1999). National and international support for total prohibition of alcohol is almost non-existent. Only a handful of the seventy Moslem countries in the world implement total prohibition of alcohol.

The regulated availability of alcohol and tobacco provides the least worst option for these drugs. Although few Australians would wish to return to the days when large parts of the gambling industry were a criminal monopoly, there are major lessons to be learnt from unconscionable government appetites for the vast gambling incomes derived at huge social cost. Prostitution is another example of an activity detested by a large proportion of the population while strongly desired by a not insignificant proportion of the population. One choice is to fail in attempts to eradicate prostitution resulting in a criminal controlled industry with poor public health outcomes and rampant official corruption. The alternative is to accept that prostitution cannot be eradicated but can be regulated to achieve better public health outcomes and minimise official corruption.

Failing to control illicit drugs

Reducing consumption plays an important part of the public health approach to alcohol and tobacco because adverse consequences are closely correlated with consumption and toxicity is intrinsic. In the case of heroin, amphetamine and cocaine, we know from decades of careful experience that medical prescription is accompanied by minimal side effects. Most of the toxicity of these drugs under prohibition arises from their distribution through criminal monopolies. Because heroin is quickly metabolised to morphine, the side effects and benefits of prescribing heroin are very similar to the side effects and benefits of prescribing morphine. Morphine is a very commonly prescribed drug. Serious complications occur rarely when morphine is controlled by medical prescription.

Notwithstanding vigorous attempts to restrict supply, availability of illicit drugs in Australia has been increasing rapidly. The price of street drugs in Australia is falling while purity is rising. Reported availability of street drugs under prohibition varies from "easy" to "very easy" (National Drug and Alcohol Research Centre, 1999). Illicit drugs are available even in our prisons. Estimates of the number of injecting drug users in Australia doubled every decade for the last three decades (Law, 1999) and has probably increased even more rapidly in the last few years. The rapid increase in the number of injecting drug users in Australia in recent years is suggested by the rising number and increasing quantities of illicit drug seizures and the declining age of persons arrested for drug related offences, attending drug treatment centres and those attending needle syringe programmes. The reported age of initiation of drug injecting is also falling. While each of these indicators is not particularly reliable on its own, the fact that all indicators are unfortunately moving in the same direction at

present cannot be ignored. Prohibition supporters argue that the high price of street drugs resulting from law enforcement activity should depress consumption of illicit drugs. Despite the appeal of this theoretical argument, consumption of illicit drugs in Australia has been increasing rapidly for decades despite increasing emphasis on law enforcement.

The cannabis industry in Australia is at present twice the size of the wine industry and three quarters the size of the Australian beer industry (Clements, 1999). Nevertheless cannabis is still prohibited in Australia. Total prohibition of cannabis is the most common policy around the world but it is disintegrating rapidly. The gap between *de jure* and *de facto* policies is growing and is rapidly becoming unsustainable. Cannabis is the most widely used illicit drug in Australia. The estimated prevalence of lifetime cannabis use among Australians over the age of 14 increased from 12% in 1973 to 39% in 1998 (Australian Institute of Health and Welfare, 1999)

The benefits of regulating cannabis cultivation and sale

Regulated availability of cannabis has many advantages. It undermines the criminal network that is provided with a *de facto* monopoly under current drug policy and also allows separate markets to develop for cannabis and other, more dangerous drugs. Separating markets reduces the chance that young people seeking to purchase cannabis might encounter drugs like heroin. Regulated availability reduces the opportunity for police corruption and makes age controls possible. The \$5 billion/year Australian cannabis industry currently pays no taxation. Regulated availability provides an opportunity to generate substantial tax and considerably reduce government outlays. Cannabis taxes could be hypothecated for drug prevention and treatment. Regulated availability of cannabis also would provide an opportunity for more consistent and honest drug education. In many countries, growing numbers of responsible and influential members of the community are advocating consideration of regulated cultivation and sale of cannabis.

Choosing the option of regulated cultivation and sale of cannabis would send a clear message to the criminals who currently control the market that the days of their lucrative easy profits are over. The extraordinary profitability of this industry is the oxygen that keeps it alive and growing. Regulated cultivation and sale of cannabis would separate this market from the market for drugs such as heroin, amphetamine and cocaine. In the Al Capone approach to cannabis supply, young people trying to purchase cannabis are at great risk of encountering criminals trying to also sell heroin, amphetamine and cocaine.

Cannabis is sold from government shops in some Indian cities. In conservative Switzerland, regulated cultivation and sale (with age limits) occurs in several cantons. Regulated sale (but not production) has existed in the Netherlands for several decades. Consumption of cannabis in the Netherlands is far lower than in the United States or Australia where cultivation, sale, possession and use are still illegal and attract severe penalties (Lenton et al., 2000; Zimmer, 1997).

The legal status of regulated availability of cannabis is uncertain. It may contravene the major drug conventions (1961, 1971 and 1988) although there is debate among legal experts about this. If cannabis regulation does breach international conventions and treaties, this could be overcome in several ways. The Netherlands maintains drug legislation complying fully with the international treaties but expediency clauses have been introduced specifying that prosecution will only occur if it is in the national interest. Another possibility is ignoring national breaches in conventions and international treaties. The Australian government has acknowledged in 2000 breaching several treaties covering mandatory sentencing of young people, the environment, human rights, and the treatment of indigenous populations. The Australian government recently announced that international commitments are being reviewed, raising the possibility of one-day removing cannabis from the international conventions. Some other countries are now seriously considering this possibility.

There is growing community and political support for drug law reform in Australia and many other countries. The resounding failure of prohibition has prompted a search for more effective approaches.

Regulation of heroin, amphetamine and cocaine through medical prescription

Heroin and cocaine were made available for drug dependent persons in the United Kingdom through medical prescription under the 1920 Dangerous Drugs Act (Spear, 1994). This medical approach to management of drug dependent persons was consolidated by the Rolleston Committee in 1926 (Trebach, 1982). Maintenance prescription of drugs of dependence was endorsed but only under the proviso that all other avenues for drug free rehabilitation had already been attempted but without success. Rolleston argued that the aim of medical prescription under these circumstances was to encourage drug users to lead a "normal and useful life". To zero tolerance supporters who argue that "there are worse things than death for drug users", a useful and normal life for a drug user lawfully maintained on drugs of dependence is worse than death. Amphetamine prescription for amphetamine dependent persons was introduced much later but then fell into disfavour. In the last decade, there has been growing interest in amphetamine prescription for amphetamine dependent persons and a number of scientific studies have been published evaluating the intervention (Myles, 1997).

Injectable morphine was available in over forty cities of the United States between 1920 and 1924. This policy was terminated not because it was unsuccessful, but because it appeared to contradict alcohol prohibition. Injectable morphine was also available on prescription in Italy in the 1980s.

An observational trial of heroin prescription was conducted in Switzerland between 1994 and 1997. The trial produced impressive results with improved physical and mental health, less crime, reduced homelessness, increased employment and less illicit drug use in a treatment refractory population. There were no drug overdose deaths among the eleven hundred patients prescribed heroin over an eighteen-month period. Lack of a control arm means that the study (Ward, 1998) occupies a lower place in the hierarchy of scientific research designs than a blinded randomised controlled trial. But the results should not be dismissed entirely (as they have been by ill-informed

commentators). The Geneva component of the Swiss study did involve a randomised control design and the results of this component were very similar to the results of the national study overall. The results of one study are rarely regarded as conclusive, especially if a control arm is lacking. Several other European countries have been sufficiently impressed by the results that they have decided to conduct prescription heroin trials themselves.

Medical prescription of amphetamines has also been provided for the management of amphetamine dependence. In the United Kingdom, amphetamine dependence is managed by prescription on a routine basis in many cities. Evaluation literature has been increasing rapidly. Some authors have argued that the effectiveness of prescription amphetamine is of comparable effectiveness to methadone treatment. (Charnaud, 1998) A pilot study of amphetamine prescription in Australia demonstrated the feasibility of the intervention and concluded that a definitive evaluation study could be undertaken (Shearer, 1999). Research of this kind is also being conducted in the United States. It may be possible to treat cocaine users with amphetamine prescription obviating the need to consider evaluation of prescription cocaine treatment. The international treaties allow signatory nations to maintain the health of drug users and conduct research without defining or limiting these activities.

Zero tolerance supporters often argue that the only alternative to total prohibition is totally unregulated commercial production and sale of drugs such as heroin, amphetamine or cocaine. Commercial sale of crack cocaine from a supermarket checkout counter is self evidently so improbable as to not require further discussion. On common sense grounds alone, commercial sale of high concentration heroin, amphetamine or cocaine is indefensible. Community support for such an approach is barely measurable. Even if such an approach could be justified and gain significant community support, international obstacles to implementation would be insurmountable.

Could recreational drugs be made available through prescription or regulated sale?

The possibility of some recreational drug use being controlled by medical prescription should not be entirely discounted. Indeed, the Commonwealth Minister for Health and Aged Care (Dr Wooldridge) recently permitted prescription of Viagra (sildenafil), even though this drug is used extensively for recreational purposes. Announcing the decision, Dr Wooldridge argued that failure to provide sildenafil by prescription would inevitably lead to a considerable black market.

Another option deserving of consideration is the commercial sale of dilute versions of illicit drugs. Opium products can be purchased in some government run outlets in a few Indian cities. Little published documentation is available. Government sale of opium continued in Pakistan until February 1979. Heroin injecting was seen in the North-West frontier province of Pakistan for the first time only after sale of opium products was suspended. Within a decade of the introduction of anti-opium legislation in Hong Kong, Thailand and Laos, heroin injecting in young men replaced opium smoking in elderly men with catastrophic public health consequences (Westermeyer, 1976). The governments of Peru and Bolivia permit the sale of cocaine containing tea bags and some other crude and dilute cocaine preparations. Relatively

unrefined forms of cocaine have also been used therapeutically in the management of cocaine dependent persons in South America. It is difficult to fit "designer" drugs such as ecstasy into any of these systems but these drugs represent a relatively small public health problem in Australia.

Conclusions

We should spend more time on practical matters. That means saying less and doing more.

Deng Xiao Ping

A regulated cannabis market is the least-worst option for the drug and is superior to the current system, which has *de facto* created a criminal monopoly. Age controls and an advertising ban should accompany regulated cannabis availability. Penalties for unauthorised production or sale should be maintained. Regulated cultivation and sale will not eliminate the black market but is likely to substantially reduce its size. There is no reason to believe that regulation should increase consumption compared to unregulated availability.

Prescription availability of heroin, amphetamine and cocaine to carefully selected, treatment refractory patients will also not eliminate the black market but is safe, likely to substantially reduce the size and profitability of the black market and improve the lives and health of drug users, their families and the community.

Regulated cultivation and sale of cannabis and prescription availability of heroin, amphetamine and cocaine to severely dependent persons will not be a panacea. The choice is between problems we can bear to live with, rather than selection from a range of solutions.

That politicians still see no need for a change in policy will send a strong message to every drug trafficker and pusher in Australia that their lucrative profits are safe for the time being. Meanwhile, parents should be terrified that the policy which has seen annual drug overdose deaths increase from six to 737 in 34 years in Australia still receives support.

Prohibition supporters provide no justification for their view that more of the same will provide a different result. Will being even tougher on drugs reduce opium cultivation in Burma and Afghanistan or coca cultivation in Colombia? Will being even tougher reduce drug transport from the countries of origin to Australia? If government expenditure on law enforcement has not been enough, how much is needed to make Australia a drug free country? How many drug related arrests per year will be sufficient to bring the drug traffickers to their knees? How many inmates serving sentences for drug related offences (at \$50,000 per inmate per year) do we need to mortally wound the trafficking industry? Politicians who support a drug policy reliant on law enforcement are like the leaders of the former Soviet empire who argued to the end that only more intensive implementation of communism would finally bring the people a better life.

The preposterous claim is now being advanced that harm minimisation has been responsible for the increasing drug use and problems in Australia. There are several problems with this interpretation. Firstly, the increase in drug use began in the late 1960s and the increase in drug overdose deaths began in the late 1970s, well before the adoption of harm minimisation in 1985. There was a relatively greater increase in drug overdose deaths in the fifteen years before compared to the fifteen years after the introduction of harm minimisation (National Drug and Alcohol Research Centre, 1999). Secondly, the number of persons using heroin or amphetamine was estimated in 1999 to have increased, heroin availability was described as 'very easy' in five jurisdictions and amphetamine availability as easy/very easy in six jurisdictions (National Drug and Alcohol Research Centre, 1999). That is, worsening outcomes have persisted even since the adoption of a Tough on Drugs strategy. Thirdly, if we follow the money trail, government expenditure on measures to restrict drug use are at least ten times greater than funding for programmes to reduce harmful consequences. The then Prime Minister, all Premiers and both Chief Ministers adopted the national official drug policy of harm minimisation in Australia in 1985. This policy has been endorsed on several subsequent occasions by the Ministerial Council on Drug Strategy, Australia's paramount drug policy making body.

Better outcomes are achievable. Funding needs to be directed to interventions demonstrated in rigorous studies to have brought benefit, just as the world of private business directs investment according to likely returns. A drug policy based on common sense, science, public health and human rights, modelled on countries which have made progress like Switzerland, would achieve better outcomes within a few years.

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