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The House of Representatives Standing Committee on Family and Human Services

Inquiry into the impact of illicit drug use on families

Summary:

For decades, both nationally and internationally, law enforcement has dominated responses to the drugs listed in the 1961 and 1971 international drug treaties. While authorities have relied increasingly on a 'War Against Drugs' approach, with the majority of government expenditure in response to drugs allocated to supply control, illicit drug use has been reported from an increasing number of countries, global consumption and the range of different types of drugs available has increased steadily and the adverse health, social and economic consequences of illicit drugs have soared. Drug law enforcement measures, such as customs, police, courts and prisons, have proven to be relatively ineffective, expensive and often seriously counter-productive. Rampant police corruption linked to unsuccessful attempts to enforce drug prohibitions has been found in several recent state (1987, 1997, 2004) and a commonwealth (1985) Royal Commissions. Internationally, global drug prohibition has resulted in the emergence of several 'narco-states' (such as Afghanistan, Burma, Colombia, Peru, Bolivia, Pakistan and Mexico) and provided a lucrative income for 'narco-terrorism'. The 'War Against Drugs' is a high taxing-big government approach which has failed comprehensively and repeatedly but continues because of perceived short-term political advantages. Like many other unsuccessful government policies, the more the War Against Drugs fails as a policy, the more heavily governments invest in this approach. The War against Drugs approach identifies drug consumption itself as the primary problem to be tackled. Attempts to reduce the adverse consequences of drug use are very much a secondary consideration. The immense health, social and economic cost of legal drugs to drug users, their families and communities is ignored while generous donations are accepted from the tobacco and alcohol beverage industries. The scientific debate about harm reduction is now over: harm reduction has been shown compellingly to be effective, safe and cost-effective. Harm reduction includes efforts to promote abstinence from drugs. Efforts to reduce the harms from drugs also include attempts to find more effective, less expensive and more cost-effective government policy. Attempts to defy the powerful market forces of the illicit drug industry are destined to fail.

Terms of Reference

The Committee shall inquire into and 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.

Response to the Inquiry:

'If something cannot go on forever, it will stop'
Herbert Stein, US economist

Damien Carrick: *Don Stewart, ... does prohibition work? I mean does our crime fighting approach work?*

Don Stewart: *I don't think so. There was a period, as we all know, when there was a total prohibition on the consumption of alcoholic liquor in the United States, and it did not work. There were bootleggers, it created corruption on a large scale, and it was a terrific failure, and it was always going to be a failure.*

Damien Carrick: *Are we engaged now in a terrific failure in our zero tolerance approach to drugs?*

Don Stewart: *I think so. I think the proof of the pudding is in the eating; it hasn't stamped out drug trafficking and drug use, the criminal approach, has it? I mean every second day I pick up one of the daily newspapers, there's another story, yet another story about how the police have broken up another large drug cartel, a drug ring in Brisbane or Sydney or wherever, so you knock one off and several more seem to spring up. The fact is, some people want and need drugs, and they're going to get them somehow or another. There's still large amounts of illegal drugs being imported into this country, heroin for example, heroin is not made in this country, never has been. Large quantities, ever increasing quantities of cocaine are being brought into this country one way or another, from South America, where it is manufactured. It's not made in Australia. But other drugs are made in Australia. New drugs are being introduced, very, very dangerous drugs like ecstasy, and one reads in the newspaper of people dying from ingesting just one tablet of a bad batch or something of that nature. They're being cooked up in little laboratories in little factories, even in people's homes. Another new drug that's been introduced is ice, which is a very dangerous drug; it is a mind-altering substance that makes*

people aggressive, almost to the point of paranoia and hallucinatory effects. So it hasn't worked, but will anything work? I don't think we can just say open slather, but we've got to think more instead of the criminalisation of it, and the criminal approach and trying to stamp it out by penalty and criminal law action, we've got to think seriously about a medical approach, more seriously about how we can change things for the better. I don't think you're ever going to stop it. I really don't think that humankind will ever stop other humans getting substances such as these terrible drugs if they want them and need them. They'll find a way.

Damien Carrick: *So are you saying that it is a public health issue, and if you want to fight it, then maintain the ban, but pump big money into public health.*

Don Stewart: *Indeed. Big money. And it's a dangerous game that people are playing. What I'm suggesting, there has to be megabucks put into research on how to do things and do things better than we are.*

> Don Stewart has been a police officer, barrister, judge, royal commissioner and was the founding chairman of the National Crime Authority. (The Law Report, Radio National, ABC radio, Tuesday 13 March)
>
> http://www.abc.net.au/rn/lawreport/stories/2007/1867862.htm#transcript

(1) Deaths:

In Australia in 1998 there were an estimated 19,019 deaths attributed to tobacco, 3,271 deaths attributed to alcohol and 1,023 deaths attributed to illicit drugs. Thus of the 23,313 drug-related deaths, 81.6% were due to tobacco, 14% to alcohol and only 4.4% to illicit drugs. (English et al, 1995) Of the 161,615 estimated years of life expectancy lost to drugs, 88,266 (54.6%) were attributed to tobacco, 55,450 years (34.3%) to alcohol and 17,899 (11.1%) to illicit drugs. (English et al, 1995)

Although deaths are not the only important measure of damage to health from drugs or other causes, they are undeniably important. It may make good political sense to confine a parliamentary enquiry to illicit drugs. But it does not make good sense from a policy or health perspective to exclude the drugs responsible for 95.6% of drug-related deaths and 88.9% of drug-related years of lost life expectancy. It was made clear as long ago as the 1977 Senate enquiry ("'Drug Problems in Australia - An Intoxicated Society?") that any serious inquiry into psychoactive drugs in Australia must include consideration of tobacco, alcohol, prescription and illicit drugs.

(2) Disease:

Hospital bed-days are regarded as one of the best readily-available proxies for disease (morbidity). In Australia in 1995, there were an estimated 812,866 hospital bed-days attributed to tobacco-related diseases, 731,169 hospital bed-days attributed to alcohol-related diseases and 40,522 hospital bed-days

attributed to illicit drugs-related diseases. Thus of the 1,584,557 drug-related hospital bed-days, 51.3% were due to tobacco, 46.1% to alcohol and only 2.6% were attributed to illicit drugs. (English et al, 1995)

Disability Adjusted Life Years (DALYS) is a measure of the total health burden of a disease or injury. In Australia in 1996, tobacco accounted for 9.7% of total DALYs with alcohol responsible for 4.9% and illicit drugs for 1.8%. (Mathers et al, 2000)

Again, it may make good political sense to confine a parliamentary enquiry to illicit drugs. But it does not make good sense from either a policy or health perspective to exclude the psychoactive drugs responsible for 97.4% of drug-related hospital bed-days and 98.2% of DALYS.

For many decades now, most individuals presenting to clinical services requesting assistance for problems relating to psychoactive drugs in Australia have been taking combinations of these drug groups. Why then exclude legal drugs from this inquiry when much of the health damage occurring to people who use illegal drugs is from excessive use of legal drugs?

Drugs that are legal in some parts of the world are illegal in other parts of the world. Also, drug prohibitions come and go over time. Alcohol has been a prohibited substance in many countries including the USA (1920-1933) but has now been a legal drug in the USA for 74 years. Heroin was a legal drug in Australia until production and importation was prohibited in 1953. Before 1953, and after 1953 until stocks ran out, heroin could still be lawfully prescribed and dispensed in Australia. The decision to prohibit heroin in Australia resulted from external pressure and was severely criticised publicly at the time by the then Director General of the Commonwealth Department of Health, the Presidents of several medical Colleges and the then British Medical Association (before this organisation became the Australian Medical Association). The arbitrariness of the international decision to ban cannabis in 1924 has been documented recently (Kendell, 2003). Cannabis prohibition in this country was first considered after Australia attended an international meeting in Geneva in 1924-25. Cannabis prohibition was then introduced in Australia by the states and territories at different times over the following decades.

The arbitrariness of the international separation of legal and illegal drugs has been criticised by Mr G. Giacomelli, Executive Director of the United Nations International Drug Control Programme, who noted that [it was]

> *"increasingly difficult to justify the continued distinction among substances solely on their legal status and social acceptability. Insofar as nicotine-addiction, alcoholism, and the abuse of solvents and inhalants may represent greater threats to health than the abuse of some substances presently under the international control, pragmatism would lead to the conclusion that pursuing disparate strategies to minimize their impact is ultimately artificial, irrational and*

uneconomical." (Thirty Seventh Session of the Commission of Narcotic Drugs, Vienna, 13 April, 1994)

(3) Economic cost:

In Australia in 1988/89, the social cost to the economy from psychoactive drugs was estimated to be $34.7 billions with $21. 1 billion attributed to tobacco, $7.6 billion attributed to alcohol and $6.1 billion attributed to illicit drugs. Thus of the all drug-related costs to the economy, 61.2% were attributed to tobacco, 22% to alcohol and 17.6% to illicit drugs. (Collins and Lapsley, 2002) It may make good political sense to confine a parliamentary inquiry to illicit drugs. But it does not make good sense from a policy or economics perspective to exclude the drugs responsible for 82.4% of the cost of psychoactive drugs to the Australian economy.

(4) Social costs:

Social costs are much more difficult to quantify than health or economic costs. The social costs of illicit drugs probably exceed those resulting from tobacco but are dwarfed by those due to alcohol (Crofts, 2007) which include:

- 175 alcohol hospital admissions per day annually
- 2,500 Australians diagnosed with alcohol-related brain damage
- In last 12 months Australians consumed $23 billion worth of alcohol
- alcohol was implicated in approximately 50 percent of domestic and sexual assaults and is a major cause of imprisonment.
- 61% of Australians surveyed in 2006 by Roy Morgan Research were unaware of the link between alcohol and cancer.

(5) Drug induced psychoses and other mental disorders:

Drug induced psychoses and other mental disorders attributed to illicit drugs are a considerable problem in Australia. Amphetamine-related psychoses in Australia increased 58.2 % from 1,028 in 1999/2000 to 1,626 in 2003/04 (Australian Institute of Health and Welfare). Although possibly levelling off in recent years, there is general agreement that amphetamine consumption increased in Australia following the onset of the heroin shortage in 2000/01. Amphetamine-related problems such as psychoses and crime have continued to increase substantially, possibly due to the increasing purity of street methamphetamine or the increasing use of more rapidly absorbed forms of methamphetamine.

Although supporters of the War Against Drugs often inflate the case that cannabis causes severe drug-induced psychoses and other mental disorders, objective observers are generally somewhat sceptical of these claims. Some reputable clinicians and researchers have quite different viewpoints on the relationship between cannabis use and psychosis. There is little support for the proposition that cannabis causes schizophrenia *de novo* but more support for the proposition that cannabis exacerbates existing schizophrenia. Even if the extreme interpretations of the relationship between cannabis and mental

health problems are accepted, War Against Drugs supporters have failed to demonstrate that cannabis distributed by criminals and corrupt police - as happens inevitably under strict cannabis prohibition – is less damaging overall than regulated provision of cannabis. Taxed and regulated provision of cannabis could:

- broaden the base and lower the rate of general taxation revenue
- generate a new revenue stream for government enabling generous funding for the prevention and treatment of alcohol and drug problems
- enable mandatory warning labels to be required for all cannabis packages e.g. 'Medical authorities warn that smoking cannabis may cause severe mental health problems including schizophrenia'.
- ensure that the concentration of the most active constituent of cannabis (THC) remains within a narrow band
- enable mandatory help seeking labels to be required on all cannabis packages e.g. 'If you want to stop smoking cannabis now, ring 24 x 7 the national cannabis help line (02) 6277 4382'.
- enable proof-of-age cards to be required thereby dramatically reducing sales of cannabis to persons under the age of, say, 18 years of age.
- reduce cannabis sales to other vulnerable groups, e.g. pregnant women.

Under current arrangements (cannabis prohibition):

- the annual turnover of cannabis industry in Australia is now $5 billion, twice the financial size of the wine industry (Clements, 2004)
- cannabis is zero rated for taxation purposes in Australia
- cannabis is currently regulated by rich criminals and corrupt police
- mandatory warning labels on cannabis packages do not exist and cannot be introduced
- the THC concentration of cannabis is alleged to vary greatly and have increased over time
- mandatory help seeking labels do not exist and cannot be introduced
- proof-of-age cards do not exist and cannot be introduced
- restriction of cannabis sales to vulnerable groups, e.g. young people, pregnant women, is not possible and cannot be introduced.

Drug induced psychoses and other mental disorders attributed to the legal drug, alcohol, are also a considerable problem in Australia. But they have been excluded from this inquiry. This may make political sense but does not make sense in terms of general or health policy. The alcohol beverage industry and the tobacco industry provide generous donations to the major political parties (The ALP declined donations from the tobacco industry in 2004). In the face of such a strong public policy case to include all drug groups, the decision to exclude legal drugs inevitably invites speculation that these donations have been for more than philanthropic purposes.

In 2005, the Nobel prize winning economist Milton Friedman joined 500 other leading US Economists in calling for a 'Marijuana Regulation Debate' and

supporting a report estimating $10-14 US Billion Annual Savings and Revenues from cannabis regulation in the USA.

http://www.prohibitioncosts.org/

The full report (Jeffrey A. Miron, The Budgetary Implications of Marijuana Prohibition. 2005) by Miron, a Visiting Professor of Economics at Harvard University, is available at:

http://www.prohibitioncosts.org/MironReport.pdf

(6) The impact of harm minimisation programs on families

6.1The history of harm minimisation in Australia:

All eight Australian governments adopted harm minimisation as the official national drug policy on 2 April 1985. Apart from the five ALP governments in April 1985, there was also a Bjelke-Petersen National government in Queensland, a Gray Liberal government in Tasmania and a Tuxworth Liberal-Country government in the Northern Territory. Harm minimisation continued to receive bi-partisan support at the Federal level for the next 14 years. It is still Australia's official national drug policy. Australia's national drug strategy has been reviewed by independent experts every few years since harm minimization was adopted. On each occasion, the reviewers have recommended the retention of harm minimization as Australia's national drug policy and this recommendation has been accepted by the Ministerial Council on Drug Strategy (MCDS) – the nation's paramount drug policy making body. Harm minimisation has also been accepted by every conservative state and territory government since 1985. (This has not been as apparent in recent years as conservative parties have not formed government in any state or territory in Australia since 2002).

Although some politicians (including some Ministers and the Prime Minister) try to create the impression that harm minimisation is no longer Australia's national drug policy, this is incorrect. The web site of the National Drug Strategy hosts the official communiqués from MCDS meetings. These communiqués generally begin:

"The Ministerial Council on Drug Strategy (MCDS), the peak national policy and decision-making body for licit and illicit drugs ..."

The communiqué from the May 20 2004 meeting of MCDS noted:

"Ministers endorsed the new National Drug Strategy 2004-2009 that will take effect from 1 July 2004. The Strategy builds on the achievements and successes of its predecessor the National Drug Strategic Framework 1998-99 to 2003-04. It reflects the key elements such as the objectives, priorities and supporting advisory structures, which were endorsed by the Ministerial Council on Drug Strategy in November 2003".

"While Ministers endorsed harm minimisation as the Australian approach, they also stressed that harm minimisation does not condone drug use. They emphasised the importance of defining that harm minimisation encompasses supply reduction strategies, demand reduction strategies and harm reduction strategies."

http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/mcds-20maycommunique

From this it can be concluded that:

1 Licit drugs should be included in any serious inquiry about drugs as they are not excluded by MCDS, the paramount drug policy making body in Australia.

2 Harm minimisation remains Australia's official national drug policy.

If Australia cuts and runs from harm reduction, then we can brace ourselves for HIV infections among and from injecting drug users to start rising as needle syringe programmes and methadone treatment would have to be closed. Methadone also helps to reduce crime and drug overdose deaths, so crime and overdose deaths would increase. Nicotine gums and patches would disappear, so smokers would find it harder to quit. Expect lung cancer and other tobacco related problems to start rising. After compulsory car safety belts are banned, road crash deaths and severe injuries would soar. Are these the outcomes that voting Australians want?

Harm reduction critics, such as Drug Free Australia, falsely claim that harm reduction is opposed to treatments which promote abstinence. This is simply untrue. Harm reduction supporters consider abstinence promoting treatments as one of the diverse choices which should be available for people seeking help because their drug use is out of control. Abstinence has the attraction that it can be considered, in some respects, the ultimate form of harm reduction. However, the excessive consumption of all forms of legal and illegal drugs is often bedevilled by the problem of relapse. Relapse occurring after a period of abstinence often results in the most damaging adverse consequences as there is no cushion of drug tolerance to ameliorate the harms.

War Against Drugs advocates also falsely claim that harm reduction and drug education are mutually exclusive options. This is also not true. Harm reduction advocates support drug education which is truthful, involves the target audience in design and implementation, and is based on scientific evidence of what types of drug education work and what types do not work. Populist, simplistic, fear arousing drug education may have its supporters who make extravagant claims for its effectiveness. But rigorous evaluation of this style of drug education shows that it is ineffective.

Responses of the public to community opinion surveys depend largely on the way the questions were asked. Accordingly, some polls indicate opposition to harm reduction while most polls indicate majority support for pragmatic, evidence-based approaches. There is no getting around the fact that

throughout history, psychoactive drug use has been common in virtually all cultures. Attempts to prohibit drug use have generally failed. Prohibition can work if there is little demand for the banned drugs, if it is difficult to produce or smuggle this drug and provided that the (inevitable) replacement drug is less dangerous than the prohibited drug.

6.2 Harm minimisation in Australia today: walking both sides of the street?

The Howard government has provided $10 million annually to state and territory governments since 1999 to enhance their needle syringe programmes. It has also generously supported and funded harm reduction in Asia to reduce the spread of HIV among injecting drug users in our region. In the last two decades, Australia has remained one of the most vigorous defenders of harm reduction at UN forums in Vienna, Geneva and New York. The strong advocacy for harm minimisation by Australia in international forums has continued uninterrupted during the last 11 years. The Howard government has also generously funded measures to divert selected drug using offenders from expensive and ineffective criminal justice punishments to less expensive and far more effective drug treatment. These are all harm reduction policies that the community should thoroughly commend. Yet they are irreconcilable with the Howard government's public position of support for zero tolerance and opposition to harm reduction. The approach of saying one thing in public and discretely implementing an opposite policy in practice is sometimes called 'walking both sides of the street' or 'having a bob each way'.

Despite its strong private support for harm minimization, the Commonwealth Government has publicly supported a War Against Drugs approach since 1997. The War Against Drugs is marketed in Australia under a 'Tough on Drugs' label. Perhaps this is because focus groups disliked the 'War Against Drugs' label.

The temptation for politicians to resort to the quick fix of zero tolerance unfortunately spans the political spectrum. On June 14, 2006, in an aside in Parliament , the (then) Opposition leader, Mr Kim Beazley said to Federal minister for health, Mr. Tony Abbott, "You're soft on drugs, Tony, you give free needles to heroin addicts." Similar comments can be found on both sides of politics in Australia today. For example, the Prime Minister said in 2002 that "the path to success does not lie in giving in to the drug barons; it does not lie in giving in to the harm minimisation philosophy." (Hansard, Thursday, December 12, 2002, The Hon John Howard MP). Support and criticism of harm minimisation today is a division within, rather than between, the major political parties in Australia.

It is worth noting that the first support for needle syringe programmes in the United Kingdom in the mid 1980s came from the Monday Club, a conservative group within the Conservative Party. The Monday Club persuaded the then Prime Minister (Mrs. Margaret Thatcher) to introduce a national needle syringe programmes to prevent HIV spread among injecting drug users. Mrs Thatchers' Home Secretary, Mr Michael Howard, famously said that 'prisons

are an expensive way of making bad people worse'. Fiscal conservatives who favour a 'low taxing –small government-improved outcomes' approach support a more business like, return-on-investment, evidence-based approach to drug policy. On the other hand, War Against Drugs supporters emphasise the sending of messages rather than the reduction of deaths, disease, crime and corruption. Inevitably, this involves a high taxing-big government approach.

6.3 Practical drug policies or gesture politics?

In contrast to the situation in Australia, the government of the USA has consistently rejected harm reduction. The USA, with 14.7 new AIDS cases per 100,000 in 2003, has by far the highest rate of AIDS in the developed world. The US rate is now more than 12 times higher than in Australia which had 1.2 new AIDS cases per 100,000 in 2003. More than a third of new AIDS cases in the USA are injecting drug users. The USA, with a population of 300 million, provides only 25 million sterile needles and syringes a year to reduce the spread of HIV while Australia, with a population of 20 million, provides 32 million sterile needles and syringes a year. Practical drug policy has kept HIV under control in Australia while gesture politics has increased HIV spread in the USA.

A study commissioned by the Commonwealth Department of Health in Australia (Return on Investment in Needle and Syringe Programs In Australia. Health Outcomes International Pty Ltd in Association with the National Centre for HIV Epidemiology and Clinical Research and Professor Michael Drummond, Centre of Health Economics, York University for the Australian Government Department of Health and Ageing, October 2002) estimated that by 2000 needle syringe programs cost Australia's governments $130 million but prevented 25,000 HIV and 21,000 hepatitis C infections and by 2010 will have prevented 4500 AIDS deaths and 90 deaths from hepatitis C. Needle syringe programmes saved Australian governments at least $ 2.4 billion allowing for a 5 per cent annual discount for future benefits (as is conventional in government accounting). If this discount is not deducted, the savings were estimated to be as much as $ 7.7 billion. This major evaluation was based on a study of data from 103 cities around the world. Cities with needle syringe programmes had an average annual 18.6 per cent decrease in HIV, compared with an average annual 8.1 per cent increase in HIV in cities without such programs.
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-metadata-roireport.htm

This report was launched by Major Brian Watters, then Chair of the Australian National Council on AIDS. Although for many years a severe critic of needle syringe programmes, Major Watters now supports needle syringe programmes and advocates for their introduction in prisons. Opposition to needle syringe programmes in this country is tantamount to arguing that HIV is the epidemic that Australia has to have. Is that a responsible position? The problem here is that bad policy can be good politics.

Tobacco is responsible for the deaths of approximately 19,000 Australians every year. It is hard to understand why a political party claiming to be 'Tough on Drugs' still accepts generous donations of millions of dollars every year from the tobacco industry if tobacco is responsible for about 20 times more deaths than illicit drugs. The ALP continued to accept generous donations every year from the tobacco industry until 2004 when it announced that these donations would no longer be considered acceptable.

6.4 International support for harm reduction

International support has grown steadily for harm reduction. International supporters now include the World Health Organisation (WHO), the European Region of WHO, the Eastern Mediterranean Region (EMRO) of WHO, UNAIDS, UNICEF, the World Bank and the International Red Cross, the Red Crescent Federation. Explicit national supporters include Australia, New Zealand, France, Brazil, Canada, Vietnam, Taiwan, Afghanistan and Morocco. All 25 members of the European Union now have needle syringe programmes and provide methadone maintenance treatment. All major countries in Asia now support harm reduction.

Leaders of UN organizations with responsibility for drug policy have been increasingly explicit about their growing support for harm reduction. Dr. Gro Harlem Brundtland, former Prime Minister of Norway and then Director-General, World Health Organization noted in 2000 that "the key to limiting the spread of HIV lies in harm reduction among intravenous drug users. In other words, efforts to stem the spread of drug use must contain an acceptance of the need to provide needles and condoms to those who already are addicted to these drugs". (Moscow, 2 November 2000, Address to the Russian Academy of Medical Science).

However, this was not a new position for WHO. Support for harm reduction can be found in many WHO documents and reports from decades earlier. The WHO Expert Committee Drug Dependence 1974 supported 'concern for preventing and reducing problems rather than just drug use.' Again in 1993, the WHO Expert Committee on Drug Dependence concluded that the "primary goal of national policies should be to minimize the harm associated with the use of alcohol, tobacco, and other psychoactive drugs ... for maximum effectiveness, national policies should be oriented to explicitly defined 'harm minimization goals." (Twenty-eighth Report, Geneva, WHO Technical report Series No. 836, 1993).

The United Nations Office on Drugs and Crime (UNODC) is still divided on the question of harm reduction but within the organization support is growing and opposition declining.

National and international opposition to harm reduction is shrinking. The International Narcotics Control Board (INCB) is the last remaining member of the UN family with some responsibility for drug policy to still remain opposed to harm reduction. The most important national opponent of harm reduction remains the USA. Other countries critical of harm reduction include Saudi

Arabia and Russia. Sweden, for long one of the most vociferous critics of harm reduction, is now divided on harm reduction. Sweden is now increasing methadone treatment and needle syringe programmes. Japan has stopped opposing harm reduction in Asia. in June 2005, the Programme Coordinating Board meeting of UNAIDS to decide the organization's policy on HIV prevention voted 21: 1 to retain support for and cite terms such as 'harm reduction', 'needle syringe programmes' and 'methadone maintenance treatment'. The only country in opposition was the USA. The US Office of National Drug Control Policy still commented on 28 July 2006 that

> *'Proponents (of harm reduction) contend harm should be reduced by needle exchange, 'safe' injection facilities, decriminalisation or legalisation of drugs, heroin maintenance, and other measures. Such measures are acquiescence: attempts to manage consequences of drug abuse rather than addressing the problem directly.'*

Harm reduction has a much longer history than generally realised. As long ago as 1926, an influential UK report by Sir Humphrey Rolleston, then President of the Royal College of Physicians and a pillar of the establishment, argued that 'indefinite administration of morphine or heroin would be permitted for those in whom a complete withdrawal ... produces serious symptoms that cannot be treated satisfactorily under ordinary conditions of practice' and for those who are 'capable of leading a fairly normal and useful life so long as they take a certain quantity, usually small, of their drug of addiction but not otherwise'. (Rolleston Report, Ministry of Health, Departmental Committee on Morphine and Heroin Addiction, HMSO, 1926). Consequently, severely dependent, treatment-refractory heroin users could be treated thereafter with heroin prescription. This is still the case. The United Kingdom is now expanding the availability of heroin prescription.

6.5 Scientific support for harm reduction

The scientific debate about harm reduction is now well and truly over. This has been the case for more than a decade. Seven evaluations of needle syringe programmes carried out by or on behalf of US government agencies (National Commission on AIDS, 1991; Centres for Disease Control and Prevention, 1993; General Accounting Office, 1994; Office of Technology Assessment of the US Congress, 1995; National Institutes of Health Consensus Panel, 1997; Satcher, D, Surgeon General US Dept of Health & Human Sciences, 2001; Institute of Medicine of the National Academy of Science, 2001) have concluded that this intervention is effective is reducing HIV among injecting drug users, is safe (i.e. does not increase initiation, frequency or the duration of injecting drug use or have other serious side effects) and is cost effective. An international review commissioned by WHO came to the same conclusions (Wodak, Cooney, 2004). These finding were endorsed by a recent US Institute of Medicine report (Preventing HIV Infection among Injecting Drug Users in High Risk Countries: An Assessment of the Evidence. Committee on the Prevention of HIV Infection among Injecting Drug Users in High-Risk Countries. National Academies Press. 2006).

As Ms D. Shalala, US Secretary, Health and Human Services noted:

> *'A meticulous scientific review has now proven that needle-exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs'* (Research shows needle exchange programs reduce HIV infection without increasing drug use [press release] Washington, April 20, 1998).

Scientific support for methadone and buprenorphine maintenance treatment is now also extremely strong. Methadone maintenance treatment, the most frequently evaluated intervention in all of medicine, has been endorsed by WHO, UNAIDS and UNODC. In 2005, methadone and buprenorphine were added to the WHO Essential Drugs List.

Scientific supporters of harm reduction include the most senior and experienced ranks of clinicians and researchers in the alcohol and drug field. In contrast, the few and diminishing number of critics of harm reduction are generally clinicians and researchers of little standing in the alcohol and drug field. For example, a search using Google Scholar of speakers (Torgny Peterson, Trevor Grice, Kerstin Kall, Brian Watters, Frans Koopmans, David G. Evans, Jay R. Bacik), at a forthcoming conference Convened by Drug Free Australia ('Exposing the Reality: a National and International Perspective on Illicit Drug Use' April 27-29th 2007) found only one scientific paper published in a reputable journal by any of these speakers.

6.6 Political, legal and academic opinions regarding the effectiveness of drug prohibition

Although it is often assumed that the political expression of realistic assessment of drug policy are virtually suicidal, there are numerous national and international examples of senior politicians acknowledging the relative in-effectiveness, high cost and often counter-productive effects of supply control. In 1989, the Parliamentary Joint Committee on the National Crime Authority concluded that

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

In 1997, NSW Royal Commissioner Justice James Wood came to the same conclusion noting that 'It is fanciful to think that drug addicts can be prevented from obtaining and using prohibited drugs'.

In 2000, the Police Foundation of the United Kingdom concluded that

> *'the present law on cannabis produces more harm than it prevents. It is very expensive of the time and resources of the criminal justice system and especially of the police. It inevitably bears more heavily on young people in the streets of inner cities, who are also more likely to be from minority ethnic communities, and as such is inimical to police-community relations. It criminalises large numbers of otherwise law-abiding, mainly young, people to the detriment of their futures. It has become a proxy for the control of public order; and it inhibits accurate education about the relative risks of different drugs including the risks of cannabis itself. Weighing these costs against the harms of cannabis, we are convinced that a better balance is needed and would be achieved if our recommendations were implemented.* (Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act of 1971).

The Foundation added

> *'There can be no doubt that, in implementing the law, the present concentration on cannabis weakens respect for the law. We have encountered a wide sense of unease, indeed scepticism, about the present control regime in relation to cannabis. It inhibits accurate education about the relative risks of different drugs including the risks of cannabis itself. It gives large numbers of otherwise law-abiding people a criminal record. It inordinately penalises and marginalises young people for what might be little more than youthful experimentation. It bears most heavily on young people in the streets of inner cities who are also more likely to be poor and members of minority ethnic communities. The evidence strongly indicates that the current law and its operation creates more harm than the drug itself. ...We see our recommendations as the first steps of an incremental process. The aims of this process are to achieve less coercive but more effective ways of reducing the harms of cannabis, and to bring those harms and the harms of the law into a better balance.'*

A major UK parliamentary report concluded in 2002 that

> *"There are no easy answers to the problems posed by drug abuse, but it seems to us that certain trends are unmistakable. If there is any single lesson from the experience of the last 30 years, it is that policies based wholly or mainly on enforcement are destined to fail. It remains an unhappy fact that the best efforts of police and Customs have had little, if any, impact on the availability of illegal drugs and this is reflected in the prices on the street which are as low as they have ever been. The best that can be said, and the evidence for this is shaky, is that we have succeeded in containing the problem".* (The Government's Drug Policy: Is It Working? Chairperson, House of Commons Home Affairs Select Committee, United Kingdom. May 2002.)

The Committee also commented that:

"many sensible and thoughtful people have argued that we should go a step further and embrace legalisation and regulation of all or most presently illegal drugs. We acknowledge there are some attractive arguments. However, those who urge this course upon us are inviting us to take a step into the unknown. To tread where no other society has yet trod... It may well be that in years to come a future generation will take a different view. Drug policy should not be set in stone. It will evolve like any other."

Mr C. Mullin MP, Chairperson, of the Committee, commented in 2002 "attempts to combat illegal drugs by means of law enforcement have proved so manifestly unsuccessful that it is difficult to argue for the status quo".

One of the most remarkable recent reports on illicit drugs was a confidential report produced by the Strategy Unit Drugs Project in 2003 for the UK Cabinet (leaked by The Guardian in 2005). Some highlights:

- *[Illicit drug] 'Production: Interventions to reduce production are complex, time-consuming and expensive to achieve. They often result in displacement of production elsewhere'* (p 56)

- *'Trafficking: Traffickers have adapted effectively to government interventions. They run highly profitable businesses and can withstand temporary shocks to their profitability. Interventions have been short-lived or have had a negligible impact on the retail market'.* (p 56)

- *'Impact of intervention: Even if supply interventions did not successfully increase price, the evidence is not sufficiently strong to prove that this would reduce harm'.* (p 56)

- *'Western influence in production areas is limited because a drugs economy thrives where the rule of law has failed, or where international norms have been breached.'* (p.60)

- *'Price mark ups for shipping across a border: coffee 18%; heroin 360%; cocaine 1,000%'.* (p 66)

- *'Modelled profits per kg for a major Afghan trafficker: 26% to 58%. Comparable private sector profit margins: Exxon 8%; P&G 7%; Gucci 30%; LVMH 48%'.* (p 69)

- *'A sustained seizure rate of over 60% is required to put a successful trafficker out of business – anecdotal evidence suggests that seizure rates as high as 80% may be needed in some cases. Sustained successful interventions on this scale have never been achieved'.* (p 73).

- *'The entire estimated UK supply of heroin and cocaine could be transported into the country in five standard-sized shipping containers'.* (p 79).

- *'The long-term decline in the real price of drugs, against a backdrop of rising consumption, indicates that an ample supply of heroin and cocaine has been reaching the UK market'.* (p 80)

- *'Despite seizures, real prices for heroin and cocaine in the UK have halved over the last ten years'.* (p 91).

- *'Conclusions on the drugs supply market: over the past 10-15 years, despite interventions at every point in the supply chain, cocaine and heroin consumption have been rising, prices falling and drugs have continued to reach users. Government interventions against the drug business are a cost of doing business, rather than a substantive threat to the industry's viability. However, by increasing risk, government interventions are likely to have slowed the decline in prices'.* (p 94)

- *'However, the cause of the [Australian heroin] drought is unclear*
  –the Australian government argued that law enforcement played a key role
  –but there were also severe droughts at the same time in source countries
  –and the drought may have been due to marketing by Asian crime syndicates to promote methamphetamines.' (p 97)

- *'There is no evidence to suggest that law enforcement can create such droughts.'* (p.102)

- *'It is possible, therefore, that price increases may even increase overall harm, as determined users commit more crime to fund their habit and more than offset the reduction in crime from lapsed users. But it is also plausible that sustained price rises, at a far higher level than has hitherto been achieved – could have a significant long-term effect as users either face difficulties in increasing criminal income to fund consumption and become incarcerated, or seek treatment'.* (p 99).

- *'The supply side outcomes that are most likely to reduce some harms, tend to be those that are hardest to achieve. Higher prices increase some harms, reduce others'.* (p 102).

- *'The drugs supply market is highly sophisticated, and attempts to intervene have not resulted in sustainable disruption to the market at any level. As a result:*
  -the supply of drugs has increased
  -prices are low enough not to deter initiation
  -but prices are high enough to cause heavy users to commit high levels of crime to fund their habits'. (p 104).

- *'Over the past 10-15 years, despite interventions at every point in the supply chain, cocaine and heroin consumption has been rising, prices falling and drugs have continued to reach users. Government interventions against the drug business are a cost of business, rather than a substantive threat to the industry's viability.'* (p.94)

- *'The use of high harm causing drugs has risen dramatically over the last 30 years.'* (p.38)

- *'Drug use is responsible for the great majority of some types of crime, such as shoplifting and burglary' (including 85 per cent of shoplifting, 70-80 per cent of burglaries, 54 per cent of robberies).* (p.25)

- *'The high profitability of the drugs business is derived from a premium for taking on risk, as well as from the willingness of drug users to pay high prices.'* (p.66)

- *[but even if they could...] 'price increases may even increase overall harm, as determined users commit more crime to fund their habit and more than offset the reduction in crime from lapsed users.'* (p.99)

- *"The drugs supply market is highly sophisticated, and attempts to intervene have not resulted in sustainable disruption to the market at any level."* (p.104)

Strategy Unit Drugs Project. London. Cabinet Office's Strategy Unit, 1-105, July 1, Whitehall, London. 2003.

http://image.guardian.co.uk/sys-files/Guardian/documents/2005/07/05/Report.pdf

Similarly realistic sentiments have been expressed on the other side of the Atlantic by some unlikely commentators. Former US Secretary of State George P. Shultz told an audience at a Stanford Business School alumni gathering on October 7, 1989:

> *"It seems to me we're not really going to get anywhere until we can take the criminality out of the drug business and the incentives for criminality out of it. Frankly, the only way I can think of to accomplish this is to make it possible for addicts to buy drugs at some regulated place at a price that approximates their cost... We need at least to consider and examine forms of controlled legalization of drugs... No politician wants to say what I have just said, not for a minute."*

At his confirmation hearings, Secretary of Defense-designate Donald H. Rumsfeld said that

'the nation's drug problem can best be attacked by drying up demand rather than targeting foreign traffickers' arguing that illicit drug use is "overwhelmingly a demand problem."

Rumsfeld added that

"If demand persists, it's going to find ways to get what it wants. And if it isn't from Colombia, it's going to be from someplace else." (Los Angeles Times, 22 January, 2001).

Even President Bush is on record with some astonishingly frank admissions about the relative ineffectiveness of supply control. Bush noted that "as long as there is a demand for drugs in this country, some crook is gonna figure out how to get 'em here." (12 February, 2002). At a meeting with the then President of Mexico, Vicente Fox, in February 2001, President Bush conceded

"One of the reasons why drugs are shipped—the main reason why drugs are shipped through Mexico to the United States is because United States citizens use drugs. And our nation must do a better job of educating our citizenry about the dangers and evils of drug use."

The most influential economist of the last half century was the Nobel Laureate Milton Friedman, for decades an avid critic of drug prohibition. Friedman asked:

"Who would believe that a democratic government would pursue for eight decades a failed policy that produced tens of millions of victims and trillions of dollars of illicit profits for drug dealers; cost taxpayers hundreds of billions of dollars; increased crime and destroyed inner cities; fostered wide-spread corruption and violations of human rights - and all with no success in achieving the stated and unattainable objective of a drug-free America."

Noting that 'Most of the harm that comes from drugs is because they are illegal' Friedman added:

"Moreover, if even a small fraction of the money we now spend on trying to enforce drug prohibition were devoted to treatment and rehabilitation, in an atmosphere of compassion not punishment, the reduction in drug usage and in the harm done to the users could be dramatic."

Friedman also argued that:

"So long as large sums of money are involved-and they are bound to be if drugs are illegal-it is literally hopeless to expect to end the traffic or even to reduce seriously its scope. In drugs, as in other areas, persuasion and example are likely to be far more effective than the use of force to shape others in our image."

Many other leading US conservatives, such as William F Buckley (and the late Barry Goldwater), strongly support drug law reform. Some support drug law reform for fiscal reasons (low taxes, small government), others for libertarian reasons. This is also reflected in the strong and growing support for drug law reform among conservative US think tanks such as the Cato Institute (of which Mr. Rupert Murdoch was a long time Member of the Board). The influential weekly publication, 'The Economist', has strongly advocated for realistic and pragmatic drug law reform for decades. The conservative Institute of Public Affairs in Australia published a commentary in 2001 arguing the case for drug law reform (Hyde, John. 'Drugs: Time for a Rethink'. Volume 53, Number 3, September, pp 10-11) which concluded that 'the legal provision of highly addictive drugs is risky. But so too is the refusal to consider carefully the arguments in its favour'.

David Boyum and Peter Reuter concluded in a report published by the influential and conservative American Enterprise Institute for Public Policy Research in 2005

> *"There is strikingly little evidence that tougher law enforcement can materially reduce drug use. By contrast, drug treatment services remain in short supply, even though research indicates that treatment expenditures easily pay for themselves in terms of reduced crime and improved productivity."*
> (Boyum D, Reuter P. An Analytic Assessment of U.S. Drug Policy American Enterprise Institute. 2005).

http://www.aei.org/books/bookID.812,filter.all/book_detail.asp

At the opposite end of the political spectrum, Mr Ira Glasser, then President of the ACLU noted that:

> *"Criminal prohibition is profoundly wrong in principle, generally ineffective in practice, and has created problems that the drugs themselves were powerless to create.... The state has no legitimate power to send me to prison for eating too much red meat or fat-laden ice cream ... even if an excess of red meat and ice cream demonstrably leads to premature heart attacks and strokes.... Obesity and compulsive eating disorders ... are not a justification to put people in jail, to search them for possession of forbidden foods, or to seize their property when they are caught with such foods. Even more certainly, the self-abuse of compulsive overeating by some cannot possibly justify punishing others for eating the same foods, but in moderation and without apparent ill effects..... Similarly, excessive and compulsive consumption of alcohol or tobacco does not justify imprisonment, police searches or seizures of property.... Why we do it with other substances, like, for example, marijuana ... is the key question this nation needs to begin openly and fairly debating."*

6.7 Opinions of UN drug organisations

The impression is often created that the international drug regulatory system is totally inflexible. Yet the 1997 UNDCP World Drug Report stated:

> *"...[none of the] three international drug Conventions insist on the establishment of drug consumption per se as a punishable offense. Only the 1988 Convention clearly requires parties to establish as criminal offenses under law the possession, purchase or cultivation of controlled drugs for the purpose of non-medical, personal consumption, unless to do so would be contrary to the constitutional principles and basic concepts of their legal systems."* (World Drug Report, New York: Oxford University Press, 1997: p 185).

The same report was also surprisingly frank about the growing case for drug law reform:

> *'In recent years there has been increasing criticism that the resources poured into the 'war against drugs' have been badly spent; and that the international drug control regime, instead of contributing to the health and welfare of nations, may have aggravated the situation. ... Amidst perceptions of an impasse in the drug policy field, numerous pressure groups have emerged, calling for changes to international drug control through the relaxation of prohibition - for example, through modifications of the existing drug control Conventions – and through a new emphasis on measures to reduce the harm associated with illicit drug use. Because these groups are eclectic in back ground and include academics, politicians, medical scientists, economists and influential opinion leaders, for the most part, motivated by serious and well founded concerns, they represent a serious challenge to the current philosophy of drug control."* (World Drug Report. UNDCP, Oxford University Press, 1997, pp 184-201).

Emphasising the existence of considerable existing flexibility, the authors noted that:

> *"Laws - and even the International Conventions - are not written in stone; they can be changed when the democratic will of nations so wishes it".* (World Drug Report, The United Nations International Drug Control Programme, Oxford University Press, 1997 p199).

A paper produced under the auspices of the UN International Drug Control Program (UNDCP) concluded that:

> *present levels of enforcement will have little deterrent or preventive impact on drug trafficking to Europe and that the implications of its analysis for increasing the effectiveness of European law enforcement are "not encouraging. The balance of evidence suggests increasing enforcement will impact only marginally upon prices due to rapidly diminishing marginal returns."* (Farrell Graham, Mansur Kashfia & Tullis Melissa, `Cocaine and Heroin in Europe 1983-93: a Cross-National

Comparison of Trafficking and Prices,' British Journal of Criminology, 1996; 36 (2):255-281).

Similarly, analyses conducted by the United Nations Office for Drug Control and Crime Prevention suggest that a maximum of five percent of the global illegal drug flow is seized by law enforcement. (United Nations Office for Drug Control and Crime Prevention. Global Illicit Drug Trends 2001. New York: The Office, 2001).

Even the INCB has felt the need for some occasional expressions of realism noting that 'The ultimate aim of the conventions is to reduce harm'. (Report of the International Narcotics Control Board for 2003. (INCB, 2004) The following year, the INCB commented that

> *"It is all too easy for government action against the drug problem to focus on supply, which is just one element of the problem. While that may produce results, even dramatic results, in the short term, including large seizures of illicit drugs, it does not and cannot have a long-term effect because new sources soon emerge to meet continuing demand."* (Report of the International Narcotic Control Board for 2004. International Narcotic Control Board, 2005. Vienna).

6.8 Alcohol and harm reduction

Harm reduction was an accepted part of community responses to alcohol long before the recognition of AIDS and the close connection between HIV and injecting drug users prompted growing support for more pragmatic approaches. 'Making the world safe for drunks' has been a recognised and accepted part of responsible alcohol policy in many countries for decades. Attempts to reduce harmful and hazardous alcohol consumption continued but were supplemented by efforts to reduce the harms that intoxicated persons do to themselves and others. Car safety belts are an example of harm reduction applied to alcohol. Unfortunately, it is not possible to prevent some drivers from being intoxicated while in charge of a vehicle. Car safety belts reduce deaths and severe injury to intoxicated drivers and their passengers. Although some feared that drivers wearing car safety belts would compensate for their greater safety by driving more recklessly, it is now well accepted that net deaths and severe injury are decreased.

In 1991, a B vitamin (thiamine) was added compulsorily to all flour in Australia to reduce the huge health, social and economic costs of severe alcohol related brain damage. This is another example of harm reduction. Australia used to have one of the highest rates in the world of the Wernicke-Korsakoff syndrome (WKS) - caused by thiamine deficiency. WKS is now only seen very rarely in this country. Would Australian opponents of harm reduction want to ban car safety belts and thiamine fortification of flour?

Nicotine is the addictive ingredient of cigarettes. Nicotine Replacement Therapy (NRT) in the form of gums and patches help smokers to quit. There

is no difference in principle between NRT and methadone maintenance treatment. Would Australian opponents of harm reduction want to ban NRT?

6.9 Heroin trials

The first senior serving politician to publicly support heroin trials in Australia was the then (Liberal) NSW Leader of the Opposition in June 1984 (Mr. N. Greiner). The then (Liberal) ACT Chief Minister (Ms. K. Carnell) was a fervent advocate of a heroin trial in the early 1990s. In August 1997, the Howard Government aborted a rigorous scientific trial of heroin assisted treatment. At the time the ACT heroin trial was aborted, 45% of respondents expressed support, while 47% were opposed in a national opinion poll. (Newspoll and *The Australian*. Heroin trial poll. Available at: <http://newspoll.com.au/cgi-bin/display_poll_data.pl> (accessed 4 April 2002). Since 1997, the results of two large, scrupulous trials of heroin-assisted treatment in the Netherlands and Germany have been reported.

The Dutch trial involved 430 severely dependent heroin users who had not benefited from multiple other treatments. The majority (52%) of those treated with a combination of heroin and methadone improved according to a multi-domain response index (comprising physical health, mental health and social functioning) compared to only 28% of those receiving standard methadone maintenance treatment. After 12 months, those who had received heroin treatment were transferred to standard methadone maintenance treatment and 82% of those who had previously responded well to heroin substantially and progressively deteriorated.

Three countries (the United Kingdom, Switzerland, the Netherlands) now permit heroin assisted treatment to be available as a routine treatment option in selected cases. This is now being debated in Germany after the recent successful national heroin trial. Trials are underway in Canada and Spain. The concern that heroin trials might not be justifiable because worthwhile health or social benefits would not be achieved is now clearly unfounded. Worthwhile benefits include noteworthy physical and mental health improvements, reduced illicit drug use, substantially reduced crime and improved social functioning. Pharmaceutical heroin has not been diverted to the black market. The accusation that heroin trials would lead to more permissive community attitudes to illicit drug use is unsupported by evidence. This treatment can be provided without clinics being inundated by large numbers of inappropriate drug users from neighbouring areas.

In the Swiss trial, the majority (60%) of those who left heroin treatment transferred to other forms of treatments while 22% transferred to abstinence treatment. Previous experience of abstinence treatment was a strong predictor of successful outcome from heroin assisted treatment in the Netherlands. Initiation of heroin assisted treatment in Switzerland coincided with considerable expansion and improvement of a range of drug treatments including methadone maintenance treatment.

Heroin assisted treatment is more expensive than many other forms of drug treatments (but still much less expensive than most drug law enforcement interventions). Evaluation of the Swiss trial found that economic benefits were twice the financial costs of heroin assisted treatment. There is no evidence that heroin assisted treatment undermined drug law enforcement in Switzerland or the Netherlands while an appreciable reduction in crime was reported.

On present evidence, heroin assisted treatment is feasible and safe. There is increasing evidence for effectiveness, especially for treatment refractory, severely heroin dependent persons. The major indication at present is for severely heroin dependent persons for whom multiple attempts at diverse treatments have provided little benefit. Although representing only a small proportion of the heroin using population, this group accounts disproportionately for property crime and recruitment of novice users. Leading Australian researchers concluded in 2001 that "clinical trials are clearly required to ascertain whether heroin maintenance may be an effective and economic treatment modality for heroin dependence in the Australian context" (Warner-Smith M, Lynskey M, Darke S, Hall W. Heroin overdose, prevalence, correlates, consequences and interventions. Australian National Council on Drugs. Woden. 2001. Page 40)

6.10 Entertainment

Although usually credited as one of the most reliable supporters of zero tolerance, even the controversial radio figure, Mr Alan Jones, has expressed serious doubts about the War Against Drugs:

> *"Well it's controversial, whenever it's discussed, this question about drugs, what do you do? One thing's for sure: we seem to have failed on every front. Never has there been such a saturation of such drugs in our society and such abuse of the well-being of our young people and such crime. There was a bloke murdered in Surrey Hills arguably at the centre of a drug ring. Frank Sartor, the Lord Mayor, last night supported the trial of legal heroin for hard core users claiming it could reduce crime.*
>
> *Talking about the medically controlled prescription of drugs for long term users. I never thought would even be giving serious consideration to such a proposal. I have to say we spent billions of dollars on drug education and everything else and we still have an increasing number of kids addicted, dying and the proliferation of drug sellers, people making big money out of drug addition. Is there some way you can eliminate the drug pushers? Would you do that if you sold it to the addict?*
>
> *The Daily Telegraph have [sic] taken a tough stand on this as I have in the past. We've almost been at one and they've always had an excellent view on this, it's just interesting to note their view today. Editorially, they say Mr Sartor is stepping well beyond his brief by*

toying with such an idea . . . but I would have thought there would have been public debate on this. John Howard rejected the heroin trial in the ACT last year . . . I said at the time it was the right thing to do but the stuff still keeps coming in, its quality is questionable, mixed with everything imaginable and it's killing kids and I for one have seen it first hand.

The Daily Telegraph editorial says that nothing has changed and it is absolutely right, in fact it's gotten worse. We've tried everything, do we need to try something different? The Telegraph is right when it says the heroin trade is an insidious cancer within our society that destroys the lives of users and their families. The question is: What is the appropriate answer? I'm not sure the answer is as forthcoming as it once was. I used to think that cracking down on this and arresting people, charging people, jailing people, you were going to win the battle. We are not winning the battle. Do we have to decide to re-deploy the troops? My view is: we might have to". (Transcript of a commentary broadcast on The Allan Jones Show, December 15 1998, Radio 2UE).

6.11 'It's the economy stupid'

According to the United Nations Office on Drugs and Crime (UNODC), the global illicit drug trade has an annual turnover of $ US 322 billion. This represents about 60 % of Australia's GDP and exceeds the combined GDP of more than 88% of the countries in the world. The economic size of the illicit drugs industry in the UK is said to be comparable with British Airways. Not only is size of the illicit drug trade awesome, it is also extremely lucrative. The 2003 confidential research report by the Strategy Unit to the Blair Cabinet, estimated that 26-58% of the turnover of the illicit drug trade was profit. This contrasts with margins of approximately 7-8% in most conventional companies.

In Afghanistan, average wages per day for all provinces (NRVA) in 2005 were: land clearing - 181 (M), 95 (F); opium wage labour – 197 (M), 100 (F); opium harvest – 329 (M), 150 (F); handicraft – 111 (M), 101 (F); unskilled construction 171 (M), 109 (F). Is it any surprise that labourers in one of the poorest countries in the world seek employment in the opium industry? Afghanistan currently produces 92% of the world's heroin.

It is true that agreement on the need to respect powerful market forces is not universal. This notion is not supported by Cuba, North Korea and supporters of the War Against Drugs.

One of the reasons that drugs remains such a topical issue is that the community is doomed to poor results because politicians continue to invest in interventions known to provide a poor return. A major US study found that the savings of cocaine supply-control programs are smaller than the control costs (an estimated 15 cents on the dollar for source-country control, 32 cents on the dollar for interdiction, and 52 cents on the dollar for domestic

enforcement). In contrast, the savings of cocaine treatment programs are larger than the control costs with an estimated reduction in costs of crime and lost productivity of $7.46 for every dollar spent on treatment. Despite the far greater return for investment in treatment of drug users of $7.46, drug treatment received 7% of government expenditure with 93% allocated to drug law enforcement interventions which returned 15, 32 and 52 cents per dollar. (C. Peter Rydell, Susan S Everingham. Controlling Cocaine: Supply Versus Demand Programs. RAND 1994. Prepared for the Office of National Drug Control Policy, United States Army. RAND Drug Policy Research Center).

6.12 The community are ahead of most politicians on drug policy

There is little doubt that the War Against Drugs helped many politicians to get elected in previous decades. But although many politicians are still fearful of the potential political price to be paid for supporting evidence-based policies, there are increasing signs that the community is now far ahead of most politicians. There are many examples from around the world of a majority of voters supporting harm reduction and drug law reform.

In September 1997, harm reduction and retaining the option of heroin assisted treatment was supported by 71% of voters in Switzerland (with majorities in all 26 cantons).

While privately supportive of medically supervised injecting rooms, the Kennett government went to the 1999 polls publicly opposed to their introduction while the Opposition policies included a pledge to establish five injecting centres. Soon after the 1999 election, the Bracks government fought two by-elections in which injecting centres were a critical issue. Although the candidates opposed to injecting centres received lavish financial support, both were defeated.

Opinion polls have been conducted among 300 residents in the Kings Cross Area of Sydney for several years regarding the Medically Supervised Injecting Centre. Overwhelming and majorities have always supported the MSIC. The majorities increased after the centre was opened. The proportion of residents who agreed with the establishment of the MSIC in Kings Cross in the 2005 was 73%, a slight fall from 78% reported in 2002. Majorities have always supported needle syringe programmes and methadone maintenance treatment in Australia.

In Vancouver, Phillip Owen was Mayor from 1993 to 2003. He was initially elected on a platform which included support for the War Against Drugs. During his last term, he began to publicly support harm reduction and lost the endorsement of his party. Larry Campbell, a former narcotics policeman and former City Coroner, ran on a harm reduction ticket against an opponent who strongly supported the War Against Drugs. Campbell and his ticket won in a landslide. The current Mayor (Sam Sullivan) is also a strong supporter of harm reduction and drug law reform.

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

1 Emphasise that the paramount objective of a modern drug policy for legal and illegal drugs is to reduce death, disease, crime and corruption (with reduction of drug consumption a potential means to achieve this end). The beneficiaries of drug policy should be drug users, their families and the entire community..

2 Accept the comprehensive failure and futility of continuing the War Against Drugs, that is, to continue relying heavily on law enforcement to control illicit drugs. Policy heavily reliant on supply control is expensive and ineffective and often produces serious unintended negative consequences.

3 Recognise that illicit drug use, like legal drug use, is primarily a health and social issue (with an important subsidiary role for law enforcement).

4 Increase funding for health and social interventions to the current level of illicit drug law enforcement, fund interventions on the basis of evidence of effectiveness and safety and improving the return on investment.

5 Accept that illicit drugs are likely to continue to be available in most countries for the foreseeable future but that a realistic goal for policy is to regulate as much of that market as possible. However, as with legal drugs, criminal sanctions should continue to be applied against individuals who operate outside the law. Thus the production, sale, purchase, possession and consumption of unsanctioned quantities or unsanctioned types of mood altering drugs would continue to attract criminal sanctions. The threshold levels and magnitude of penalties for offences is likely to remain subject to continuing debate.

6 Recognise that the least-worst option for cannabis is to control demand and supply by taxation and regulation, introduce strict proof of age measures for all sales, ban all cannabis advertising and donations from the cannabis industry to political parties and mandate that all cannabis packaging must include government health warnings and information about availability of help.

7 Expand and improve drug treatment to maximize the number of drug users attracted, retained and benefited by effective, safe and cost effective drug treatment. This will require expansion of capacity, broadening of options and enhancement of quality. Drug treatment should be raised to reach the level of other forms of health care.

8 Accept the central role played by rigorous, independent, scientific research in continuous quality improvement for health, social, educational and law enforcement interventions. Research in drug treatment is required to identify new and more effective interventions to attract drug users not previously attracted by conventional treatments as well as treatment-refractory, severely-dependent drug users. Research should drive efforts to identify the least expensive, most effective and safest means of reducing drug-related harm.

This would include educational and other efforts to discourage drug initiation and continuing use, drug law enforcement and all forms of drug treatment.

9 Recognise that some individuals will inevitably continue to want to use drugs outside the drug treatment system. Therefore communities should be prepared to return to policy adopted in many developed countries a century ago when retail sale was sanctioned of small quantities of low concentration, oral formulations of some opioids and stimulants. Opium for eating (legal in Australia until 1906), and cocaine containing Coca Cola (available until 1903) are some examples of legally available low concentration oral formulations of some opioids and stimulants a century ago. While the illicit drug market under current conditions in many countries is at present extremely volatile, a drug market where profits have been undermined is likely to be smaller and less volatile. The illicit drug market should be carefully monitored with any future introduction of new or revised formulations considered with the aim of maximising benefits and minimising risks.

10 Acknowledge that while the community of nations has long embraced a drug policy largely formulated in the 1961, 1971 and 1988 international drug treaties, monitored and implemented through a range of United Nations organizations, these only require prohibition of nominated drugs where in the opinion of a party (i.e. country), prohibition provides 'the most appropriate means of protecting the public health and welfare' (Single Convention, 2.5 b). Countries adopting a modern drug policy would continue to honour the letter and spirit of all international drug policy commitments and treaty obligations.

Switzerland - a case study:

In the late 1980s, Switzerland was overwhelmed by illicit drugs and drug problem. Crime soared. HIV was spreading rapidly among injecting drug users. Drug overdose deaths were increasing rapidly. Authorities increased the resources available for police drug squads and increased the severity of penalties for drug offences. When the situation deteriorated, authorities increased the resources available for police drug squads and increased the severity of penalties for drug offences. After some time, the authorities realised that a War Against Drugs was not reducing drug problems or drug consumption. In the 1990s, authorities adopted harm reduction implementing needle syringe programmes and expanding and improving methadone maintenance treatment. Funding for health and social interventions was raised to the level of drug law enforcement. A heroin trial was established for severely dependent, treatment refractory heroin users and evaluated. This treatment was deemed to be successful. Heroin assisted treatment now accounts for a stable 5% of all heroin users in treatment. Modest drug law reform has been started. In 1997, the President of Switzerland opened the annual conference of the International Harm Reduction Association to express the gratitude of Switzerland for the excellent advice received. Swiss policies are now based on science and respect for human rights.

Dr Alex Wodak,
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Australian Drug Law Reform Foundation.
Saturday, 17 March 2007

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