Inquiry into Substance Abuse in Australian Communities by the House of Representatives Standing Committee on Family and Community Affairs

Submission of Families and Friends for Drug Law Reform (ACT) Inc.

List of recommendations

1. Existing and proposed drug policy measures should be continued or implemented only if there is sound evidence that they are working or are likely to do so.
2. The soundness of evidence for drug policy measures should be critically evaluated by those with recognised qualifications in the particular disciplines concerned.
3. Lack of scientific proof should not be used as a ground to reject trials of new measures if there is evidence that they could be effective.
4. Drug policy measures should promote the welfare of individuals and the community.
5. Drug policy measures should not intensify suffering in the cause of achieving the ideal of a drug free society.
6. The Committee should identify the treatment delays experienced in each state or territory for government funded programs and recommend action that will reduce the delays.
7. Because it is much more effective, a greater proportion of funding should be devoted to treatment and less to law enforcement.
8. The following principles should be applied in the management of drug addiction:
   - include families in treatment regimes,
   - reduce the stigma and shame that makes it doubly hard to overcome addiction,
   - coordinate the provision of treatment services,
   - ensure treatment services are non-punitive and non-judgemental, and
   - provide an equivalent level of treatment for addiction as is provided for other health conditions.
9. Those who are using drugs should be taught survival skills such as the avoidance of blood borne diseases by using clean syringes and avoidance of fatal overdoses by not using alone.
10. In order to reduce the high risk of overdosing after periods of abstinence, special attention should be paid to providing transitional support on release from prison and on leaving abstinence based drug treatment.
11. More funding should be diverted to interventions targeting users before they become entangled with the legal system, than to later interventions, such as drug courts.
12. It is noted that police in many jurisdictions do not attend overdoses and often advertise this fact so that when a person does overdose, friends will be more likely to call an ambulance. The Committee should encourage all Australian police jurisdictions to follow this practice.
13. Drug education is best delivered as part of an integrated syllabus of education in life skills by qualified educators or supervised by qualified educators. It should not be delivered by inadequately trained people.
14. Objective and realistic evaluation and review of education programs based on evidence of what works is essential.

15. Australia should reject the tough law and order approach to drugs adopted by a number of jurisdictions in the United States.
16. Drug policies should contain a set of measurable social, health and economic objectives and a specified process for continuing evaluation and review.
17. Funding to implement drug policies should be on the basis of effectiveness as measured against the objectives.
18. A greater proportion of funding should go to favour health and social rather than law and order programs.
19. At least the same effort should be put into identifying the enormous economic costs to the community of illicit drugs as has been put into the identification by the Productivity Commission of the costs of gambling.

Introduction

Families and Friends for Drug Law Reform

Families and Friends for Drug Law Reform was formed in April 1995 around a group of people who had a child, relative or friend who had died from a drug overdose death. The grief that all shared had turned into frustration and anger that those lives should not have been lost; that all would be alive today if drug use and addiction was treated as a social and medical problem and not law and order one. Since then the group has been intent on reducing the tragedy from illicit drugs, reducing the marginalisation and shame, raising awareness of the issues surrounding illicit drugs and encouraging the search and adoption of better drug policies.

Families and Friends for Drug Law Reform does not promote the view that all drugs should be freely available. Based on the evidence it is clear that this extreme would be (as is the opposite extreme – total prohibition) detrimental to society.

Families and Friends for Drug Law Reform's interest is to promote sensible, evidence based drug policies that cause the least possible harm to individuals, their families and to society. It believes that this could best be achieved by treating drug abuse and addiction as a health issue rather than a criminal one.

Social Costs

The social costs of the current policies are far reaching. The current laws and policies have not prevented the drugs from reaching our young people but have given rise to

- more concentrated forms being smuggled into the country at exorbitant profits (and introduced more efficient but more dangerous ingestion routes ie injection),
- corruption of officials,
- growing drug related crimes,
- growth in prison industries,
- adverse health outcomes for users,
- marginalisation and stigmatisation,
- promotion of a particular moralistic stance that countenances widespread suffering and death as part of a crusade to achieve a mirage of a drug free society,
- inadequate treatment services and
- disempowerment and fracturing of families.

The life of a user and consequently for family members is often chaotic and highly stressful. Some examples of personal stories from families are included in *Attachment 1*.

In those cases where death occurs (whether it be by accident, suicide or by murder) the tragedy for family and friends is immeasurable.

Over the last 10 years over 4,300 persons have died from illicit drug overdose. That such a toll is met with so woefully inadequate a response is a tragedy of national proportion. There are still not enough treatment options and services. There is now more treatment but the level of resources is not keeping pace with the growing need for it. Moreover, treatment through drug courts and diversion schemes is still backed by the threat of criminal sanctions. This further marginalises users from their family and support networks. For no medical condition other than addiction (and only addiction to illicit drugs) is the criminal law given such a role. There is also too much reluctance to trial measures that are likely to work.

Drug policy must be based on critically evaluated evidence

Recommendation 1 & 2

The community debate on drugs is characterised by fear, dogmatism and wildly conflicting claims. It is of prime importance that existing and proposed measures should be continued or implemented only if there is sound evidence that they are working or are likely to do so. Whether evidence is sound should be critically evaluated by those with recognised qualifications in the particular disciplines concerned. This evaluation should also be able to withstand critical lay scrutiny. Without such an approach, drug policy and the lives that depend on it will continue to be gambled away.

Recommendation 3

Equally, it is wrong to use lack of scientific proof as a smoke screen for rejecting a measure when there is evidence that the measure could be effective. At the very least measures for which there is strong evidence short of proof should be trialled.

We must be clear about the moral position we are coming from

It is obvious that drug policy should not be made in a moral vacuum. For its part Families and Friends for Drug Law Reform believes it is morally wrong for governments to persevere with policies in the face of credible evidence that those policies intensify suffering and lead to death. Aware as so many of our members are of what addiction does to people, we do not wish to see illicit drugs as available as they now are or for them to be commercially promoted like alcohol. On the other hand we utterly reject the proposition that we should work to achieve the mirage of a drug free society when that means continuing the alienation, stigmatisation, suffering and death of our youth. Our duty should be to promote the welfare of the individuals and the community and not wage an ideological war against addiction.

Recommendation 4 & 5

Treatment

Treatment is seven times more effective than law enforcement[1] in reducing drug use. However at the moment treatment services are inadequate. Long waiting lists exist for one of the most effective and cheapest– methadone maintenance. People who wish to do something about their drug use today may have to wait for up to three months before treatment is available. It does not take a great deal of imagination to understand what may happen to them. The opportunity, and perhaps the only one that may present itself, will have been lost.

It is not appropriate for the response to be "that they chose to take drugs and they must wait". This is blaming a human being with a medical or psychological problem, something that is not done for other conditions. For example accident victims are not

made to wait because they caused the accident. Nor are heart attack victims who may have over-indulged all their life.

Recommendation 6

The Committee should identify the treatment delays experienced in each state or territory for government funded programs and recommend action that will overcome the delays. Government funded programs are the most important because these are where the most seriously affected, and often the poorest, have to turn for assistance.

The range of treatment options is limited. The nature of addiction as a chronic relapsing disorder should be recognised in the range of treatment options provided and in the way treatment options are offered. There is no one best treatment; a variety of treatments need to be provided. If, say, an abstinence treatment fails there should be another treatment option the person could be slotted into.

Recommendation 7

Because it is much more effective, a greater proportion of funding should be devoted to treatment and less to law enforcement. Lives could be saved but in addition, individual health would improve, family relationships could stabilise and drug related crime would reduce. The latter aspect would provide not only social benefits but real economic benefits[*].

Current policies contribute to the disempowerment and fracturing of families – the fundamental societal building block. Wherever possible it is important to maintain family links – particularly in provision of treatment.

Recommendation

Changes to the way in which addiction is managed would provide social benefits. The following principles should be applied in the management of drug addiction:

- include families in treatment regimes,
- reduce the stigma and shame that makes it doubly hard to overcome addiction,
- coordinate the provision of treatment services,
- ensure treatment services are non-punitive and non-judgemental, and
- provide an equivalent level of treatment for addiction as is provided for other health conditions.

The first step in this process is to recognise that drug addiction is a chronic relapsing condition for which there is no 'cure' but with treatment and good management the condition can be controlled. Often remission is confused with a cure. Remission can last for the remainder of a person's life.

Lack of support and information for families

Many of our members have experienced stigmatisation, lack of support and support services and inadequate and often inappropriate advice when trying to deal with a drug-using member of the family. As a result families often adopt inappropriate responses. All too often that bad advice or information costs a life. Telling someone not to take drugs when they are addicted to them and have tried several times to give them up is worse than useless. Those who are using drugs should be taught survival skills such as the avoidance of blood borne diseases by using clean syringes and avoidance of fatal overdose by not using alone. They should be trained in basic resuscitation techniques. They must not be deterred from calling an ambulance for fear of police attendance. The evidence shows that if users can be kept alive they will more than likely get over their drug habit. Processes that lead to more and better support and information for families should be put in place.

Recommendation 9

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[*] The Swiss have estimated that a net benefit of 45 Swiss francs per patient day flowed from their heroin prescription program. Similar results can be calculated for methadone treatment.

Compulsory treatment, prisons and drug courts

Families and Friends for Drug Law Reform notes that the present government provides funding for diversion to compulsory treatment or counselling and many state jurisdictions are trialing or considering drug courts. On balance compulsory treatments provide no greater results than non-compulsory treatments. In Sweden[2] where compulsory diversion to treatment is standard practice there is no greater abstinence rates. Moreover, it appears that a user who is put through such a process is actually at greater risk of overdose. This risk of overdose is also high for those who have recently been discharged from places like prisons where people may have stopped using drugs. Special attention should be paid to this by providing transitional support on release from prison and on leaving abstinence based drug treatment.

Recommendation 10

The current drug court trials in NSW and other jurisdictions provide a Rolls Royce standard of treatment to a limited number of users. The intervention is very expensive and deals with issues after the event. The same funding used for the drug court could have reduced the methadone program waiting list significantly which in turn is likely to have had an even greater effect on the reduction of the crime rate. More funding should be diverted to interventions targeting users before they become entangled with the legal system than to later interventions such as drug courts. Too little funding and research has been put into dealing with the basic causes and the associated health problems (eg family breakdown, unemployment, homelessness, poverty, mental illness, experimentation, etc). This should be rectified. It would be more cost effective to be pro-active by dealing with the causes and not with the consequences such as crime caused by the need to obtain money to support a drug addiction.

Recommendation 11

Police issues

The stated aim of all Australian Law Enforcement Agencies is to catch the Mr Bigs, not so much to catch the drug user. In the latest Australian Illicit Drug Report 98-99 there were 65,836 arrests of drug users and only 17,688 arrests of drug providers. The chances are that a large proportion of the drug providers arrested were dependent drug users who were user-dealers, that is supplying drugs to others so that they could support their own habit. The recent claims of over 7,000 drug arrests in the Cabramatta area appears not to have had any impact on the availability or price of drugs. This is not so much a criticism of the police but simply identifying the difficulty or in fact the impossibility of these approaches to have anything other than a marginal effect.

Recommendation

It is noted that police in many jurisdictions do not attend overdoses and often advertise this fact so that when a person does overdose, friends will be more likely to call an ambulance. The Committee should encourage all Australian police jurisdictions to follow this practice. When the ambulance is called the matter is a health and not a police issue – saving a life is most important and this is the role of the ambulance officers.

Police in Australia, following the trend from the US[3], are becoming more involved in education aspects of drug issues. This is a misdirection and ineffective use of police resources. At best drug education presently has only a marginal effect on delaying drug uptake or reducing drug use. Drug education is best delivered as part of an integrated syllabus of education in life skills by qualified educators or supervised by qualified educators. It should not be delivered by inadequately trained people.

Recommendation 13

Families and Friends for Drug Law Reform is also concerned about the recent initiative by the Federal Government on funding for diversionary approaches. Concerns relate to effectiveness of such approaches which appear to have no scientific or evidential underpinnings. There is also doubt whether there are sufficient referral services to make the system work.

Attitudes

Attitudes of the community generally and of some doctors, some alcohol and drug professionals toward those addicted to drugs need to be addressed.

Because of the prohibition policies the community has been instilled with the attitude which sees drug addicts as misfits and criminals rather than people needing help. Treatment is often seen as a form of punishment rather than health care. This is rarely productive. Users are alienated and are less likely to seek help.

Comprehensive Drug Policy Needed

The current drug policies comprise prohibition for some drugs and regulation for others. It is an unbalanced mishmash and often contradictory set of policies. For example what objective criteria has determined that some drugs are legal while others have been declared illegal?

Illicit drug use has increased from 1995 to 1998[4]. Overdose deaths has been increasing and shows no sign of reducing or even levelling off. There were 737 deaths in 1998 and 1999 deaths are likely to be higher still. Although illicit drug seizures are up, it does not reflect a reduction in availability of drugs, it is more a reflection of increasing supply and availability of drugs and perhaps another pointer to failure of current prohibition policies.

The current illicit drug policy, of which the "Tough on Drugs Strategy" forms a part, has failed to stop the drugs from reaching our young people and there are indications that harm from illicit drugs is increasing[*,5]. The current illicit drug policies and much of the implementation of those policies are not based on evidence. They are based on adherence to a 'law and order' approach and an unfounded faith of effectiveness with only minor concessions to health and education approaches.

Education is one aspect of implementation of those policies. Education programs are rarely evaluated and are presently of limited effectiveness[6]. If there is to be an expectation that provision of education to young people will assist them to live safely with drugs then greater effort and resources are required to find and implement education programs that deliver real benefits. Faith and expectation that such programs should work is not sufficient. Objective and realistic evaluation and review of education programs based on evidence of what works is essential.

Recommendation 14

The balance of funding allocation is wrong. It is contrary to evidence and research of what is effective. A greater proportion of funding should go to favour health and social rather than law and order programs.

Recommendation 18

Current Australian policies follow very closely the US model, although Australian policy has not yet been taken to the US extremes. There is no evidence that the US policy is effective. Drug use in US is spreading into country areas and the growing number of persons in prison for drug related offences continues to rise. US policing approaches the excesses of the inquisitions of the McCarthy era in its hunt for communists. For example a person apprehended for drug related matters receives a lighter sentence by "snitching" another person involved in drugs. An approach that can see drug dealers receive minimum sentences while a 'snitched' client (victim) receives the maximum sentence. *(See Attachment 1).* Families and Friends for Drug Law Reform cautions against further progression down the US path of the war on drugs.

Recommendation 15

A comprehensive policy relating to all drugs for Australia is required. A revised policy based on evidence should take a more health-oriented approach. It would also look to

[*] The one shining exception is the ongoing benefits from introduction of the needle exchange in 1985 as part of the harm minimisation strategy.

policies in other countries which have been successful in reducing the level of harm caused by drugs and even the level of drug use itself[7] (*see Attachment 2 for elements of the Swiss and Dutch policies)*. It would take into account that, based on past evidence, it will not be possible to eliminate drugs from the world[φ] and that we have to learn to live with drugs in the least harmful way. It would take into account the harms caused by the current policies themselves and not by the drugs they purport but fail to prohibit.

Recommendation 16

In addition, such a policy would contain a set of measurable social, health and economic objectives and a specified process for continuing evaluation and review. Such evaluations should be followed by revisions to the policy to improve effectiveness in terms of the social and economic objectives specified. There is a continual need for adjustment to maximise desired social outcomes

Recommendation 17

Funding to implement such policies should be on the basis of effectiveness as measured against the objectives. Rehabilitation and detoxification centres receiving government funding should be required to evaluate the effectiveness of their programs. Significant funding for trials and research to provide the sound scientific underpinning necessary to achieve effective policies is required.

Economic Costs

Illicit drugs are the subject of a gigantic, unregulated and untaxed black market industry. In 1997 Access Economics estimated the industry to have a turnover in Australia of $7 billion which placed it between tobacco ($4.2 billion) and behind gambling ($9.6). The indications are that this is a substantial underestimate. A recent study by the University of Western Australia estimated annual expenditure in 1995 on marijuana alone as $5.072 billion. This represents a 33% growth since 1988[8]. Estimates of drug use trends suggest that turnover is steadily increasing. As Access Economic pointed out "Imposition of a GST would do little to tax this part of the black economy".

The illicit drug industry appears to distort the normal economic models of supply and demand. Because many of the drugs are addictive, demand for them is relatively insensitive to price so that it is possible that while increased law enforcement effort may increase price, demand will not be greatly reduced. In that case it could be expected that addicted users will respond by seeking to increase their income by actions such as increased drug dealing or property crime.

Recommendation 19

Much of the economic cost is unknown. At least the same effort should be put into identifying the enormous economic costs to the community of illicit drugs as has been put into the identification by the Productivity Commission of the costs of gambling. A reference for such an inquiry is important in that it will provide independent and complementary advice to studies relating to health as well as meeting the operating principle of the Commission of concern for the wellbeing of the community as a whole.

If anything the grounds for an enquiry on illicit drugs is more urgent than for gambling because:

- the turnover of the illicit drug industry is about the same ($11 billion gambled away annually compared to a $7 billion turnover for illegal drugs on the basis of old figures);
- an alarming number of children and young people have serious drugs problems whereas gambling is mainly an adult activity;

[φ] Examination of the United Nations Drug Control Program Annual Reports shows that the weather conditions prevailing in producer countries have greater influence on opium production then the resources and efforts of the United Nations.

- drug use has more immediate health implications than gambling: close to 1,000 mainly young Australians will die this year from heroin overdoses;
- the number of those seriously affected by the illicit drug industry extends to more than the five others affected by each problem gambler. Not only does addicted drug use crash through families like a road train but drug addiction is a major cause of crime and increased costs in insurance, law enforcement, criminal justice and health systems.

Matters recommended for inclusion in the Productivity Commission Inquiry are contained in *Attachment 3*.

Attachments

1. Personal stories

A mother's story

We first discovered our son was using heroin just a little over two weeks before he died. He had overdosed close to our home and a friend alerted us. Our daughter called the ambulance. My son was unconscious. I was distraught. I was so thankful that the ambulance men were there quietly and efficiently helping my son. But I couldn't understand why the police were also there harassing me, my daughter and my son's friend. There has to be something terribly wrong when a parent is harassed by police when she has just discovered her son's life is in jeopardy. My gut feeling that night was that this was not right, there was something very wrong with this system. I guess this was the beginning of my belief that there was an injustice in our drug laws. You see, I knew my son, the police didn't. They would have seen him the way the laws told them to see him – as a criminal. Here was an opportunity to help him. He had not harmed anyone else – but the law got in the way.

The ambulance took my son to hospital but he awoke to find the police at the end of his bed. He discharged himself and for the next two weeks we saw little of him – he was afraid the police would call. He then took a hurried, unplanned holiday. He overdosed and died while on that holiday. He was alone at the time. Involvement of the law frightened my son away from available treatment and help.

It was August 1992 when I discovered that my son was using heroin and in September 1992, just two weeks later, at the age of 24 my son was dead.

He accomplished so much in his short life including having a book of computer programs published at the age of 16. He was Captain of his Primary School, he received distinctions in the Australian Mathematics Competition every year from year 7 to yr 12, he was an accomplished cross-country runner, played the organ, worked on a paper run, did all the things most kids do. Who would have thought this could happen to him? He was baptised and confirmed in the Christian Church. He attended Sunday School, youth group and church for many years.

What might have happened if the police had not involved themselves in this health issue of reviving someone from an overdose?

Just six months before he died he graduated with a degree in computer science, he had a good job and his later hobbies were playing chess and doing the daily cryptic crossword. Did he fit the stereotype that many people have towards young people who use drugs? I think not! I know that many do not deserve the stigma that is placed on them and their families by society.

Dean

Dean, the brother of one of our members died from a heroin overdose. He was 28 years old. He had become dependant on heroin some years before but unlike the stereotype that is portrayed, he was able to hold down a steady job. His employer held him in high regard even though he knew of Deane's drug problem. Dean had been on the ACT's methadone program and had reduced to the lowest dose.

How many other people have to submit to urine tests or have to go daily to a special location to get their drug? Do they have to put in a plan to their doctor if they want a weekend holiday and plead a special case for drugs to take away with them?

He was depressed by his inability to get completely off methadone and felt as if he was being treated as a virtual prisoner under remote surveillance by the need to attend the methadone clinic every morning on his way to work as well as random urine testing to prove he was not using heroin.

There were limited treatment options available and there was a stigma associated with being a dependent drug user.

Central Coast

A Central Coast father did everything he could to arrange treatment for his daughter. He was finally successful in finding her a residential treatment bed and then rang every day to check her progress. When he was allowed, and it was infrequent, he spoke to her on the telephone. He was not allowed to visit.

Where else in health services are such draconian rules applied? Where else would they be tolerated? What good was served by her eviction from the program?

One day after being told his daughter was progressing well she was caught smoking tobacco on the roof with another inmate and they were both evicted. Her father was not contacted to collect her nor was he advised of the situation.

The next day he received a visit from the police. His daughter had a fatal overdose of heroin the night she was evicted.

Peta's brother

Peta's brother who is serving a 15 year sentence for armed robbery which he committed to support heroin dependency, went into prison at 22 years of age and is now 34.

He accepts responsibility for his actions but he, along with 7 out of 10 other inmates in this gaol for drug related crime, has trouble accepting how keeping him in prison will help his addiction - the real reason for his incarceration. He asks the question how can you abstain in an environment like a prison where drugs are available?

Armed robbery is a serious offence but if he had been able to receive heroin on prescription he would not have had to commit the crime in the first place. And how will the gaol help his addiction?

Each time he relapses and uses drugs, (relapse is common in addiction) he is punished further. Points are scored against him and his parole date recedes.

Duncan Campbell

Duncan Campbell who writes a column in the Australian newspaper claimed in the title of one of his articles that "Addicts deserve a dose of empathy". The subtitle was "The war on drugs failed to save my child". Duncan Campbell describes how his daughter tried and failed all the currently known treatments including naltrexone. He writes "Imagine living and dying like this for 20 years. Imagine repeatedly trying the seven ways [of overcoming heroin addiction], and always relapsing and eroding your self-respect. Imagine desperately finding money and faking your life away. Imagine having to depend on the most callous criminals. Imagine wishing the impossible: just to visit your family doctor for regular small injections or prescriptions."

A telling point in the article by Duncan Campbell was that he likened this war on drugs to the Vietnam War. An unwinable war and yet the body count continues to rise. In 1998 the body count was 737 opiate overdose deaths and still

His daughter Jennifer was found dead in the kitchen by her partner. Her partner did not use heroin but he loved Jennifer despite the fact that she was dependent on heroin.

"I am wrongly imprisoned for 19 years" *[Edited version]*

Source: Marie Claire

Author: Dorothy Gaines, as told to Ann Colin Herbst

Pubdate: May, 2000

Fax: (212) 649-5050

Address: 1790 Broadway, 3d Floor, New York, NY 10019

Website: http://www.marieclaire.com

Dorothy Gaines, 41, is behind bars with no chance for parole. Yet she says she's innocent. And the only evidence against her came from convicted criminals who implicated her to reduce their own jail time.

If you had told me 10 years ago that I would be serving a prison sentence of more than 19 years for delivering crack and having cocaine in my house, I would have laughed in your face. At the time, I was a respected nurse technician at Providence Hospital in Mobile, Alabama, where I lived with my husband, Terrell, and my three children. I went to church, paid my taxes and always taught my kids – Natasha, now 26, Chara, 17, and Phillip, 15 – to abide by the law. I felt like I had finally made it, even though the road up to that point had been a fairly rough one.

My problems began when I was 15 and met Larry Johnson, who was five years my senior, Basically, I fell into the wrong arms. We had a brief relationship and I became pregnant with Natasha. Larry never owned up to being Natasha's father.

Yet even as a young single mother, I never gave up on my dreams. I worked at a paper plant while studying for my nurse technician's degree. And by 1982, everything seemed to be looking up for me. I had fallen in love with a wonderful man named Charles, and soon after, Chara and Phillip were born.

But in 1986, tragedy struck again. Out of the blue, Charles had a heart attack and died at the age of 32.

Two years later, an old family friend, Terrell Hines, moved back to town. After living with Terrell for a year, I discovered he had become addicted to crack. I put him in a four-month inpatient rehabilitation program. He seemed to have beaten his problem, and things got back to normal.

The Nightmare Begins

But on a Saturday morning in August 1993, my life turned upside down. My children and I were getting ready to go to a family reunion when suddenly, I saw about 12 police cars and 20 officers in my driveway.

The police, who had a search warrant, came inside and tore up my house. They told me they were looking for money and drugs. Even though they did not find anything – no drugs, no money, no beepers, no paraphernalia, no phone records, no bank records – Terrell and I were arrested.

Larry Johnson, Natasha's father, had lied to authorities and said I was involved in a Mobile-based drug ring. Apparently, Larry had been sentenced to 15 years in prison for drug and gun charges. In exchange for reduced jail time, he agreed to cooperate with authorities and then implicated me.

Specifically, Larry claimed I once delivered three ounces of crack cocaine to him at work, and that I once stored over a kilogram of powder cocaine at my house. I had no knowledge of it. I had never seen any drugs in my home.

Soon afterward, I was appointed an attorney who I asked him to have my case severed from three other defendants who were facing similar charges, but he refused.

On March 10, 1995, the judge sentenced me to prison on two counts: conspiracy to distribute crack and powder cocaine, and possession with intent to distribute. No evidence of drugs had ever been found; the jury found me guilty based solely on the say-so of witnesses who knew they could reduce their own sentences by testifying against me.

When the judge sentenced me to 235 months, my three children – who were all in the courtroom – started screaming. I felt completely numb. I asked my attorney, "How long is that?" When he said, "19 years, seven months," I lost it. Even if the judge had wanted to, he couldn't have given me a lighter sentence. The mandatory minimum sentencing laws – which are harshly written for drug offenders, particularly people convicted of selling crack cocaine – do not allow for a judge's discretion. So even though I was a non-violent person with no previous criminal record, I was sentenced to a longer term than even some convicted rapists or murderers.

The worst part is the effect my imprisonment has had on my children. Because I was determined that Chara and Phillip not go into foster care, Natasha dropped out of college to support her younger siblings.

Phillip is struggling the most, though. He went from being on the honor roll to getting failing grades. He has tried to commit suicide twice and was arrested recently for petty offences, like shoplifting. He says he wants to go to prison so he can be with me.

When I think back on how scary this process has been and how I've been caught up in the system, I sometimes can't believe I'm living in America.

2. Other Countries' Drug Policies

Swiss drug policy

Results of the policy of the federal government for reducing drug problems

The fourfold drug policy (prevention, treatment, harm reduction and law enforcement):

- has led to a decrease in the number of new hard drug users among youth;
- has helped a multitude of drug-dependent individuals escape the vicious cycle of addiction;
- protects the physical and mental well-being of drug-dependent individuals.

In the last few years:

- the incidence of HIV and Hepatitis infections has been noticeably reduced;
- mortality from overdose has been noticeably reduced;
- the open drug scenes have been eliminated;
- the crime rate connected with obtaining drugs has been substantially reduced;
- the number of drug addicts in treatment has almost doubled.

The various forms of treatment are encouraging thousands of drug-dependent individuals who opt for the difficult road out of addiction. Drug-dependent individuals have a chance to regain their independence and be reintegrated into society.

Source: Swiss Federal Office of Public Health, http://www.admin.ch

Dutch drug policy

The main aim of the drugs policy is to reduce the risks of drug use to the individual drug users, their immediate environment, as well as society in general. The reduction of supply and demand is also an important objective. With respect to the individual, the protection of their health is the key aim. In this context, prevention and care are core policy issues. With respect to the protection of society as a whole, measures in the field of public order and safety are important issues.

The Opium Act is the main law in which regulations on drugs are laid down. Various other types of legislation may also be applied in investigation and prosecution. One example is the 'pluk-ze' (clean them out) legislation (law on financial penalties) which makes it possible to tackle money laundering. The Public Prosecutors office has also issued directives for circumstances in which more severe sentences are to be used, such as selling to vulnerable groups (school children, psychiatric patients) and trade in the vicinity of schools and psychiatric hospitals. But the government policy is also based on the premise that criminal prosecution must be no more damaging to the drug users than the drug use itself.

Dutch drug policy is aimed at maintaining a separation between the market for soft drugs (cannabis products such as hashish and marijuana) and the market for drugs that carry an unacceptable risk (such as the hard drugs heroin and cocaine). Furthermore, the policy is also aimed at preventing drug users from ending up in an illegal environment, where they are difficult to reach for prevention and intervention.

The Opium Act

The Opium Act of 1919 (amended in 1928 and 1976) regulates the production, distribution and consumption of "psychoactive" substances. Possession, commercial distribution, production, import and export and advertising the sale or distribution of all drugs is punishable by law. Since 1985, this has also covered activities preparatory to trafficking in hard drugs. The use of drugs is not punishable by law. Activities relating

to soft drugs and hard drugs for medicinal and scientific purposes are allowed provided the Minister of VWS has granted special permission.

Since 1976, a distinction has been made between soft drugs and hard drugs. This distinction was established as a result of a 1972 report from the Working Group on Narcotic Drugs (the Baan Committee). Using a 'risk scale', based on medical, pharmacological, socio-scientific and psychological data, a distinction was made between drugs which pose an unacceptable hazard to health ('hard drugs', such as heroin, cocaine, LSD and amphetamines) and hemp products ('soft drugs' such as hashish and marijuana). Hard drugs were listed on schedule I and soft drugs were listed on schedule II (sub b) of the Opium Act. Since 2 July 1993, barbiturates and tranquillisers have been listed on schedule II (sub a) due to the fact that the Netherlands ratified the Psychotropic Substances Treaty.

Coffee Shops

Over the years so-called coffee shops emerged. The sale of hard drugs at these premises is strictly forbidden, but the sale of soft drugs is not prosecuted provided certain conditions are met. The reasons for this policy are the desire to separate the markets for hard drugs and soft drugs, to avoid criminalisation and administrative clarity. The government wants to prevent (often young) soft drug users to resort to a market where there are more drugs for them to switch to and where they might more easily end up in criminal circles.

According to police estimates the number of coffee shops in the Netherlands was 1200 to 1500 in 1991. A research bureau estimated their number at 1460 in 1995 and 1293 in 1996, but there are both lower and higher estimates, all of which are as well founded as each other. The coffee shops are mainly small, café-like enterprises catering for a diverse public from various social backgrounds. Most offer a wide range of hashish and marijuana products from various countries and of varying quality. They have various functions. Some act solely as shops, in others people may use drugs if they buy something, while others serve mainly as meeting places where little is bought and people stay longer. These latter type may have a nuisance-reducing effect, as there is less lingering in the streets.

Prevention and education

Prevention, information and education play an important role in Dutch drug policy. The project 'Healthy schools and stimulants', specifically aimed at secondary school pupils, was launched in 1991. The project is a cooperative effort on the part of the Trimbos Institute, the out-patient facilities for addiction care and local public health services, together with local authorities. The project provides information on tobacco, alcohol, cannabis and gambling, aimed specifically at the ages at which students generally have their first contacts with the substance or in question or gambling. For cannabis this is usually around 15 years old. Besides providing information, the project is also aimed at establishing regulations (no substance use in schools), detection and guidance. By mid 1996, 30% of schools were implementing this project on a structural basis. A specific consumer public is being advised on 'sensible use' in leaflets distributed in various coffee shops. 'Tips on Hash and Grass' warns against the harmful effects on concentration and the ability to react, the use of cannabis as a means of overcoming problems, eating space-cake, simultaneous use with alcohol or medication and taking hashish and grass out of the country.

Criticism and Praise

The Dutch cannabis policy has been both praised and criticised nationally and internationally. In terms of social acceptability, the current policy is regularly under discussion, particularly with regard to drugs-related nuisance. The policy has also been

criticised by EU countries, which regard the Netherlands as being out of tune, particularly regarding the harmonisation of legislation on narcotics. This has resulted in a tendency towards a more repressive approach. On the other hand, the Dutch cannabis policy has achieved the objective of a (relative) separation of the soft and hard drugs markets. The fact that cannabis is relatively easy to obtain in coffee shops has not resulted in a greater increase in use than in other countries. Furthermore, the number of hard drug addicts has stabilised and the Netherlands has few drugs-related deaths compared with other countries. In recent years, other countries have also come to realise that a certain decriminalisation of soft drug use is worth considering in the context of public health, the prevention of social damage to users and the limitation of aggressive small-scale trade in the street. In addition to Switzerland and Denmark, a process aimed at the decriminalisation of soft drug use has also been started in Germany, Great Britain and Spain. Daily reports in the newspapers indicate that such developments are in full swing at both a national and an international level.

Expediency principle

The principle of expediency has been included in the Dutch Penal Code. This empowers the Public Prosecutor to refrain from prosecution of criminal offences if this is in the public interest. The guidelines for investigation and prosecution were amended on 1 October 1996. These guidelines establish the priorities in the investigation and prosecution of Opium Act offences. Punishable offences involving hard drugs other than for individual use take the highest priority, followed by punishable offences involving soft drugs other than for individual use. Investigation and prosecution of possession of hard drugs for individual consumption (generally 0.5 gram) and soft drugs to a maximum of 5 grams carry the lowest priority. If coffee shops comply with the guidelines, the sale of a maximum of 5 grams of hashish and marijuana per transaction is generally not investigated. The police do confiscate all drugs discovered. Coffee shops involved in the sale of trade or consumption stocks for export are subject to priority investigation and prosecution. The same applies to soft drugs sales via other points of sale, such as cafes, shops, take-away centres, couriers or taxis, commercial telephone lines, mail order, etc.

Stepping-stone hypothesis

The assumption that cannabis consumers run a higher risk of switching to hard drugs, especially heroin, is known as 'the stepping-stone hypothesis'. This idea was first put forward in the forties in the USA and has since greatly influenced public opinion, as well as American and international drug policies. Opinions differ as to whether or not the hypothesis is correct. As for a possible switch from cannabis to hard drugs, it is clear that the pharmacological properties of cannabis are irrelevant in this respect. There is no physically determined tendency towards switching from soft to harder substances. Social factors, however, do appear to play a role. The more users become integrated in an environment ('subculture') where, apart from cannabis, hard drugs can also be obtained, the greater the chance that they may switch to hard drugs. Separation of the drug markets is therefore essential and forms the basis of the current cannabis policy.

Source: Trimbos-instituut, Utrecht, The Netherlands

3. Matters to be included in Productivity Commission Inquiry

The Productivity Commission inquiry should address the following:

The overall cost to Australian governments and the community of the existing untaxed and unregulated illicit drug industry.

1. Economic cost of drug related corruption;
2. Economic implications of the illicit industry being completely beyond the new GST regime;
3. Comparison of the economic costs to governments and the community of alternative drug policies such as treating the "illicit" drugs as primarily a health and social issue including:
    - permitting medical and pharmaceutical professions to control supply of at least some drugs; and
    - strict drug regulation eg. in limited quantities, no advertising or self production only;
    - the economic costs and benefits of continuing to pursue harm minimisation strategies.
4. Cost benefit analyses of drug strategies of other countries.
5. The economic links between social welfare indicators such as employment, poverty etc and the costs of drug use or abuse.
6. The cost of eliminating or reducing the illicit drug trade to acceptable levels by the current or any newly identified approaches.
7. The economic benefits that might flow from interventions that seek to address drug use before those involved come in contact with the law enforcement system.
8. The extent to which problems associated with illicit drug use add to the costs of delivery of social welfare services including health, education, unemployment relief and public housing.
9. The extent to which problems associated with illicit drug use add to costs of delivery of health services, education, unemployment relief, public housing and the delivery of other social and welfare services. (The indications are that the cost of addressing many social problems is increased by 10 or more percent because they are accentuated through drug use.)
10. What policy interventions are likely to have most impact on the $7 billion illicit drug industry to make those drugs less available?
11. What are the costs to the community of drug related crime? In particular are surveys conducted by the insurance industry (RACV and NRMA) correct that fear of property crime are major causes of household and business concern and a cause of higher premiums?
12. What economic strategies can reduce the acknowledged scope for drug financed corruption?

    Numerous enquiries, including Royal Commissions have found an intimate link between the drug trade and corruption. For example, the 1997 Wood Royal Commission into the NSW Police Service wrote that:

    "The corrupting influence of the trade in narcotics has been emphasised at almost every stage of the Royal Commission inquiries . . ." (§1.41)

    and

    "There was an overwhelming body or evidence suggesting the existence of close relationships between police and those involved in the supply of drugs. This encompassed a variety of activities

ranging from police turning a blind eye to the criminality of the favoured in return for regular payments, to active assistance when they happened to be caught, to tip-offs of pending police activity, and to affirmative police action aimed at driving out competitors" (§4.135).

With the huge amounts of money involved there is no reason to believe that corruption is limited to police services; the scope may extend even to the purchase of public comment and political action favourable to the maintenance of profit by this illicit trade.

Endnotes

[1] Controlling Cocaine: Supply versus demand programs, C Peter Rydell & Susan S Everingham, Rand Drug Policy Research Centre.

[2] See Lesson lost in the translation by Richard Walsh, "http://www.ffdlr.org.au/commentary/Lesson lost in the translation by Richard Walsh.htm"; and Sweden's drug policy – does it have the answers for Australia by B McConnell, "http://www.ffdlr.org.au/commentary/Swedens drug policy.htm".

[3] The US DARE program exclusively has police deliver an education program to school children. Evaluation of that program has shown that it does not reduce or delay drug use but increases drug use.

[4] 1998 National Drug Strategy Household Survey, Australian Institute of health and Welfare.

[5] See Tough on Drugs Report Card at "http://www.ffdlr.org.au/media/rReport card.rtf"

[6] See Educating young people about drugs: A systematic review, David White and Martin Pitts, Addiction (1998) 93(10), 1475 – 1487.

[7]. The most recent household surveys show that the Netherlands has less than half the Australian usage rate of those who have ever used cannabis (15.6% compared to 39.3%).

[8] The economics of marijuana production, Clements & Daryl, (1999)