Supplementary submission of Families and Friends for Drug Law Reform to the Inquiry by the Parliamentary Joint Committee on the Australian Crime Commission into Amphetamines and other Synthetic Drugs.

Members of the Committee sought additional information by way of a supplementary submission from Families and Friends for Drug Law Reform. That additional information is contained in this supplementary submission.

The Committee also asked FFDLR to consider the possible application of Medicare in relation to the treatment of drug addiction. FFDLR undertook to undertake that consideration and write to the Committee. That additional submission will be forwarded shortly when it has been completed.

What would FFDLR do if it was a benevolent dictator

Senator McDonald asked a question "if you were the benevolent dictator of Australia and saw this problem, how would you fix it?" We provide here some additional thoughts on that issue.

In our main submission, oral presentation and in this submission FFDLR is not pursuing an ideological position but calling for policies based on evidence and based on trials of different approaches where that evidence is not available. Steady, cautious steps should be taken with evaluations at every stage and adjustments made to new programs as the need arises.

In following the evidence FFDLR believes it is clear that there are more effective approaches to illicit drug issues than have been employed to date. It is also evident that over-reliance on the criminal justice system (necessary though it is in some cases), has reached the limit of its effectiveness in making a difference to drug problems.

There is evidence to show that funding of treatment and treatment options is up to seven times more effective than law enforcement in reducing drug use[1]. There is evidence to show that provision of treatment is effective in reducing drug related crime[2].

However, treatment programs are under-funded and thus people with addictions have difficulty in accessing them. In relation to methamphetamines, insufficient research funds have been provided by governments to enable effective treatment options to be developed and as a result hospitals and GPs are having great difficulty in coping with the needs of those addicted to these substances.

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[1] Controlling Cocaine: Supply versus demand programs, C.Peter Rydell, Susan S. Everingham, Rand Policy Research Centre, 1994
See also essays in the National Review at http://www.nationalreview.com/12feb96/drug.html

2 Methadone Maintenance Treatment as a Crime Control Measure, Wayne Hall, Director, National Drug and Alcohol Research Centre, Crime and Justice Bulletin No 29 June 1996, http://www.actsofpassion.nsw.gov.au/bocsar1.nsf/files/cjb29.pdf/$file/cjb29.pdf

There is evidence to show, in respect of cannabis (and it is likely to be true for other drugs) that the strength of the law and threat of severe punishment has little if any effect on the population's use of the drug.

Thus as a benevolent dictator FFDLR would develop drug policies and laws on the basis of evidence and would monitor constantly those policies and laws. Such policies would give much more emphasis to treatment, research and appropriate education and less weight to law enforcement. Where the new laws and policies were found to be less than optimally effective, and new evidence for improving their effectiveness emerged, they would be changed appropriately.

Drug education programs

The effectiveness of drug education programs is limited for two major reasons:

1. Programs that use scare tactics as a means of preventing or stopping use do not have credibility with young people.

A program that exaggerates or states untruths is doomed to failure.

This is firstly because personal experience demonstrates the falseness. In Europe young people reported that 68% of them knew someone who had smoked cannabis. It is reasonable to expect similar figures in Australia. Thus, a claim that smoking cannabis causes schizophrenia can be seen to be false, because most recipients of the message will know someone, if not several friends, who have used cannabis and do not have schizophrenia. Secondly, with ready access to information today, for example the internet, a student can easily discover the facts for himself, eg a claim that cannabis is 30 times stronger today than it was in the 1970s can easily be disproved by accessing any number of drug and alcohol research sites on the internet. Thus, together with other exaggerated messages, the balance of any drug education program is likely to be discounted or ignored.

This extract of a presentation made to the ACT Council of Parents and Citizens Association in 1996 adds another dimension:[3]

> *'I guess before my brother started using heroin, I believed the scare tactics. The one shot of heroin and you're addicted. Once an addict always an addict. That once you start using it you start on a one way road down to become part of the living dead. So when I found out he was using heroin, I just panicked and couldn't talk about it at all.*
>
> *I had no idea about harm reduction even though I went to drug counselors and read many pamphlets about the drug. Nobody told me that an ambulance officer, if called promptly, could effectively revive someone from a heroin overdose. Nobody told me that you shouldn't use heroin with other drugs like alcohol. Nobody said make sure he doesn't use alone. All they said was 'don't lend him money, don't let him use in the house' the only advice was judgemental and moral - nothing that might actually*

[3] Drug Education: Ignorance Can Be Tragic, Knowledge Can Save Lives, J McConnell, presentation to ACT Council of Parents & Citizens Associations, 2 Dec 1996

keep him alive. And I think that if I had known then what I know now, things might have been different.'

2. The expectation that any type of drug education will be effective.

It is not true that just any type of drug education will be effective. The US DARE program, a school-based program run by police that in many cases was shown to increase drug use. Some programs may be effective but because very few are evaluated for effectiveness, it simply cannot be known whether or not those programs are effective.

The most significant study into effectiveness of drug education programs is the 1998 study by White and Pitts[4] which undertook a meta-analysis of drug education programs and evaluated their effectiveness. The authors located 4876 studies of drug education programs, which they reduced to a mere 71 that were able to be evaluated.

The authors concluded that the effect of the drug education programs was very small and was less effective with the passage of time:

> *'An effect size of 0.037 (the combined effect size of studies with follow-up to 1 year) is certainly small.*
>
> *That statistic suggests that drugs education has such a trivial impact on behaviour that in its present form it is of no practical relevance.*
>
> *Another way of expressing the meaning of this effect size is that 3.7% of young people* [less than 4 in 100] *who would use drugs delay their onset of use or are persuaded to never use.'*

A more recent, but work-in-progress, meta-analysis[5] suggests that the effect may be greater than that earlier study indicated and could amount to 13.6%. However the study only identified 12 programs for that component of the analysis, thus producing a wide confidence interval. That is while the sampling average comes out at 13.6% the confidence interval indicates that it could really be a low as 3.5% - a figure within the range of the first study. The outcomes of the final report of this study should be monitored.

A significant point made in the study is the "need for researchers to investigate program effectiveness", which it goes on to say that the majority of school-based drug prevention program outcome evaluations fail to do.

The general lack of evaluation of school based drug education was also reflected in the UK Annual Report of Her Majesty's Chief Inspector of Schools 2004/05:[6]

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4 Educating young people about drugs: a systematic review David White and Marion Pitts, Division of Psychology, Staffordshire University, UK, 1998

[5] http://www.turningpoint.org.au/research/dpmp_monographs/dpmp_monograph07.pdf)

6 The Annual Report of Her Majesty's Chief Inspector of Schools 2004/05

'While some drug education programmes have had a positive impact on pupils' attitudes, knowledge and resistance, the effectiveness of most British programmes have not been properly evaluated'.

That report went on to say:

'By the end of Key Stage 4, pupils have a good knowledge of drugs and are aware of, but do not always accept, the risks associated with their use. Most pupils have a good knowledge of the law as it relates to illegal drugs …. While some drug education programmes have had a positive impact on pupils' attitudes, knowledge and resistance, the effectiveness of most British drug education programmes has not been properly evaluated.'

The European Monitoring Centre for Drugs and Drug Addiction in its 2005 annual report made positive comments in respect of a holistic, all of community UK drug education program called "Blueprint"[7]. Blueprint is a large research programme which aims to find out what works in teaching young people about drugs and drug use. It is based upon evidence suggesting that combining school-based education on drugs with parental involvement, media campaigns, local health initiatives and community partnerships is more effective than school interventions alone. The research concludes in 2007 and it will be worth monitoring Blueprint's progress.

In 1999/2000 the Australian Government provided $27.3 million over four years to 2002-2003 for school drug education under the *Tough on Drugs in Schools* Initiative. The follow up review in 2004 concluded:[8]

'The programmes and initiatives funded through the COAG Tough on Drugs in Schools Initiative complement the preventative school drug education programmes under the NSDES [National School Drug Education Strategy] *with the aim of increasing the capacity of schools and their communities to respond to illicit drug use.*

The available evidence indicates that the NSDES has made a significant contribution to the development and support of school drug education across Australian schools. All States and Territories have established policies, strategies and expertise to support their schools in their drug education activities, and are now seeking to consolidate and extend their achievements. More schools across Australia now have or are developing policies, strategies and programmes that underpin school drug education.'

However there is little mention of its effectiveness in reducing the use of drugs by young people except for the following statement which was buried in the report:

'Importantly, the evaluation does not seek to assess the effectiveness of school drug education in influencing students' knowledge of, attitudes towards, or participation

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7 http://www.drugs.gov.uk/young-people/blueprint/

8 Department of Education Science and Training (DEST) Evaluation of the National School Drug Education Strategy (NSDES) and COAG Tough On Drugs in Schools Initiative Final Report, 2004

in, drug use. The focus of the evaluation is clearly on the NSDES itself and the extent to which it has achieved its defined objectives.'

This leaves the open question of whether the $27.3 million was spent effectively. One would naturally expect that a drug education program adopted by schools to be aimed at influencing drug use. It is simply not known whether the programs paid for by the $27.3 million had been successful or not.

Similarly there is no evidence that the "tough on drugs" or "zero tolerance of drugs in schools" policies are effective. Indeed there have been news reports of some schools expelling students for possession of small quantities of drugs as a direct consequence of the zero tolerance of drugs in schools policy. This policy was interpreted by some schools as "zero tolerance of drug users in this school".

In a national study examining how Catholic schools respond to drug incidents, Father Peter Norden concluded:[9]

'There was no evidence presented that suggested that such a "tough on drugs" approach led to a reduction in student drug use or problematic drug behaviour. On the contrary, a great deal of evidence was provided to the consultation that an approach that "shifted the problem" to another school, or more subtly, pushed it underground, increased the risk that students with difficulties in this area became more unlikely to access sources of guidance, direction and support.'

That report also stressed the importance of the need to keep students connected to their community. Often schools are the last community to which some students are connected.

Recommended guidelines for drug education funding

The question to be answered is how to make better use of money spent on drug education. In short, some discipline and structure about the allocation of funds is needed. Drug education programs must be based on the best possible evidence and have clear objectives. The temptation to run with a public relations type programs of unknown value should be resisted.

Thus FFDLR recommends for school drug education:

1. **Clear objective to be defined:**

School drug education should be aimed at

a) preventing or delaying the uptake of drugs, or

b) where drugs are already being used, to reduce the harm associated with that use, including the cessation of drug use (note that drugs would include all drugs - legal and illegal, non-prescribed use of prescription drugs and non prescription drugs).

2. **Programs to be targeted:**

[9] Keeping them connected; A national study examining how Catholic Schools can best respond to incidents of illicit drug use, Father Peter Norden SJ, Jesuit Social Services, March 2005

Programs should be targeted according to either a) or b) above.

3. **Only effective programs to be used:**

Only programs that have been proven to be effective in achieving a) or b) above and which are appropriate to the circumstances are to be funded.

4. **Research needed:**

An exception to item 3 would be allowed to provide for small pilot studies for new programs. However in those cases the study must be scrupulously supervised and evaluated and that evaluation must be specifically in relation to items a) and b) above.

Treating drugs differently

Mr Hayes asked the question: "we should be realigning our policy settings to allow for differentiation of various drugs. How would you see that occurring, bearing in mind that they are proscribed, illicit drugs? How would you see realigning the settings, effectively saying one drug is less harmful to a human?"

It is already the case that drugs are treated differently. Some drugs are regulated, some drugs are ignored, others are prohibited. Alcohol, tobacco, prescription medicines are regulated. Some homeopathic and "natural" medicines" have few, if any controls, and a class of drugs called illegal are prohibited. There has been little science or logic behind the reasons why this is so.

The legislative and administrative arrangements in respect of alcohol, tobacco and illegal drugs are mostly historical, lacking any scientific rigour, and have little bearing on the relative dangers or harms of the drugs – particularly in respect of illegal drugs when one includes not only the consequences or harms caused to people by the drugs themselves but also the effects of the attempts to prevent people from using the drugs.

One direct consequence is the shift in the drug market from relatively less harmful forms of the drug to the more harmful (and more compact and easier to smuggle). Examples are from beer to spirits in the US alcohol prohibition era, from opium to heroin to fentanyl and methylfentanyl (synthetic opiates that are up to 100 times more potent than heroin)[10], from amphetamines to methamphetamines to "ice", from coca to cocaine to crack cocaine.

For those selling the drugs the more concentrated forms are more attractive because they are easier to smuggle and for some forms of the drugs for short periods of time until the laws catch up some forms are not yet illegal. For those buying a more concentrated form gives a bigger "bang for the buck". However the risk is that the concentration and exact purity is not known and can lead to severe adverse health consequences.

Thus it stands to reason that if one of the objectives of the laws, policies and practices relating to drugs is one of harm reduction, and accepting the fact that some people will use drugs, the use of less harmful drugs and less harmful forms of drugs is to be preferred. While developing policies may be difficult politically (mostly because years of

[10] The state of the drugs problem in Europe, European Union Annual Report 2005, http://europa.eu.int.

messages saying "drugs are bad" have conditioned the population and made such approaches the victims of their own success), it is not difficult in a practical sense.

Such approaches are already in place. The most dangerous drugs in terms of causing death and disease, tobacco and alcohol, are regulated and controlled (although some would argue not sufficiently well regulated).

But within the field of illegal drugs, cannabis is treated differently to other such drugs. In The Netherlands cannabis, although still classified as an illegal drug, is regulated through "coffee shops". Although still illegal, Dutch police do not generally involve themselves with the shops. The Government regulates the licensing, operating conditions, location and numbers of such shops.

In Australia states and territories apply different rules for cannabis. Some states and the territories have an expiation notice system which protects the user from the harsh excesses of the criminal justice system.

While one would be tempted to ask: "would such differentiation lead to increased drug use?" the more important question is: "would such a practice increase the harm?"

The answer to both questions would seem to be "no", but some trials and gathering of additional evidence may be necessary to confirm the answer.

There is however sufficient evidence in FFDLR's view that increased use would not be a consequence. The Dutch use of cannabis stood at 4.5% of the population who used in the last year[11]. The use of cannabis in the last year in Australia according the 2001 Household Survey stood at 12.9 % and, with the possible exception of NT, there was no significant difference in percentage of users identified.

A landmark study undertaken for the Department of Health and Aged Care[12] compared cannabis use in SA which had a cannabis expiation system, with WA which did not have such a scheme at the time. Amongst other things it found that:

> *their offence apprehension and subsequent arrest (WA) or issuing of a CEN (SA) had no impact on their patterns of cannabis or other drug use* [but] *…offenders found that negative employment consequences arising from a cannabis offence apprehension were more likely to be experienced by offenders in Western Australia compared to South Australia (eg. loss of job, missing out on job opportunity). Those in the WA system were also more likely to report relationship problems, accommodation problems and further involvement with the criminal justice system related to their first minor cannabis offence.*

After the publication of that report the Western Australian Government introduced a cannabis expiation scheme which is still in existence.

It is unfortunate that the current advocacy of tougher drug penalties by the Federal Government and its pressure to have states and territories remove cannabis expiation

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[11] A guide to Dutch Drug Policy, The Netherlands Ministry of Foreign Affairs, 2000

[12] The social impacts of the cannabis expiation notice scheme in south Australia, Monograph Series No 34 – 38, Department of Health and Aged Care, Canberra, 1998

schemes lacks merit and does not have sufficient regard for the evidence nor the consequences of such actions for individuals who have an addiction.

Some people have taken advantage of such schemes by forming a cooperative or growing the prescribed number of plants hydroponically and marketing the produce. However the removal of what has been well thought through legislation when more sophisticated and appropriate approaches are possible, shows a lack of proper consideration of the evidence and insufficient foresight of the possible outcomes.

Families and Friends for Drug Law Reform urges the Committee to recommend that:

- **the strategy of pressing for the winding back of the cannabis expiation schemes be withdrawn,**
- **the examination, with a view to adoption, of schemes that will provide differentiated approaches according to the relative harms that can be caused by particular drugs,**
- **in the context of amphetamines, in principle the approach adopted for the more harmful 'ice' should be different from the approach to other amphetamines, and**
- **those who simply use should not be prosecuted.**

Furthermore, high priority should be given to the provision of more resources for research and the treatment of those affected by illicit drugs and in particular amphetamines.

B McConnell

President

Families and Friends for Drug Law Reform