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Submission

on the

Impact of Illicit Drug Use on Families

to the

Standing Committee on Family and Human Services

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1. Introduction

On 16 February 2005, after reviewing the 2003-2004 Annual Report of the Department of Family and Community Services, the House of Representatives Standing Committee on Family and Human Services resolved to conduct an inquiry into the impact of illicit drug use on families.

The Committee is inquiring into and will report on how the Australian Government can better address the impact of the importation, production, sale, use and prevention of illicit drugs on families. The Committee is particularly interested in:

(1) the financial, social and personal cost to families who have a member(s) using illicit drugs, including the impact of drug induced psychoses or other mental disorders;

(2) the impact of harm minimisation programs on families; and

(3) ways to strengthen families who are coping with a member(s) using illicit drugs.

On 8 February 2007 the Committee invited public submissions on its terms of reference to be received by 23 March 2007.

2. Cost to families

The financial, social and personal cost to families who have a member using illicit drugs is enormous. The following nine accounts, which have been told first hand to Festival of Light Australia, merely serve to illustrate some aspects of the cost to families who have a member using illicit drugs.

2.1 Boy introduced to marijuana by his uncle

A country father told us that when his son reached his teens, the family sent him to board with his grandmother and uncle close to Adelaide so that he could attend a good city school. Unknown to the boy's parents, the uncle grew marijuana in the family home, under South Australia's "soft" cannabis laws which then allowed ten plants to be grown for personal use at the risk of only an on-the-spot fine.

The uncle introduced his nephew to marijuana, and the boy became dependent on the drug. At the age of 24, he had been unable to hold down a steady job and had been admitted to Glenside [Mental Health Service Campus] on four occasions with psychotic attacks. The parents were desperate for an effective program to free their son from his cannabis addiction, but said the SA Drug and Alcohol Services Council (DASC) had insisted that marijuana was a relatively minor problem, and that their son was probably on amphetamines as well (he wasn't).

Some parents have told Festival of Light Australia that when they sent their child to the local doctor to discuss the child's cannabis problem, the doctor told them not to worry - that it was a "soft" drug and wouldn't do them much harm. Another parent has told us her child was actually advised by a doctor to "smoke a joint before bedtime" to alleviate sleeping difficulties!

2.2 Country boy suicidal

Another country family told us that their son had smoked marijuana from his teen years, and that by the time he reached his 20s he had become very depressed. "He was talking suicide," his parents said. "We became very alarmed and hid all our guns. We couldn't get through to him. Finally his sister

managed to persuade him to give up the marijuana. Now, six months later, he is back to normal. He can now see what it was doing to him - but he couldn't see it at the time."

2.3 Brother committed suicide

A woman from a southern Adelaide suburb has told us about the tragic suicide of her younger brother, aged 32, in the Adelaide Myer Centre in 1995. "He was suffering from schizophrenia, which had been triggered by his abuse of marijuana," the woman said. "He was the youngest of six children. It has ruined our parents' lives."

2.4 Chronic depression

Another woman told us of her friend's son (21) who was living with his de facto wife and their two young children. "They are in a terrible state," she said. "The young man has been dependent on marijuana for some years and has become chronically depressed. He is so bad he stays in bed until 2 o'clock in the afternoon every day. They live on welfare payments. He is unable to hold down a job, or help his partner with their children. He was referred to a psychiatrist, and related his symptoms to the doctor. The psychiatrist asked, 'Are you on marijuana?' The young man said 'Yes', and the psychiatrist said, 'Well I'm sorry - there is nothing I can do for you. I see people like you all the time.'"

2.5 School drug education counter-productive

Another woman whose family attends church regularly has told us about her son who had been given "drug education" at school which was completely counter-productive. The drug education consisted of being told, at age 14, to "do a project on drugs" - with no further instructions.

Her son and his friends decided to research glue sniffing by trying it themselves. They were apprehended by a teacher, and suspended from school for two weeks. The mother said she felt helpless - she and her son were given no advice, and no assistance by school counsellors or anyone else.

About the time of his glue sniffing experiment, her son was given free "dope" by friends at school and began smoking it without his mother's knowledge. His mother first realised the problem after police phoned her to say her son had been arrested for helping to steal a car. Much later, after a number of brushes with the law, her son revealed that he "borrowed" cars to get to his dope dealer when his need for another bong became overwhelming. The son finally broke his addiction when he spent some months in a youth detention centre.

However after his recovery and admission to university, he left home to board with other students - and the temptation to join them in smoking dope became too strong. The prognosis for this young man was not good. He suffered constant anxiety, bordering on paranoia, when he smoked marijuana.

2.6 Husband grew marijuana

Another woman has told us of her husband who grew marijuana in their backyard in one of Adelaide's north eastern suburbs - again, encouraged by SA's soft cannabis laws. The woman wanted to save her marriage, so she didn't want to "dob in" her husband. He had a low-status job with little responsibility and seemed to get by with his dope-smoking lifestyle.

However the couple's two children had smoked marijuana from their teen years, and have not fared well. Their son, in his late 20s, had never been able to hold down a steady job. He had several

admissions to hospital with psychotic episodes, and finally realised what marijuana was doing to him. He managed to get off the dope and at one stage pulled up and burned all his father's plants. His mind felt much clearer, but memory and depression problems continued to plague him.

The woman's daughter had also been unable to hold down a job because of her drug abuse. She was living with her boyfriend in a country town (where rent is cheap) and became pregnant, so the couple married. Her mother told her of the possibility of the marijuana damaging the unborn baby, and the daughter decided to quit. However her young husband still smoked dope - and his wife became increasingly concerned that he does not pull his weight in the marriage or in helping to care for the baby.

2.7 Marijuana led to heroin abuse

A young man in his 20s has told us that his illicit drug problem began in his late teens. He had grown up with his mother, his father having abandoned the family when he was a baby. He began smoking at 14 - his mother smoked and so did other kids at school. He said his school did not give him any drug education about harm associated with smoking.

He began drinking alcohol at 17 as a way of escaping his problems. He used to binge drink, but stopped when he saw what happened to one of his friends who was an alcoholic - he didn't want to end up like that. Then a neighbour who grew cannabis plants in her backyard offered him some free dope as "a friendly gesture". He thought marijuana was great - a way of escape without the downside of alcohol, or so he believed. However he soon became a heavy user and was paying $5000 a year for it.

He also turned to heroin. At his lowest point he suffered a psychotic episode and was admitted to Glenside for six weeks. He then realised his problem, and went to Teen Challenge, which ran a rehabilitation program called Turning Point. He continued to struggle with his addictions and the life problems which have been a contributing factor.

2.8 Methadone, valium and heroin overdose

A distraught mother ("Lynne") telephoned us about her 21 year old daughter ("Jane") who was found dead by the side of an Adelaide suburban road several years ago. An autopsy found that Jane's body contained morphine (from heroin) as well as legally prescribed methadone and benzodiazepines (valium). While her death was officially described as a heroin overdose, it is clear that legal methadone and valium also played a part.

Lynne said methadone programs do not prevent heroin abuse. Jane had told her she found methadone more addictive than heroin. Lynne told us that Jane began smoking cigarettes towards the end of her school days, probably because of peer pressure and lax discipline at the (private) school. Neither parent smoked, and Jane was aware of the health problems of cigarette smoking. She began smoking marijuana shortly afterwards, and told her mother that marijuana was less harmful than tobacco.

Lynne and her husband were experiencing serious marital problems at this time, and Jane suffered greatly. She felt betrayed by her father, who deserted the family. Lynne said that Jane was using drugs to block out her emotional pain, and it wasn't long before she took up heroin. After leaving school and doing quite well in a TAFE course, Jane had a couple of jobs for a few months at a time, but was never able to hold one down for long. She was sacked, partly because of drug-related problems and partly because of her emotional problems.

Jane saw psychiatrists and underwent detox programs, but nothing helped. After detoxing, she would simply go back onto heroin. Lynne said one psychiatrist in particular was not supportive of her efforts

to keep her daughter away from the drug scene. He seemed to be unconcerned by the "revolving door" of treatment and failure - it certainly seemed to guarantee him a steady supply of patients.

Sometimes Jane's friends would bring drugs to her while she was in hospital for detox! Then there a light shone briefly at the end of the tunnel - Jane was accepted for a live-in rehabilitation program in the country. Lynne hoped that 12 months away from the city would free her daughter from her unhelpful friendships in the drug scene that were leading her astray, and retrain her mind for positive living. But Jane's city psychiatrist said the 12 months country program was unnecessary, and Jane soon managed to deliberately break the rules so that she would be sent back to the city.

Her city doctor prescribed her methadone and valium - she would sometimes consume over ten valium tablets at a time. The doctor simply gave her what she asked for, but did not solve her problems. Three weeks after going back to this doctor, Jane was dead. Lynne is convinced that if a compulsory, secure rehabilitation program had been operating in Adelaide, as in Sweden, her daughter would be alive and off drugs today. She said counselling for Jane's emotional problems could not work while her mind was befuddled from the effect of drugs.

2.9 Brother using marijuana committed suicide

Speaking at the Adelaide funeral of her 28 year old brother, Gordon, on 17 May 2001, Carmel MacKenzie made a plea, which represents the thoughts of many families who have lost loved ones to the scourge of drugs. She said "Gordon was addicted to the drug marijuana. Many of you would say that marijuana can't hurt you, that it is a soft drug and can be used socially with no ill effects. Gordon is an example of those statements being a lie. Most of Gordon's friends would already know that he was a marijuana user. In fact, some of you sitting here today have actively participated in these activities with him.

"He was my brother whom I most dearly loved and I tried to help him in every way thinkable. I could see the inner turmoil within him, the helplessness, and the loss of self-esteem. It all began with a simple choice he made when he was only 15 years old, which led him down the road to self-destruction. The choice he made was to have his first joint of marijuana. As time went by, he became a heavier user. About four years ago his use of marijuana contributed to and probably caused a psychotic episode. It put him into hospital, and then forever labelled him as a person suffering from a mental disorder. In one way it was a label he hated and denied, and in another way it was a label he would cling to in order to justify his right to continue using marijuana.

"Even though Gordon's mental stability improved tremendously since four years ago, the damage had been done – damage to his self-esteem, his personal life and financially. The inner turmoil was agonizing for him. His life was falling apart in all directions, but he continued to clutch his marijuana despite being told he must stop for medical reasons.

"Only recently, Gordon started growing three plants which he planned to sell to help pay his way. We believe this only happened over the past few months – but once again the guilt and agony of his decision to do this was breaking his heart and causing an even lower self-esteem.

"On Monday night last week, he killed himself. What were the thoughts going through his head, what were the events of that day that led Gordon to make the most final of all choices? We, his family, will probably never know what happened that evening.

"Gordon died a tragic death. I want his death to become a meaningful example. An example to some of you, his friends, who are similarly caught up in that tangled death spiral that eventually caught Gordon and took his life. Gordon started down this road when he was 15 years old - that is, 13 years ago - by making one simple choice that could have all too easily been avoided. He chose to smoke that first joint of marijuana and he chose to continue with that lifestyle even though he openly agreed that he was continuing down a road of self-destruction.

"I beg all of you who are here today who are in a similar position, to start making positive choices. Choose to stop using marijuana. Choose to stop growing marijuana. Choose to stop selling marijuana. Please, please don't allow yourself to be dragged to the sad depths that Gordon was."[1]

3. Harm minimisation

The endorsement of harm minimisation has proved to be a costly and mistaken detour in Australian drug policy. It is time to completely abandon all aspects of harm minimisation and implement fully a zero tolerance approach to illicit drug use in Australia.

3.1 Road to recovery

The Committee's predecessor, the Standing Committee on Family and Community Affairs, issued[2], on 8 September 2003 after a three and a half year inquiry, a very significant report on illicit substance use in Australian communities. The report, entitled Road to Recovery, had as its key recommendation (122) that "the Commonwealth, State and Territory governments replace the current focus of the National Drug Strategy on harm minimisation with a new focus on harm prevention and treatment of substance dependent people."

Harm minimisation has been one of the key principles of Australia's drug strategy since 1985. It has been used to justify a range of measures that tolerate the use of illicit drugs while attempting to minimise particular harms to drug users, such as overdosing, contracting infectious diseases and other adverse side effects. Many of the supporters of harm minimisation stress the impossibility of significantly reducing the level of illicit drug use and often tend to ascribe harm to the illicit nature of the drugs consumed rather than to the substances themselves. Harm minimisation measures implemented or proposed in Australia include needle and syringe exchanges, injecting rooms, heroin prescription, methadone substitution, liberal cannabis laws and testing kits for ecstasy.

The Committee's recommendation, if implemented, would refocus our drug strategy towards preventing new users from taking up illicit drugs and providing effective treatments aimed at cessation of substance abuse for those who are chronic substance abusers.

In regard to treatment for heroin addicts, the Committee recommended (52) that the ultimate objective of methadone maintenance must be to assist users to become abstinent from all opioids and that priority be given to treatments, including naltrexone, that focus on abstinence at the ultimate outcome (54). The committee also recommended that, as a matter of urgency, the Commonwealth fund a trial of naltrexone implants, coupled with the support services required for efficacy, and that naltrexone be placed on the Pharmaceutical Benefit Scheme for the treatment of opioid dependence.

The Committee was impressed with the beneficial results from therapeutic communities, such as those run by Teen Challenge. It recommended (56) funding to establish such communities throughout urban and rural areas in every State.

The Committee recommended that heroin prescription trials not proceed (57).

The myth, often propagated by advocates of liberal drug laws, that cannabis use is relatively harmless was seen as a major problem, and as one factor in the widespread use of cannabis, especially by young people. The Committee accepted the weight of evidence that there are serious dangers to physical and mental health associated with regular cannabis use and called for urgent development and dissemination of cannabis cessation strategies. (61-63)

Labor MPs Graham Edwards, Julia Irwin and Harry Quick unfortunately dissented from the Committee's report on key recommendations, defending the longstanding focus on harm

minimisation, supporting injecting rooms, prescription heroin trials and methadone maintenance without any abstinence goal, and opposing the Committee's support for naltrexone and therapeutic communities.

Significantly, and to her credit, Labor MP and former ACTU head, Jennie George not only refused to join her colleagues in their dissent but in her own additional remarks strongly endorsed the view that "prevention and treatment of substance abuse should be enhanced". She stressed "the urgent need for further research into the use of naltrexone given that many people are now 'parked' on methadone maintenance programs." She accurately described opioid dependency as a "chronic, relapsing disease" that cannot be wished away. Society has an "obligation to provide the necessary support for people seeking to break their dependency". Her remarks point the way to what should be a bipartisan drug policy as adopted in Sweden as opposed to the partisan support of harm minimisation and drug liberalisation by the ALP, especially in New South Wales, with the Kings Cross injecting room, and Western Australia with its liberalised cannabis law.

One disappointing aspect of the Report is its partial endorsement of needle and syringe distribution programs. At a cost of over $20 million to taxpayers nearly 32 million needles were distributed in the year 1999/2000. The Committee noted the claim in the "Evaluation of Council of Australian Government's initiatives on illicit drugs: final report" that needle distribution programs had resulted in the prevention of 25,000 cases of HIV and 21,000 cases of hepatitis C over the ten years from 1991. Nonetheless the Committee did recommend (66) that the Australian National Audit Office undertake a complete evaluation of needle and syringe programs assessing distribution, inadequate exchange, accountability and the impact on both HIV and hepatitis C. The Committee expressed particular concern that the incidence of HIV and hepatitis C was escalating despite the quantity of syringes distributed. The Committee did not seem to be aware of the body of evidence[3] which demonstrates that needle exchanges actually increase the rate of needle sharing and that hepatitis C is spread among users of needle exchanges even when they refrain from sharing needles but share drug ampoules, water, cotton swabs, and other paraphernalia.

3.2 Government response to Road to Recovery

The Government's response[4] to the Road to Recovery report was not published until July 2006.

Disappointingly the Government failed to explicitly respond to recommendation 122 that "the Commonwealth, state and territory governments replace the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment of substance dependent people." Instead the Government's response referred to the National Drug Strategy 2004-2009, under which "all governments and the non-government sector are continuing to work together to prevent drug abuse (reducing supply and reducing demand) while also ensuring the necessary support and treatment (reducing harm) for people seeking to break their dependency."

The National Drug Strategy 2004-2009[5] explicitly endorses harm minimisation as "the primary principle underpinning the National Drug Strategy. It refers to policies and programs aimed at reducing drug-related harm... Harm minimisation includes preventing anticipated harm and reducing actual harm." Harm reduction strategies are defined as "strategies that are designed to reduce the impacts of drug-related harm on individuals and communities. Governments do not condone illegal risk behaviours such as injecting drug use: they acknowledge that these behaviours occur and that they have a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviours can cause."

As long as harm minimisation and harm reduction strategies remain part of the National Drug Strategy the families of Australia will continue to experience the cost of this reckless approach to illicit drug use.

3.3 Abandoning harm minimisation

This Committee should endorse as its own Recommendation 122 from the Road to recovery report that: "the Commonwealth, State and Territory governments replace the current focus of the National Drug Strategy on harm minimisation with a new focus on harm prevention and treatment of substance dependent people."

Specifically, the Committee should recommend to the Commonwealth Government that it cease all financial support for harm minimisation programs including needle exchanges, cannabis infringement notice schemes, and methadone substitution programs (unless these have as their goal a proven pathway to complete abstinence).

RECOMMENDATION 1: That the Committee calls on the Commonwealth, State and Territory governments to replace the current focus of the National Drug Strategy on harm minimisation and harm reduction strategies with a new focus on reducing the recruitment of young people to drug abuse; enabling drug abusers to stop their drug abuse as well as continuing the focus on reducing the availability of illicit drugs.

RECOMMENDATION 2: That the Committee calls on the Commonwealth Government to immediately cease all financial support for harm minimisation programs including needle exchanges, cannabis infringement notice schemes, and methadone substitution programs (unless these have as their goal a proven pathway to complete abstinence).

3.4 Sydney Medically Supervised Injecting Centre

The Sydney Medically Supervised Injecting Centre located at 66 Darlinghurst Road Kings Cross allows injecting drug users to bring illicit drugs onto the premises and inject these illicit drugs while on the premises. New South Wakes drug law has been amended to accommodate this use of illicit drugs in the name of "harm minimisation".

The existence of the Sydney Medically Supervised Injecting Centre has been the object of repeated censures of Australia by the International Narcotics Control Board since its annual report in 2000.[6] The establishment of the injecting centre is in violation of Australia's commitments under the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol and the Convention on Psychotropic Substances of 1971.

The Commonwealth can not wash its hands of responsibility for the continued existence of this drug injecting room.

Section 307.10 of the Criminal Code (Commonwealth) makes it an offence to "possessing border controlled drugs ... reasonably suspected of having been unlawfully imported." This offence is part of a series of offences established in Commonwealth precisely in order to complement state and territory laws and ensure full compliance with Australia's obligations under the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol and the Convention on Psychotropic Substances of 1971.

The Commonwealth Government ought to direct the federal police to actively enforce the provisions of Section 307.10 of the Criminal Code against any person in the vicinity of the Sydney Medically Supervised Injecting Centre who is in possession of heroin, cocaine or any other "border controlled drug reasonably suspected of having been unlawfully imported." Such active policing would rapidly result in the closure of the drug injecting room and send a clear message to all states and territories that the Commonwealth will not allow any such breaches of its commitment under the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol and the Convention on Psychotropic Substances of 1971.

The abuse of narcotics and psychotropic substances is an international problem and Australia's participation in these international conventions is entirely appropriate. The enforcement of Commonwealth law on the possession of border controlled drugs in the face of state toleration of such possession is imperative if Australia's "tough on drugs policy" is to have any meaning at all.

RECOMMENDATION 3: That the Committee urge the Commonwealth Government to direct the federal police to actively enforce the provisions of Section 307.10 of the Criminal Code against any person in the vicinity of the Sydney Medically Supervised Injecting Centre who is in possession of heroin, cocaine or any other "border controlled drug reasonably suspected of having been unlawfully imported" in order to send a clear message to all states and territories that the Commonwealth will not allow any such breaches of its commitment under the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol and the Convention on Psychotropic Substances of 1971.

4. Strengthening families

Australian families who bear the cost of illicit drug use by their members look to the Commonwealth Government to adopt as the basis of a national drug policy a model which has proven success in reducing the use of illicit drugs. Such a model is available.

4.1 The Swedish model

The table below[7] compares Australia and Sweden for annual prevalence of use of various categories of illicit drug expressed as a percentage of the population aged 15-64. Prevalence in Australia ranges from 500% (for opiates) to 1900% (for amphetamines) of prevalence in Sweden for use of particular drugs.

	Australia	**Sweden**
Opiates	0.5	0.1
Cocaine	1.2	0.2
Cannabis	13.3	2.2
Amphetamines	3.8	0.2
Ecstasy	4.0	0.4

A recent review of Sweden's drug policy by the United Nations Office of Drugs and Crime concluded[8]:

"Following a short period of liberalization in the second half of the 1960s, Sweden has pursued restrictive drug control strategies that address both drug supply and drug demand. In parallel, Sweden has invested heavily in addressing the drug problem. Drug-related expenditures were equivalent to 0.5 per cent of GDP, the second highest proportion among all EU countries. This investment has paid off. The number of drug users in Sweden today seems to be smaller than it was before the advent of a concerted drug policy, starting in 1969 when the Government introduced a ten point programme against drugs. In 2006, 6 per cent of the students age 15-16 had used drugs, down from 15 per cent in

1971... While average levels of life-time prevalence of drug use among 15-16 years in Europe amounted to 22 per cent on average, the corresponding rate in Sweden was 8 per cent in 2003, before falling to 6 per cent in 2006... The ambitious goal of the drug-free society has been questioned not only outside the country but in Sweden itself, as a number of research papers on the subject attest. Nevertheless, despite several reviews of expert commissions, the vision has not been found to be obsolete or misdirected. As shown in this report, the prevalence and incidence rates of drug abuse have fallen in Sweden while they have increased in most other European countries. It is perhaps that ambitious vision that has enabled Sweden to achieve this remarkable result."

The current Swedish National Action Plan on Drugs was unanimously endorsed by the Swedish Parliament in April 2006. Cross party support for this policy is a notable feature. "All parties agreed that the overall goal of the Swedish drug policy remains to strive for a drug-free society... There is a wide consensus about the overall goal of the drug policy, namely the drug-free society and its objectives: to reduce the recruitment of young people to drug abuse; to enable drug abusers to stop their drug abuse, and to reduce the availability of illicit drugs... The goal is outlined as follows: The drug policy is based on the right to a life with dignity in a society that guards the needs of the individual to feel safe and secure. Narcotic drugs should never be allowed to threaten the health, the quality of life and the security of the individual nor the general welfare or the development of democracy. The goal is a society free of drugs."[9]

RECOMMENDATION 4: That the Committee calls on the Commonwealth Government to investigate the detailed operation of the successful Swedish drug policy and to adopt it as a model for a new National Drug Strategy.

5. Recommendations

RECOMMENDATION 1: That the Committee calls on the Commonwealth, State and Territory governments to replace the current focus of the National Drug Strategy on harm minimisation and harm reduction strategies with a new focus on reducing the recruitment of young people to drug abuse; enabling drug abusers to stop their drug abuse as well as continuing the focus on reducing the availability of illicit drugs.

RECOMMENDATION 2: That the Committee calls on the Commonwealth Government to immediately cease all financial support for harm minimisation programs including needle exchanges, cannabis infringement notice schemes, and methadone substitution programs (unless these have as their goal a proven pathway to complete abstinence).

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6. Endnotes

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1 "Choices... a loving sister speaks out at her brother's funeral", *Light*, August 2001, p 12.

2 http://www.aph.gov.au/house/committee/fca/subabuse/report.htm

3 Fred J. Payne "An Evidence Based Review of Needle Exchange Programs", February 2005 at: http://www.childrensaidsfund.org/showarticle.asp?id=246

4 http://www.aph.gov.au/house/committee/fca/subabuse/gresponse.pdf

5http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/978CCA3285B6CA42CA25717D000297A4/$File/framework0409.pdf

6 "Drug injection rooms, where addicts may inject themselves with illicit substances, are being established in a number of developed countries, often with the approval of national and/or local authorities. The Board believes that any national, state or local authority that permits the establishment and operation of drug injection rooms or any outlet to facilitate the abuse of drugs (by injection or any other route of administration) also facilitates illicit drug trafficking. The Board reminds Governments that they have an obligation to combat illicit drug trafficking in all its forms. Parties to the 1988 Convention are required, subject to their constitutional principles and the basic concepts of their legal systems, to establish as a criminal offence the possession and purchase of drugs for personal (non-medical) consumption. By permitting drug injection rooms, a Government could be considered to be in contravention of the international drug control treaties by facilitating in, aiding and/or abetting the commission of crimes involving illegal drug possession and use, as well as other criminal offences, including drug trafficking. The international drug control treaties were established many decades ago precisely to eliminate places, such as opium dens, where drugs could be abused with impunity." (Report of the International Narcotics Control Board Report for 1999, para. 176)

"**Error! Main Document Only.**Some States unfortunately challenge the policy of the federal Government and choose to support policies that run counter to the treaty obligation limiting the use of drugs to medical and scientific purposes only, by establishing heroin injection rooms where illicitly obtained drugs can be injected under supervision." (**Error! Main Document Only.**Report of the International Narcotics Control Board Report for 2000, para. 525);

"The Board regrets that local authorities in the Australian state of New South Wales have permitted the establishment of a drug injection room, setting aside the concerns expressed by the Board that the operation of such facilities, where addicts inject themselves with illicit substances, condones illicit drug use and drug trafficking and runs counter to the provisions of the international drug control treaties. The Board notes that the national policy in Australia does not support the establishment of drug injection rooms. The Board urges the Government to ensure that all of its states comply fully with the provisions of the international drug control treaties, to which Australia is a party." (**Error! Main Document Only.**Report of the International Narcotics Control Board Report for 2001, para. 559);

"The Board maintains its opposition, expressed in its report for 2001, on the establishment in Australia of a drug injection room in the state of New South Wales, and regrets that the project has been extended." (Report of the International Narcotics Control Board for 2002, para. 535);

"In previous reports, the Board expressed its concern about the decision on the establishment in Australia of a drug injection room in the State of New South Wales. The Board notes that the

Government of Australia does not support that decision but has no power to intervene since it leaves certain matters of health and law enforcement under the jurisdiction of its states and territories. That, however, puts into question the capacity of the Commonwealth of Australia to ensure the implementation of the provisions of the international drug control treaties throughout its territories. (Report of the International Narcotics Control Board for 2003, para. 576.)

"As mentioned in its previous reports, the Board continues to be concerned about the establishment of a drug injection room in the Australian state of New South Wales and about the four-year extension of the trial period. The Board is pleased to note that no other state of Australia plans to establish such an injection room." "Report of the International Narcotics Control Board Report for 2004", para. 562

Annual reports of the INCB are available at: http://www.incb.org/incb/annual_report.html

7 2006 World Drug Report, Volume 2, Chapter 6.1 at:
http://www.unodc.org/unodc/en/world_drug_report.html

8 United Nations Office of Drugs and Crime, "Sweden's Successful Drug Policy: a Review of the Evidence", February 2007, p.51 at: http://www.unodc.org/pdf/research/Swedish_drug_control.pdf

9 United Nations Office of Drugs and Crime, "Sweden's Successful Drug Policy: a Review of the Evidence", February 2007, p.20 at http://www.unodc.org/pdf/research/Swedish_drug_control.pdf