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Joint Submission to tne House Standing Committee on Family and Human Services An Inquiry into the impact of illicit drug use on families

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The List is a multi-disciplinary collaboration of professionals committed to honesty and scientific accuracy in the debate on drugs policy. It was established in 2004, and publicly launched at the Club Health Conference in Sydney in 2005. Its creation was in response to the worrying departure in political circles from the accepted tenets of 'harm minimisation', focussing as it does on reducing injury, illness and death, towards the rhetoric of prohibition and the morality of drug use. The membership of "The List" is a growing group drawn from such disparate areas as medicine, scientific research, law enforcement, state and local government, peer education groups and user advocates, but all committed to the Australian tradition of harm minimization.

The List exists to ensure that the Australian public is provided with the scientific and medical facts regarding illicit drugs and drugs policy. Where necessary it will refute misrepresentation of drugs policy or science by any party; political, media-related, or religious. Armed with the facts, the Australian public can make rational decisions about how to stop young Australians succumbing to the harms of drug use. It is entirely acceptable for there to be a moral dimension in the debate on drugs; it just shouldn't be misrepresented as science.

The Historical Background to Harm Minimisation.

Prior to commenting on the current situation in Australia, it is perhaps useful to review the historical origins of the current state of affairs.

Before 1985, Australia had not distinguished itself from other international countries in the arena of drugs policy. Australian drug laws generally followed the development of international drug treaties. Until the late 1960s, there was relatively little use (or public awareness) of illicit drug use in Australia. As Manderson has indicated, early home-grown drugs policy served more to control ethnic minorities than to preserve the health of Australian colonists and settlers (Manderson 1993). As a consequence, few resources were devoted to law enforcement. In the early 1970s, there was an increase in the use of illicit drugs. A number of studies reported an increase in the use of marijuana and heroin. The increase in heroin dependence during the early 1970s corresponded with a marked increase in property crime. A general assumption was that these developments were linked.

In the absence of any domestic initiative, Australian drug policy during the 1970s and early 80s adopted the "war-on-drugs" approach of the United States. Penalties were raised, the burden of proof needed for conviction was lowered, and civil asset forfeiture laws were introduced. The primary solution to the problem of illicit drug use, despite the lack of any supporting scientific evidence, was viewed to be increasingly harsh law enforcement.

In what might be regarded as a period of relative Enlightenment, Australia's drug policy underwent a major shift with the inception of National Campaign Against Drug Abuse (NCADA) in 1985 (Bammer et al, 2002). This represented an innovative departure from the mantra of the failing American 'War on Drugs'. This same war had resulted in the expenditure of billions of dollars, the incarceration of thousands of citizens for minor possession offences, on the basis of little or no scientific evidence. The change in Australia meant that the traditionalist punitive approach was dropped

and replaced with a focus on public health and harm reduction. The NCADA stressed that drug use should be treated primarily as a health issue. Drug policy authority was placed under the Federal Department of Health rather than the Federal Attorney General's Department, due at least in part to the emergence of HIV/AIDS. The new program involved a partnership between the federal government and the States and Territories. It also took the first steps in developing relationships between health and law enforcement in a comprehensive strategy involving an integrated approach to licit as well as illicit drugs.

The impact of this approach came to be considered best practice globally, with Australia truly leading the way in innovative global drugs policy, with demonstrable and scientifically proven benefits resulting in Canada and a number of European countries, and eventually the EU following suite.

Domestically, the policy initially continued, even with a change of government in Canberra. For a while, it appeared that Australia would avoid the finger-pointing and name-calling that characterised the level of debate in America. (Bammer et al 2002). For what appears to be political purposes, the federal Liberal government introduced it's 'Tough on Drugs' policy in 1997, bringing its rhetoric more into line with the American 'War on Drugs'. Initially it appeared that this would not impede the science behind the policy, as the government of the day continued to support many of the original programmes, while espousing the martial rhetoric demanded by their followers and more right wing elements of the media (McArthur 1999, Bammer et al 2002, Ritter et al 2005). The first indication that politics would begin to take precedence over science occurred in 1997, at the beginning of what was to be Australia's first controlled trial of prescription heroin. A communiqué issued by the Ministerial Council on Drug Strategy (MCDS)- ostensibly the peak decision making body on drugs policy in Australia- on 31 July 1997 stated: "If a number of preconditions can be met, the ACT Government [will] undertake a small trial of the controlled availability of heroin involving 40 people". On 19 August, Federal Cabinet independently stopped the trial, on the dubious grounds that the Commonwealth would be required to pass special legislation permitting importation of heroin -- a claim disputed contemporaneously by both the then Federal Attorney General and Health Minister. The Prime Minister over-ruled the commencement of this medically designed, ethically approved trial on the grounds of what appears to be personal preference, citing that it would 'send the wrong message'.

Only a few researchers had the courage to take issue with this position. One of Australia's leading lights, Prof. Alex Wodak, wrote at the time"

> "policy (including funding) has been based on ideology rather than evidence. If we want to help drug users lead normal and useful lives and offer some hope to their families and their communities, the first step is an unswerving commitment to evidence-based policy and practice without political interference. Tragically, in this country illicit drug policy has become inviolable while politicans remain terrified of losing an election lest rationality be misinterpreted as "being soft on drugs""(Wodak, 1997).

Further attempts to undermine the principles and successes of harm minimisation continued into the lead up to the 2004 federal elections. The Australian House of Representatives Liberal party report, *"Road to Recovery"* from 2003 is an example of the questionable level of science brought to bear by the opponents of harm minimisation (House of Representatives Standing Committee on Family and Community Affairs, 2003). The following quotes are taken from that report:

> ▪*[T]he committee is ...confused by the use of the term, harm minimisation, particularly its relationship to the tough on drugs approach.*
> ▪*The committee is concerned about the way in which the term harm minimisation may appear to encourage the maintenance of a drug habit and give rise to the idea that taking drugs is alright.*
> ▪*Harm prevention and treatment should be considered as a focus for the new phase of the NDS, and the review of the current phase should include a consideration of the changes in policy and practice that might be needed in the move from a harm minimisation to a harm prevention and treatment approach.*

It is worth pausing to examine these statements briefly. Setting aside any obvious but frivolous commentary regarding the capacity or otherwise of the committee to understand a fairly straightforward principle, or indeed, whether those who are so easily confused should be charged with the serious business of writing a federal senate report, these comments still bear scrutiny. Legislators *should* be able to understand the principles of both sides of the drug policy debate- indeed, it could be argued that if they understood them better, that they would feel less devoted to the cause of prohibition. What is subtly implied, and has been more clearly alluded to more recently by the federal Under-secretary of State for Health (Bauer 2004), is the suggestion that *because* a policy runs in opposition to the government's 'Tough on Drugs' stance, that it is the divergent scientific view that must be mistaken, and not the political ideology. Such a devotion to an ideology in the absence of any evidence is usually preserve of formal religions, or the leadership of failed states. As a curious sort of *a priori* argument, it would rarely pass muster at a secondary school debate, and would be dismissed out of hand in the world of science. Most people would reasonably accept that being elected doesn't make anyone an expert in anything other than being elected. We have yet to arrive at a point in Australia where we select our brain surgeons or nuclear scientists in popularity contests. The general community might also reasonably that a sensible government would seek advice from experts on policy and implement policy based on the best available information. Australians might be surprised at the autonomy some politicians have decided to show in deciding what is best for Australia regarding drugs policy, bravely ignoring what is known, proven and suggested, in favour of what are often religiously-based, moral ideologies. It can hardly be considered the scientific community's fault if the government has chosen to follow a policy line that deviates from what is known in the research, less so if the same government decides to invest billions in a programme that is failing. Unfortunately, as has been shown in other fields in Australia (Lowe 2007), attempts have been made to bend the research on drugs policy to suit a certain political ideology, a situation where neither science nor politics ever wins. As one group of academics have recently summarised, current Australian drugs policy is "Tough on Drugs, Weak on Evidence" (Treloar et al 2006).

Fortunately, the peak medical body in Australia, the Australian Medical Association (AMA) demonstrated real leadership in the field in response to *The Road to Recovery*. In their media release of September 11 2003, Chair of the AMA's Public Health Committee, Dr Choong-Siew Yong, expressed very real reservations with this report.

"The report seems to replace harm minimisation with harm prevention but there is little explanation as to what is meant by this change in direction.

"The AMA is concerned that this change in direction is a push towards the concept of zero tolerance.

"The public health implications of such a dramatic shift in national policy would be catastrophic.

"Under this philosophy we will see an in the spread of blood borne diseases and an increase in drug related crime and drug related deaths.

"Zero tolerance or it neo-euphemism "harm prevention" is something the AMA believes the Australian community should be very wary of embracing as the sole answer to illicit drug use in the community.

"The zero tolerance option will never be the panacea for all the community's drug problems."

Support for harm minimisation from the medical community remains unequivocal. In the joint document released by the Royal Australian College of Physicians, and the Royal Australian and New Zealand College of Psychiatrists, (*Illicit drug policy: Using Evidence to get Better Outcomes*, launched at International Harm Reduction Conference in Melbourne on 23rd April, 2004) criticism for any move away from these accepted principles was sharp. The consistent medical opinion, published internationally, is that there is significant merit in harm minimisation.

Even economic pragmatists find reason to support harm minimisation. The Commonwealth government's own report (Health Outcomes International 2002) unequivocally demonstrates the economic advantage of harm reduction services such as needle and syringe programs in Australia. Between 1988 and 2000, as a result of the introduction of needle and syringe programs, 25 000 HIV infections and 21 000 hepatitis C infections were prevented among people who injected drugs. As a consequence, the report estimates that 90 hepatitis-C-related deaths and 4500 HIV-related deaths would have been prevented by 2010. This translates for the taxpayer- and this year, the voter- into cost savings of up to $783 million for hepatitis C treatment and up to $7025 million for HIV treatment. All this for an estimated cost of needle and syringe programs to Australian governments between 1991 and 2000 was $150 million. Put simply for the committee, for every dollar put into the program, nearly fifty are saved. And yet bizarrely, the Liberal opposition leader, presumably with federal support, feels that if he were to be elected, he would scrap the whole system (Ong 2006).

Economists around the world are arriving at the same conclusions. The American model of the 'War on Drugs' is presumably the template upon which Australia's current federal government is basing its policy. The USA has the highest rate of imprisonment in the world, with the equivalent of the population of Western Europe behind bars (Walmsley, 2006). According to Office of National Drug Control Policy (ONDCP), federal spending in 2003 to incarcerate drug offenders in the USA

totalled nearly $3 Billion a year -- $2.525 Billion by the Bureau of Prisons, and $429.4 Million by Federal Prisoner Detention (ONDCP 2002). As many a quarter of state prisoners, and over half of federal prisoners are in jail for drug-related offences (Harrison, & Beck, 2006). Up to a third of these are for minor offences such as simple possession. And this is despite a single piece of evidence that their system offers any true benefit in reducing drug use in that country. Sweden is also frequently touted as model for drugs policy by Australian prohibitionists. Their slightly draconian approach seems to have certainly discouraged some users. But according to the very document quoted by one prohibitionist Australian organization, Drug Free Australia, over 3 times as many Swedes die from acute drug overdose than their neighbours, the Dutch (UNODC 2006). This is despite the Dutch having almost twice the population of Sweden. The Dutch also have lower rate of hepatitis C infection, often considered a surrogate marker of intravenous drug use. The Dutch have embraced harm minimisation, despite extraordinary and frequently inappropriate political pressure from the USA (Lemmens & Garretsen 1998). A useful summary of the economic implications of prohibition can be found in Thornton's paper (Thornton 2007), reviewing the work of 27 'vital economists' (those writing specifically on the economics drugs policy) and found that 22 considered the current policy of a War on Drugs as financially untenable. (Three had neutral positions and 2 favoured harsher penalties).[For a more detailed review of the so called "War on Drugs", the reader is referred to Miranda (1998), representative of a growing number of critical reviews]

What are other countries doing? The United Kingdom, instead of digging faster and deeper into the hole that 'zero tolerance' has placed them in, has imaginatively decided to think outside the box. Last year, the House of Commons Select Committee on Science and Technology Committee called for evidence from several hundred of the most senior medical, scientific and law enforcement experts in that country to re-evaluate drug classification (House of Commons Science and Technology Committee. 2006). Their degree of consensus was perhaps more startling than the findings themselves- that drugs should be classified according to the harms that they caused, that not all drugs cause the same amount of harm, and that current classifications of drugs do not reflect their potential for harm. For prohibitionists, who feel that all drugs are equally 'evil', this was an unpalatable finding. On the subject of morality, a more recent report from the same country, from the highly esteemed Royal Society of Arts, concluded that current drugs policy in the UK was 'driven more by moral panic than a practical desire to reduce harm' (RSA 2007). Some commentators in Australia, including members of this current committee, have alluded to the importance of 'morality' in designing policy. The authors respect this position, as long as it is made clear to the Australian public that drugs policy is being decided on the basis of a certain moral ideology, rather than any evidence base. If morality *is* being used to under-pin Australian drugs policy, it is also beholden on politicians forwarding this position to make it clear to the electorate that the otherwise avoidable deaths of young Australians serves a purpose of some sort. It is clearly not the role of doctors and scientists dedicated to saving lives to advance this sort of argument. The moral arguments regarding drug use are not the sole property of the prohibitionist lobby. Approaching the issue from an ethical position, there are in fact significant moral obstacles and problems with the 'zero tolerance' and prohibition positions. For those truly interested in engaging in a debate on morality and drug use, they would be well served to broaden their reading to include Miranda (1998), Bush & Neutze (2000), and Fry et al (2005).

With this information so easily accessible and freely available, one is left with uncomfortable and inescapable questions, and few rational answers. It *is* possible that drugs policy in Australia is being decided by well-meaning elected officials who are simply unaware of the research that is available to guide them in their decision making processes. This speaks to perhaps the competence of these officials but not to their integrity. How can a busy elected representative be expected to be an expert in a field that is one of the most difficult in the world to research? Such officials would be wise to listen to the real experts around them and act on their advice. Failure to do so shows a lack of wisdom that in some countries would call into question their suitability for public office. The authors of this submission have been impressed with the thoroughness of a recent senate enquiry, particularly their chairman, in their attempts to cut through the rhetoric and strong party divisions to arrive at important scientifically supported conclusions. They have demonstrated that when politicians are willing to listen to experts, they are capable of understanding the science. Not least of these conclusions was point 4.50 (Parliamentary Inquiry AOSD, 2007)-

> *"4.50 The Committee recommends that, in the execution of the National Drug Strategy, harm-reduction strategies and programs receive more attention and resources." (p. 49)*

More sinister is the possibility that the same elected officials actually *do* understand drugs policy, and choose to ignore the advice of those better informed than them for political reasons. It is not 'brave' to be a 'drug warrior'- quite the opposite in fact. It is brave to accept the evidence, and run the gauntlet of the shrieks from the 'zero tolerance' wowsers, who through policy illiteracy, threaten the health and lives of thousands of young Australians. It would be brave to have a system by which policy decisions were transparent, open to independent academic assessment. Decisions by the Ministerial Council on Drug Strategy (MCDS) occur behind closed doors, without independent scrutiny, oversight or submission. Attempts to obtain information regarding how decisions are made, and what evidence has been used to make those decisions, do not even appear to be open to freedom of information inquiry.

Harm Minimization and the Family

From the perspective of commenting on harm minimization, the family and the emergency department environment, a number of points need to be reiterated. Opponents of harm minimization claim that it is not working, at a time when a system of prohibition or 'zero tolerance' is increasingly in place. Problems with rates of drug consumption in Australia today are not because of any failing of harm minimisation; they are because Australian politicians are undermining the principles of harm minimisation and covertly promoting a system of prohibition or 'zero tolerance'. Prohibition or 'zero tolerance' has a number of negative consequences on drug consumption patterns, which have been recognized and commented upon since the failure of alcohol prohibition in the USA. They include, but are not limited to:

1. a negligible effect on the availability of drugs prohibited. If for some reason availability transiently diminishes, it increases the price of a

substance, increasingly encouraging new more ruthless profiteers into the market;
2. the promotion of binge/rapid consumption of drugs in secretive, non-socially regulated or controlled ways;
3. the emergence of contaminated product, manufactured in haste and in grossly unhygienic environments. The contaminants and substitutions are frequently more dangerous than the parent illicit products themselves (Caldicott, 2003);
4. the emergence of new, frequently even more dangerous primary products to replace those most recently banned (Caldicott, 2004);
5. because of the economic impact of prohibition, an increase in the value of the commodity being marketed, and therefore in the crime rates and criminal behaviour associated with it (Caldicott, 2005);
6. an erosion of the effect of the message behind prohibition. For example, in the latter years of alcohol prohibition in the USA of 7,000 prohibition-related arrests in New York between 1921 and 1923, only 27 resulted in convictions. The evidence from Australia is clearly that drug use has become normalized (Duff, 2003)

Young consumers of illegal drugs are increasingly afraid of seeking medical care because of the perceived legal consequences of taking drugs. Even friends who have not consumed illicit products worry that they may found culpable in some way for their associates' misadventures. As a result, they present later than they should to emergency departments, with adverse health effects. When they do present, they are often reluctant to provide an accurate description of what they may have ingested, further increasing the potential difficulty in treating overdose. Failure to implement adequate trials of pill-testing programmes, despite calls from the South Australian Drugs Summit in July 2002, the Commonwealth Department of Health and Aging's own document, *"The Prevention of Substance Use Risk and Harm in Australia"*, released in May 2004, the AMA's Public Health subcommittee, and most recently, a *further* Commonwealth report (*Inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs (AOSD) in Australia*)- again on the grounds that it sends 'the wrong message' to consumers, means that clinicians are left to merely count bodies when drugs such as paramethoxyamphetamine (PMA) re-emerge (Caldicott 2003).

Following overdose, parents frequently express their frustration in finding suitable follow up for their children and indeed unbiased information for them. Much government sourced literature is focussed on "zero tolerance", and offers no advice or help to the nearly 40% of young Australians who have chosen not to 'just say no'. In public health, no self-respecting physician would approach a major problem by limiting themselves to primary preventative measures alone- a global approach involving secondary and tertiary interventions ensure the best yield. Similarly, if a disease changes its virulence or resistance, doctors don't just struggle on with the old medications that worked in the past- they go about looking for new medications to address this change. An example of emerging programmes that address these needs is Safety First (www.safety1st.org). This was designed by Dr. Marsha Rosenbaum, who along with Dr. Jerome Beck, was one of the first people to document the emergence of MDMA/ecstasy as a recreational drug, and identify the potential for harm

associated with it. She also recognized the importance of tailoring a new set of tactics to a new type of drug. In her words

> *"While we stress the value of abstinence, we need a fallback strategy for those who still say 'maybe' or 'sometimes' or 'yes' to drugs. We need a strategy that embraces safety as its bottom line."*

The elders of the Australian drugs policy research community have stoically borne the brunt of increasingly unscientific governmental interference in drugs policy, attempts to unduly sway and influence organizations and individuals in research, and now it seems, overt personal attacks and insults. They have done so with the resignation of Boxer, the faithful plough-horse from Orwell's *Animal Farm,* with little of the recognition that they deserve from the Australian public. They presumably do so in the hope that the merit alone of the truly excellent research emerging from Australia might someday be incorporated into evidence-based policy. The calibre of that research has sadly not been appreciated by the general public, largely because of the modesty of the same researchers, and their reluctance to enter into the relatively uncouth cut-and-thrust of public politics and the media. This is not a position shared by the next generation of Australian drugs researchers. Pseudo-science should be exposed for what it is, and individual politicians should be held accountable for their positions.

It is clear to most from the scientific and economic analyses available, that the 'zero tolerance' approach to drug use has little evidence to support it. The scientific community in Australia understands this, and has perhaps conceded the morality arguments as being the beyond their remit. .We vigorously oppose this position, and refuse to surrender even moral ground to those who oppose harm minimization on ideological grounds. What is moral about accepting a policy that dooms thousands of young Australians to life with a criminal record, that results in even more deaths and injuries from illicit substances than before? For an elected body of non-experts to resort to arguments regarding what 'message' is being sent to young people, to ban medically supported research, is a very peculiar state of affairs. What makes politicians sole purveyors of 'The Message'? Is it possible that politicians have a heightened or more developed sense of morality, above and beyond that of the common people? Are we to believe that the Australian public ranks their politicians as the ultimate arbiters of morality in this country? More fundamentally, will Australian families accept the deaths and injuries of their own children as necessary casualties in an ideologically driven, scientifically unproven extension of America's 'War on Drugs'? We think not...

The List would like to finally use this opportunity in passing to condemn, in the strongest possible terms, the use of this committee to attack one of the leading lights of the international research community. This attack was made in her absence, without an opportunity for her to defend herself, in what in academic circles has largely been regarded a cowardly effort to intimidate other Australian researchers. As might be expected, the effect has been quite the opposite, galvanizing the community and renewing the resistance to such overt bullying tactics. It is gratifying to note that the Australian National Council on Drugs and Turing Point in Melbourne also condemn the 'lack of knowledge' demonstrated by the individual responsible.

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(Copies of these articles can be made available to members of the Committee upon request.)

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