Ms Shelley McInnis,
Inquiry Secretary,
House of Representatives Standing Committee on Family and
Community Affairs,
Parliament House,
Canberra, ACT. by fax 6277 4844

Dear Chairperson,

I would strongly advise your committee to address the problem of drugs from a scientific standpoint wherever this is available to guide policy. Most areas of drug use have been carefully studied over many years and many facts are known covering the diverse aspects. It is unique that in many of these areas, rather than the usual variety of opinions amongst researchers and public health experts, there is often complete unanimity on subjects about which the general public still has grave uncertainties.

Most emerging trends in dependency management, from tobacco to heroin, hold much concord and agreement. In areas where knowledge is more limited, we should still be guided by such information as is available in preference to personal speculation, however well-meaning it may be, or highly placed its source. Alcoholism and drug dependency are commonly associated with crime, violence and other antisocial behaviour, all of which respond dramatically, following appropriate treatments.

It is now clear from research that the chances of an individual initiating drug use is very largely a function of their environment. Children cannot be 'drug-proofed' however attractive such a concept may be. From twin studies, it is known that the likelihood of becoming addicted to a drug is, in contrast, very largely due to genetic factors. Hence the very different approaches needed for experimental, casual, regular and 'dependent' drug use. Everyone should now accept that even the strongest prohibitions, as in a jail setting or police state have never been successful in preventing the ready availability of popular drugs. Capital punishment does not work. But these failures should not imply an automatic legalisation policy for drugs. But banning them outright is clearly not an effective strategy of itself. Alcohol, coffee, cannabis, kava, betal nut and other drugs have all been banned at one time and on each occasion these bans have been a matter of regret by the authorities. Such bans have inevitably been reversed, sometimes in a matter of weeks, other times after years.

Your committee may hear evidence from some well-meaning folk saying:

"I do not believe in nicotine patches" or

"Our church discourages methadone treatment" or

"This hospital disapproves of naltrexone detox".

I would say to your members that such testimony carries little weight when there are copious medical trials from Australia and overseas to guide us on these matters and the choice MUST be up to the individual drug user and their own advisers, be they doctors, pastors, self-help groups or family friends. Anyone who would limit the number of available treatments according to their own preferences, as cited above, will inevitably deny some addicts the appropriate treatment, or perhaps the catalyst which commences their road to stability.

The longer one works in the field, the more one realises that there can be no single solution, although clearly for each drug of dependency there should be ready access to traditional, effective, economical interventions for those seeking help.

We know that the 'drug problem' is containable but never fully "beatable", as was shown by many

ebbs and flows in drug use throughout history. Studies of opium use in 19th century China, laudanum use in England, APC's and Bex in Australia mid 20th century, prohibition in the US in the 1920s and the global march of tobacco over 200 years all give us important lessons on these matters. There is a common thread through all these episodes, none of which caused the end of civilisation and, indeed, some developed into important export industries such as coffee, wine, tobacco and pharmaceuticals. They also comprise a large part of government revenues as taxes.

President Jimmy Carter said 20 years ago that when the laws against drugs cause more of a problem than the drugs themselves, then it is time to review those laws (I believe he was referring to cannabis). This has happened on numerous occasions in Australia such as cannabis expiation notices in ACT, NT and South Australia. These have been associated with significant benefits while causing little if any increase in drug use. It is now accepted by the AMA and many professional organisations that criminal sanctions and jail are rarely if ever an appropriate measure for young people caught with small amounts of drugs for personal use.

An intriguing new factor which has been almost completely ignored by international researchers. This is the possibility that the free availability of one drug may make the consumption of another drug less likely. It certainly is an anecdotal finding that addicts who cannot get their drug of choice are more likely to try another substance that may be available. This is well documented in the case of the Vietnam war period when cannabis was widely used early on in the conflict. When clamped down on by the military police, many 'cashed-up' American soldiers turned to the more easily concealable 'white powder', heroin. Some remain addicted 35 years later although many returned to the US and successfully detoxified.

It is just possible that if cannabis were made more freely available then the consumption of alcohol may diminish in some subjects. If so, this would be one of the most dramatic and positive public health moves ever undertaken. While comparisons of the 'relative harms' of different drugs is fraught with difficulties, it is generally agreed that alcohol has a higher scope for addiction and physical toxicity (and death) than smoked cannabis. But this is not to say that the latter is a 'harmless' drug in any way. Cannabis can and does cause harm in a proportion of those who use it.

There is a logic in being consistent with our approach to all types of drug use, employing the known behavioural and demographic features common to all drug use. This means not advertising the product publicly and giving honest, full and frank information about the drug to users, preferably before they are likely to come into contact with it. Logical, progressive taxation policy can be a beneficial process if it encourages consumption of less harmful forms of a drug (such as low alcohol beer over spirits). The flat rate GST has prevented the differential taxing of many products from environmentally unfriendly items to dangerous drugs and is, in that respect at least, retrograde. These matters are not speculative as good research is now available (especially, I understand, from the Northern Territory) to demonstrate the 'greater good' of differential excise levels.

The worst consequences of all drug use brings the victim into contact with the medical profession (sometimes for a death certificate). Yet there is still no College or Academy of addictions or dependency medicine. Australia only has a handful of 'Professors' of addictions and most are not doctors. This is a regrettable state of affairs and should be remedied immediately. There are many Australian doctors who treat dependency primarily or else as a part of their normal practice. Some are psychiatrists, some physicians but most are GPs. Over 400 GPs in NSW alone have done a methadone prescribers course. But much more is needed, starting from the medical schools which still all give grossly inadequate coverage to dependency assessments, treatments and research in their curricula.

I hope these thoughts give the committee some room to move on this stimulating and rewarding area.

With my best wishes to the committee members in this most important task.

Andrew Byrne ..

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Dr Andrew Byrne,
General Practitioner, Drug and Alcohol,
75 Redfern Street,
Redfern,
New South Wales, 2016,
Australia
Tel (61 - 2) 9319 5524 Fax 9318 0631
Email ajbyrne@ozemail.com.au
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author of: "Addict in the Family" and
"Methadone in the Treatment of Narcotic Addiction"
http://www.csdp.org/addict