ALICE IN WONDERLAND:

A REALITY CHECK ON THE HISTORY, CONSEQUENCES AND EFFICACY OF PROHIBITION AND CRIMINALISATION OF DRUG LAWS AND PROPOSALS FOR DECRIMINALISATION AND REGULATION

Attempts to stamp out the illegal drug trade have failed all over the world and have consumed more and more resources. There is no benefit in blinkered thinking. The starting point must be an acceptance that illegal drugs are established in the community and that the prohibition has not worked. […] One thing is certain: the conventional method of giving the job to the police, on top of all of their responsibilities, has failed all over the world and a new approach is needed.

The Report of a Commission of Inquiry
(The Fitzgerald Report 1989)

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I. INTRODUCTION

Since drug prohibition was first introduced into Australia in 1953, successive state and federal governments have maintained policies that prohibit and criminalise certain drugs while regulating others. These policies have been followed despite significant evidence demonstrating their failure and the severe consequences of doing so, regardless of their irrationality or inconsistency. Governments profit through the taxation of regulated drugs such as alcohol and tobacco, regardless of the harm caused by these drugs, while arbitrarily prohibiting and criminalising other drugs such as heroin and marijuana.

These governments and the media have tended to ignore or downplay the drug harm that occurs as a result of criminalisation and prohibition while actively supporting those policies. Much of the information presented in support of prohibition and criminalisation has been misleading and sensationalist. Coverage of these issues is often aimed at generating fear in people's minds. As far back as the 1950s the media has been criticised for generating hysteria over drugs.[1]

It is recognised that drug abuse is dangerous and it is clear that drug use involves risk, but it is also clear that the use and abuse of drugs are social, medical and psychological issues. After decades of prohibiting and criminalising drugs, we can now reflect on what may be learnt from these policies. Over this period many countries have reported increases in rates of drug abuse.[2]

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[1] John Caplehorn, 'An Argument for the Medical Control of Supply of Drugs to Addicts' (1990) 9(4) *Drug and Alcohol Review* 351, 353.

[2] Alex D.Wodak, 'Why the War Against Drugs Has Failed' (1991) 155 *Medical Journal of Australia* 37, 37.

None have achieved a significant reduction in the drug trade, let alone won the so-called 'war on drugs'.[3] Conversely, where drugs such as nicotine, alcohol[4] and heroin[5] have been managed within a regulated and legalised system, the rates of death or addiction from these drugs have actually decreased. When considering drug use and abuse, this paper considers and contrasts many drugs, both licit and illicit – including alcohol, nicotine, heroin and cocaine. Nicotine and ethyl alcohol are contrasting examples of deadly addictive drugs that are not prohibited.

The focus of this paper is on the history of drugs and their prohibition and criminalisation with a view to the future regulation of drugs. So the terms prohibition, criminalisation, regulation and drug are defined as follows:

Prohibition is defined as a total ban imposed by legislation. Criminalisation is defined as turning an activity into a criminal act and can occur in an environment of prohibition as well as an environment of regulation. The difference is that criminalisation under prohibition is directed at the drug and drug activity – such as use and supply – whereas criminalisation under regulation is directed at any failure to comply with the regulatory regime and the promotion of rehabilitation. Under regulation it is permissible to have and use drugs without breaching the law. The term 'regulation' refers to the process of providing a statutory system for the management of drugs in society.

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[3]Ibid.

[4]Toni Makkai, 'Alcohol and Disorder in the Australian Community: Part 1 - Victims' (December 1997), Trends & Issues in Crime and Criminal Justice No. 76, *Australian Institute of Criminology* 1, 6.

[5]Lord President of the Council, et al, 'Tackling Drugs Together: a Consultation Document on a Strategy for England 1995-1998', Her Majesty's Stationary Office, London (1994) 85.

Other important terms include addiction and dependence. Addiction is defined as a state where a person is unable to stop taking the drug either because ‘it gives pleasure, or because the person experiences withdrawal symptoms if the drug is discontinued’.[6]

For the purposes of this paper I have defined dependence as a condition where the taking of the drug meets a need for the person and the person develops a reliance upon that drug to meet that need. The term dependence is far wider than addiction and is currently preferred over the term addiction in the literature and also by the World Health Organization[7] since 1982.

In the relevant legislation, drugs are defined in very broad and inclusive terms[8] – the widest possible lay definition of a drug is anything that has a psychoactive effect when taken into the body. What can be understood from attempting to define drugs is that all substances that humans ingest have some effect on the human mind and body. It is not possible to logically discriminate between these substances using any of these criteria. Both the legislative definitions and the lay definition are wide enough to include caffeine, nicotine, alcohol, aspirin, prescription drugs, all prohibited substances, and all foods. There is no rational definition that provides a legitimate basis for differentiating between the currently criminalised and prohibited substances and other substances. They all exist on the same continuum.

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[6]Robert Marks, ‘A Freer Market for Heroin in Australia: Alternatives to Subsidizing Organised Crime’ (1990) 20 (1) *The Journal of Drug Issues* 131, 132.

[7]Ibid.

[8]Section 5 of the *Health Act 1937* (Qld).

Currently, drugs are broadly divided into three categories based on the way these substances are treated in the relevant legislation. The first category includes drugs like caffeine, nicotine, alcohol, or aspirin. These drugs are sold in shops with little or no restriction or regulation. The second category of drugs is for those that are only available on prescription, and both state and federal governments regulate these drugs. The third category consists of drugs that are prohibited and criminalised. Substances like heroin, cocaine, cannabis and ecstasy fall into this category. There is little, if any, reasoning or consistency behind these legislative categories. Also, there is no legitimate basis for using harm as a means of distinguishing between licit and illicit substances.[9] There is also no chemical basis for discriminating between drugs.

The starting point in this process is to present an historical overview of drugs in society. The next step is to consider the prohibition and criminalisation of drugs, followed by an analysis of the consequences of prohibition and criminalisation.[10] Then current drug use in society is considered. Finally, future approaches to the management of drug use and abuse and legislative reform will be considered.

II. GLOBAL HISTORICAL PERSPECTIVE ON DRUGS AND DRUG USE

Throughout history, human beings have used a wide range of drugs for a wide range of purposes. Many of those drugs are now prohibited and criminalised. Drug use and abuse has occurred on

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[9]Stephen K. Mugford, and Pat O'Malley, 'Heroin Policy and Deficit Models: the Limits of Left Realism' (1991) 15 *Crime, Law and Social Change* 19, 31.

[10]Zygmunt Zayler, 'Decriminalizing Heroin: a Controversial Approach' May (1988) *Law Institute Journal* 404, 404.

different continents, with different races, at different points in their history and cultural development. Drugs like opium, peyote, kava, coca, marijuana, tobacco and alcohol have been used for hundreds, and in some cases thousands, of years. These drugs have been associated with cultural rites, religious practices, social events, medicine and simply for personal recreation.

II A. Opium, Morphine and Diacetylmorphine (Heroin)

Humanity has an extensive history of opium usage. Historically, opium has held a special status and been interwoven into many cultures. Societies have not only used the drug recreationally, but also for medical and religious purposes. Opium is considered one of the first drugs ever discovered and it is believed to predate alcohol.[11] Opium has been used by the Swiss since at least the fourth millennium BC, both as a medicine and in religious ceremonies[12] and since 3400BC in the Tigris-Euphrates river system of lower Mesopotamia. It spread through Europe, the Middle East and North Africa by the end of the second millennium BC.[13] The Assyrians recorded the use of opium on medical tablets dated from the seventh century BC.[14] Opium has also been recorded as far back as the fifteenth century BC in Egypt and was widely used and so well known in Egypt and Greece that it was called 'Thebic' opium after the ancient Greek city of Thebes.[15] Opium was

[11] Martin Booth, *Opium A History* (1996) 15-16.

[12] Ibid.

[13] Ibid.

[14] Ibid.

[15] Ibid.

also widely used in Asia where it was both cultivated and consumed. The Chinese name for opium was "af-yong", which is very similar to the Arab name "af-yum".[16]

II B. Medical Uses of Diacetylmorphine (Heroin)

Opium is perhaps the most interesting of all of the drugs that are currently criminalised and prohibited, not only because of its extensive history, but also because from opium we obtain morphine – and from morphine, diacetylmorphine (heroin) is synthesised. Morphine was first isolated in 1803 and diamorphine was first synthesised in London by Charles Wright in 1874 and marketed by the German pharmaceutical company Bayer in 1898.[17] The active chemical in opium and heroin is morphine, the only difference being in the way they are absorbed into the brain. 'Heroin is rapidly hydrolysed to 6-monoacetylmorphine (MAM), which in turn is hydrolysed to morphine. Both heroin and 6-MAM are more lipid soluble than morphine and enter the brain more readily.'[18] 'The blood-brain barrier tends to impede the entry of morphine to the brain. The barrier is considerably less effective against heroin and MAM because both are more lipid soluble.'[19]

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[16]Ibid.

[17]Michael Gossop and Francis Keaney, 'Prescribing Diamorphine for Medical Conditions: A Very British Practice' (Spring 2004) 34 (2) *Journal of Drug Issues* 441, 442.

[18]Howard B. Gutstein and Huda Akil, 'Opioid Analgesics' in Alfred Goodman et al (eds), 'Goodman and Gilman's The Pharmacological Basis of Therapeutics' (10th ed) (2001) 569, 590.

[19]Tony Gill, Heroin Addiction (1997) *GP Drug & Alcohol Supplement No.7,* 1, 2.

Heroin is probably the most demonised and vilified chemical compound known to man. More fear, misinformation and irrationality surrounds this drug than almost any other in history. Yet, it is also the most chemically and physiologically effective pain-killer ever invented[20] and has a myriad of other valid and effective medical applications. Beside the possibility of addiction, it is commonly recognised that a person is unlikely to suffer any permanent physical or psychological side affects,[21] as a result of taking heroin – and the majority of users do not develop an addiction. Heroin has a history of medical use spanning over 130 years, which makes it one of the longest established medications.[22] The United Kingdom still makes medical use of this drug today. Heroin is produced by combining acetic anhydride (a common industrial acid) and morphine. The acidic bond fortifies the morphine, making it more powerful than ordinary morphine. Despite heroin being the most effective analgesic ever invented, opium, heroin and morphine are prohibited.[23]

Due to the prohibition and criminalisation of heroin in both Australia and the USA, medical experts in these countries are prevented from utilising this drug at all. In particular, they are prohibited from prescribing the drug for pain relief. Heroin should be available for the management of pain endured by patients suffering from incurable terminal conditions. In the

[20]Ibid 2.

[21]Marks, above n 6, 150.

[22]Gossop and Keaney, above n 17, 441.

[23]*Drugs Misuse Act 1986* (Qld).

United Kingdom, the medical profession considers that there is only a small risk of addiction and doctors are advised to use heroin because their primary obligation is to ease a patient's suffering: 'The physician should not wait until the pain becomes agonising; *no patient should ever wish for death because of a physician's reluctance to use adequate amounts of effective opioids.*'[24]

The British medical profession use heroin in wide range of treatments, including all of the following instances (which are not exhaustive): acute myocardial infarction; total hip replacement; phantom pain after major lower limb amputation; epidural diamorphine in Caesarean section; treating children in accident and emergency units; acute post-operative pain in children undergoing abdominal surgery; to reduce the stress response in ventilated newborn(s); in the treatment of the terminally ill; and for post thoracotomy analgesia.[25] During the first half of the twentieth century, Australia followed Britain, Europe, Africa and the Middle East in continuing to use the drug for medical purposes. Despite heroin's usefulness and effectiveness, this was soon to change.

II C. Heroin Use and Abuse

Despite the hysteria and misinformation surrounding heroin use, heroin can be successfully utilised in a wide range of situations by the medical profession without any of the consequences that have been predicted by opponents of regulation. Heroin can be used extensively in a medical context without people becoming addicts. Research indicates that Britain does not have a higher

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[24]Gutstein, above n 18, 610.

[25]Gossop and Keaney, above n 17, 443-4.

rate of heroin addiction than Australia.[26] The Australian Federal Police estimate that, out of a population of approximately 20 million, there are between 30,000 and 50,000 dependent heroin users in Australia.[27]

Research from the United Kingdom, whose population is approximately 60 million people, shows that in 1993 there were 18,919 notified dependent heroin users in Britain.[28] Similarly, in 1989, the Netherlands, with a more liberal harm-minimisation oriented system – and much lower penalties than Australia – had an estimated 15,000–20,000[29] dependent heroin users out of a population of just under 15 million. The Dutch view the drug problem as a matter of health and social well-being, and not primarily as one for the police and justice system.[30]

The British experience shows that people can take heroin without becoming addicts at all; without becoming addicts for life, and without dying from the mere ingestion of heroin. The fact that heroin does not automatically addict users is supported by the research, which indicates that not all heroin users are addicts.[31] Other experiments confirmed that it can take many weeks for an

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[26]Wayne D. Hall, et al, 'How Many Dependent Heroin Users Are There in Australia?' (2000) 173 (10) *Medical Journal of Australia* 528, 528.

[27]Australian Federal Police, *Illicit Drugs in Australia: Situation Report* (1991) 1, 18.

[28]Lord President of the Council, above n 5, 85.

[29]E. L. Engelsman, 'Dutch Policy on the Management of Drug-related Problems' (1989) 84 *British Journal of Addiction* 211, 211.

[30]Ibid 212.

[31]F. Neri, 'Welfare Effects of Heroin Prohibition.' (December 1992) 11(4) *Economic Papers* 73, 73.

addiction to develop and the user must consume over 0.50 grams each day.[32] The Australian Federal Police research suggests that there are between 60,000 to 90,000 recreational heroin users in Australia.[33] Recreational users are persons who are not addicted. Another definition of addiction used in the research is to '… use heroin in the face of difficulties they know, or believe, to be caused by its use – such as health, legal, and interpersonal difficulties ... use heroin daily, develop tolerance ... and experience withdrawal'.[34] Addiction and death are heavily relied upon by opponents of regulation to support their arguments.

II D. Drug Deaths

One of the strongest arguments in favour of prohibition and criminalisation is the claim that drugs (particularly heroin) kill people. This claim is frequently made in order to generate fear about drug use and abuse. In fact, this claim is demonstrably false. When considering drug abuse and addiction, it is important to carefully consider how the death rates are compiled. The statistical data on death rates from heroin in particular can be misleading because of the difficulties surrounding the issue of attributing causes of death. The rates are determined by how 'cause of death' is defined. As a result of this, death rates are more often a measure of what is commonly called 'drug-related deaths', rather than deaths that are directly and solely the result of illicit drug taking. The research shows that use of the term 'fatal overdose' or even 'drug death'

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[32] Marks, above n 6, 155.

[33] Australian Federal Police, above n 34, 9.

[34] Jeff Ward, Wayne Hall and Richard P. Mattick, 'Role of Maintenance Treatment in Opioid Dependence' (16 January 1999) 353 (9148) *The Lancet* 221, 221.

to infer that a user has died as a result of taking a high quantity, or a purer dose in excess of the user's tolerance, is false.[35] Relatively high blood levels of morphine are not found at autopsy – in fact, they are often towards the lower end of the range.[36] The studies show that the great majority of deaths are not as a result of toxic levels of morphine in the blood.[37] In one study, it was found that 74% of cases labelled as 'fatal heroin overdoses' did not have blood levels higher than groups of heroin users who died from other causes, and many fatal overdose cases did not have blood levels higher than non-fatal overdose cases.[38] Accidental deaths almost always occur as a result of a chain of events and factors, and not simply because the victim took a drug.

Often, death rates merely reflect the fact that the deceased consumed some drugs, or that the drug played a peripheral or indirect part in the death of the drug user. They do not indicate that the deceased simply consumed an illegal drug, then died directly and solely as a result of taking that drug. Yet, the figures are often used to support the idea that the consumption of the drug alone was the cause of the person's death.

Heroin, in particular, is often portrayed as an extremely lethal poison, but the medical and scientific facts do not support this proposition. When pharmaceutical-grade heroin is ingested, it

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[35] Shane Darke and Deborah Zador,'Fatal Heroin "Overdose": A Review' (1996) 91 (12) *Addiction* 1765, 1767.

[36] Ibid.

[37] J., R., Monforte, 'Some Observations Concerning Blood Morphine Concentrations in Narcotic Addicts' (1977) (22) *Journal of Forensic Sciences* 718, 720.

[38] Darke and Zador, above n 35, 1767.

acts on the central nervous system and causes 'marked respiratory depression and consequent anoxia'[39] over many hours. 'The blood concentration of morphine depends on the route of administration, drug dose, body weight, time elapsed since last dose and individual pharmacokinetics'.[40] Assuming there is no intervention, no supervision and more than 250mg[41] of pure pharmaceutical-grade heroin has been taken by a non-tolerant user, then the person *may* be at risk of death from respiratory failure after some hours.[42] However, if that person receives any medical attention, or intervention, in the many hours after taking the drug, they will not die. Instant death from a heroin overdose is, in fact, rare.[43] Studies have found that over 74% of heroin-related deaths occur more than 2 hours after heroin administration – and 79% of those people receive no medical intervention at all.[44]

People die from drug abuse for a range of reasons, including: because they take a mixture of adulterated drugs of uncertain dosage in an unsafe environment; those drugs have been made by unqualified persons in illegal, unclean and unsafe clandestine laboratories. Research on this issue has found that the people who are most likely to die as a result of a 'heroin overdose' are not naive, first-time, non-tolerant heroin users – they are older (over 30), have been using for a long

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[39] Jay M. Arena, *Poisoning: Toxicology, Symptoms, Treatments* (4th ed, 1979) 444.

[40] Darke and Zador, above n 35, 1766.

[41] Arena, above n 39, 444.

[42] Darke and Zador, above n 35, 1766.

[43] Ibid 1767.

[44] Ibid.

time, and mostly die from an overdose of a combination of opioids, alcohol and benzodiazepines.[45] The research also indicates that only about 17% of fatalities are recreational users.[46] Longer-term users tend to be more careless, reckless, and seek new experiences: so they start mixing other drugs together (poly-drug use). One study, which analysed the toxicology reports from 202 heroin-related deaths between 1994 and 1999, found poly-drug use in 90% of cases.[47] and prescription drugs in another 80% of cases.

Users mix drugs in the hope of improving the effects of these poor-quality substances and because they have become tolerant to their drug. Many persons who die from so-called drug overdoses are in the company of others[48], but medical help is not sought for a variety of reasons – including fear of prosecution. If drugs were regulated, users would be undertaking these activities in safer environments where information, support, and help are available and this would be likely to result in a reduction in the number of drug deaths.

Falsehoods about drug deaths are propagated in the media in order to sell papers or attract audiences. The media has a vested financial interest in presenting material in a sensational and alarming manner to ensure that the reader will buy their paper, or watch their broadcast. Truth

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[45] Ibid 1770.

[46] Ibid 1766.

[47] Raymond F. Martyres, Danielle Clode and Jane M. Burns, 'Seeking Drugs or Seeking Help? Escalating "Doctor Shopping" by Young Heroin Users Before Fatal Overdose' (2004) 180 (5) *Medical Journal of Australia* 211, 211.

[48] Darke and Zador, above n 35, 1766.

and accuracy run a poor second to sales and ratings. The media frequently reports that the cause of death of a drug addict was a heroin overdose. As shown above, this is almost never the case due to both the dosage needed and the length of time involved, which is over 3 to 6 hours.[49] The main effects of heroin are all relatively minor and include: sedation, relaxed euphoria, drowsiness, decreased concentration, lethargy, decreased visual acuity, respiratory depression, nausea and vomiting, constipation, and urinary retention.[50] The user develops tolerance to the drug and most of its effects, except for meiosis and constipation.[51] It is likely that a majority of drug users (including heroin users) could function in society with the proper management, support and assistance.[52] This is also true of licit-drug users such as alcoholics, but when a drug is criminalised, this becomes impossible.

A heroin user would not need to inject heroin if it was pharmaceutical grade. Many users inject street heroin simply to increase the effect they get from the adulterated, diluted drug. Street heroin is mixed with other white powders, such as artificial sweetener, in order to increase the total amount available, which increases the profit to the 'dealer'. As a result, 'street' heroin is impure and low in quality.

[49] Gill, above n, 19, 2.

[50] Ibid 2.

[51] Ibid 2.

[52] Marks, above n 6, 150.

Another factor adding to the harm associated with criminalisation and prohibition is the fact that, in Australia, heroin cannot be prescribed medically to addicts as part of their rehabilitation. Under the current regime, medical practitioners are left with no alternative but to prescribe the synthetic substitute, methadone, which is just as harmful[53], and is not particularly effective in treating addiction. Studies[54] have found that the majority of those on methadone treatment still used a range of illicit drugs, including heroin.[55] Over the period of a methadone program there is little change in the rate of drug usage for most participants, despite some programs running for almost two years.[56]

II E. Other Drugs: Mescaline, Kava and Cocaine

Mescaline[57] is obtained from the Peyote Cactus (*Lophophora williamsii*)[58] and has been used by American natives for at least 5,700 years[59] for a range of activities, including religious ceremonies. Like Peyote, Kava, which is still widely used in the South Pacific today, also has a

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[53] Australian Bureau of Criminal Intelligence, *1994 Australian Illicit Drug Report* (April 1995) 33, 33.

[54] Stephen T. Chermack, et al, 'Comparison of Patient Self-reports and Urinalysis Results Obtained Under Naturalistic Methadone Treatment Conditions' (2000) 59 *Drug and Alcohol Dependence* 43, 46.

[55] John H. Lewis and Gregory B. Chesher, 'Patterns of Heroin Use in the Methadone Programme in Sydney 1986-1987' (1990) 9(3) *Drug and Alcohol Review* 219, 220, 221.

[56] Ibid.

[57] Nerida Smith and Wayne Temple, 'Disturbing Hallucinations of Roots and Asian Leaves' (2000) 19 (11) *Pharmacist* 679, 679.

[58] Jan G. Bruhn, et al, 'Mescaline Use for 5700 Years' (25 May 2002) 359 (9320) The Lancet 1866, 1866.

[59] Ibid.

history of use in both a medical and psychological context dating back over 3000 years.[60] Kava (the 'intoxicating pepper') has been used as a sedative, muscle relaxant, diuretic and to treat nervousness and insomnia – as well as being used in traditional social gatherings and in cultural and religious ceremonies.[61]

As with the above drugs, the coca leaf (*Erythroxylon Coca*[62]), from which cocaine hydrochloride is obtained, was also used medically for thousands of years in South America. The South American Indians used coca 'for gastrointestinal ailments and motion sickness, as a fast-acting antidepressant medication, as a substitute stimulant for coffee ... and ... weight reduction and physical fitness ...'.[63] However, the use of cocaine was not limited to medical situations. The Aymara Indians, who are said to be the first users of coca[64], used the drug as medicine and more widely in religious ceremonies.[65] Initially, the drug was reserved for princes and priests, but over time its use extended to the general populace.[66] In pre-Hispanic America (from 1450 to 1530),

[60] Herbal Information Center, 'Kava Kava (Piper Methysticum)' (2004) [1] http://www.kcweb.com/herb/kavakava.htm at 28 February 2005

[61] Ibid.

[62] Gabriella Vasica and Christopher C Tennant, 'Cocaine Use and Cardiovascular Complications' (2002) 177 (5) *Medical Journal of Australia* 260, 260.

[63] A. T. Weil, 'Coca Leaf as a Therapeutic Agent' (1978) 5 (1) *American Journal of Drug and Alcohol Abuse* 75, 75.

[64] T. Appelboom, 'Consumption of Coca in History' (1991) 53 (5), *Verhandelingn Koninklijke Academie Voor Geneeskunde Van Belgie* 487, 487.

[65] Ibid.

[66] Ibid.

Coca was in widespread use amongst the general population and its recreational use outweighed any symbolic meaning it once had.[67]

Cocaine is of particular interest in view of the way that 'crack' was first presented by both the media and the government. When crack emerged in the early 1980s, media reports presented it as a totally new drug and, more importantly, as a particularly lethal drug. In fact crack was simply cocaine hydrochloride mixed with baking soda. The sole reason that cocaine hydrochloride was mixed with baking soda was to make it combustible. Cocaine hydrochloride is water soluble and non-combustible.[68] So, cocaine hydrochloride had to be inhaled into the nasal passages rather than smoked in a cigarette or pipe.

This practice is inconvenient and unhealthy because the powdered cocaine hydrochloride dissolves in the moist nasal passages and separates into cocaine and *hydrochloric acid*. The cocaine is then absorbed into the blood stream through the mucous membranes[69] of the nasal tissue, while the hydrochloric acid remains on the nasal tissues and eats into them. This causes a number of health problems, including damage to the olfactory nerve and nasal septum. Cocaine is a relatively short acting drug that affects the user within seconds of ingestion and lasts for

[67] E. Fierens, 'Archeological and Artistic Sources of Coca Consumption in Pre-hispanic America' (1991) 53(5) *Verhandelingn Koninklijke Academie Voor Geneeskunde Van Belgie* 463, 463.

[68] Vasica and Tennant, above n 62, 261.

[69] Ibid.

between five and ninety minutes.[70] A heavy user would need to inhale the drug many times a day and this could result in significant damage to the nasal passages over time.

In view of these problems, cocaine users tried ‘freebasing’, which involved vaporising cocaine hydrochloride – using ether and a flame – then inhaling the vapours.[71] A number of persons, including the famous American comedian Richard Prior, suffered facial and scalp burns while doing this. It was then discovered that when cocaine hydrochloride was mixed with sodium bicarbonate (or sodium carbonate) it became combustible and could be smoked in a pipe or cigarette.[72] Thus, crack was safer to use than cocaine hydrochloride. So, it was simply false to say it was a new drug, or to claim that it was more lethal. Claiming that crack was a new and more lethal drug is like claiming that aspirin was a new and more effective drug when it was first sold in a gelatine capsule instead of as a tablet. This is just one example of the way in which the media have for years been very careless, superficial and irresponsible[73] about reporting drugs.[74]

There are many other drugs that have been used and abused in society over time, and many new drugs are being developed all the time, but most of them will not be specifically mentioned in this paper. Some of the more common hallucinogens were Lysergic Acid (LSD) and Psilocybin.

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[70]Ibid.

[71]Ibid.

[72]Ibid.

[73]Engelsman, above n 29, 216.

[74]Zayler, above n 10, 404.

Psilocybin is found in certain mushrooms known as ‘goldtops’ and these mushrooms grow naturally in the wild. Of the modern drugs, the one that is currently most popular is the amphetamine-based group of drugs, such as Methamphetamine (speed) and Methylenedioxymethamphetamine (ecstasy). Having considered the history of a range of illicit drugs, licit drugs will now be considered.

II F. Licit Drugs including Alcohol, Tobacco, Prescription and Non-prescription Medicines

Australia has some of the highest per capita consumption rates of regulated prescription and non-prescription analgesics and antidepressant drugs in the world as the research shows. Australians were provided with 5.1 million anti-depressant prescriptions in 1990, and this increased to 8.2 million prescriptions in 1998.[75] Over this time the use of the newer drugs, selective serotonin reuptake inhibitors increased significantly, as is indicated by the huge increase in prescriptions, while the use of the previous alterative, tricyclic antidepressants, decreased by only 25% .[76] In 1998, Australian levels of antidepressant use were similar to the United States – and the Australian rate of increase in use between 1993 and 1998 was only second to Sweden.[77]

[75] Peter McManus, et al, ‘Recent Trends in the Use of Antidepressant Drugs in Australia 1990-1998’ (2000) 173 *Medical Journal of Australia* 458, 458.

[76] Ibid.

[77] Ibid.

Australians are also the third highest users of prescription psycho-stimulant medications for children in the world.[78] These drugs are also prone to abuse, and such usage rates reveal a culture that indulges in widespread drug use and has a liberal attitude to prescribing these drugs to children. Currently in Australia, alcohol and tobacco are regulated and provide a source of profit to the government through taxation.

Governments in Australia maintain this position despite the research showing that alcohol and tobacco have a history of causing thousands of painful, tragic and prolonged deaths every year. 'In 1990, of the estimated 25,500 deaths attributed to drug use, 71% were due to tobacco, 26% to alcohol, 2% to opiates and 1% to other drugs, including over-the-counter medications.'[79]

Tobacco, alone, has an appalling record – and if addiction and death rates were the criteria for prohibition and criminalisation, then this drug would be the first to qualify. In 1998, some 19,019 Australians died from tobacco-related diseases[80] and the rate has only declined slightly over the past few years. In 1998, tobacco accounted for over 82% of all drug-caused deaths, including

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[78]Constantine G Berbatis, V. Bruce Sunderland and Max Bulsara, 'Licit Psychostimulant Consumption in Australia, 1984–2000: International & Jurisdictional Comparison' (2002) 177 (10) *The Medical Journal of Australia* 539, 539.

[79]Tobie L Sacks and Nicholas A Keks, 'Alcohol and Drug Dependence: Diagnosis and Management' (1998) 168 (7) *The Medical Journal of Australia* 355, 355.

[80]Bruno Ridolfo and Chris. Stevenson, 'The Quantification of Drug-caused Mortality and Morbidity in Australia' 1998 (2001) (7) *Drug Statistics Series, Australian Institute of Health and Welfare* 98.

alcohol and illicit-drug deaths.[81] The total number of deaths recorded in Australia in 1998 was 127,202 [82] and, in 1998, tobacco was responsible for causing about 15% of those deaths.[83]

Nicotine is one of the most addictive substances known to man. In its pure form, it is more lethal than any of the other drugs mentioned. The lethal dosage of nicotine for an adult is 60 mg[84], whereas the lethal dosage for strychnine is 75 mg[85]. The lethal dosage for arsenic is 200 mg[86] and for heroin it is over 250 mg for a non-tolerant user.[87]

Even more disconcerting is the fact that in studies aimed at determining sequential patterns of drug use, it was found that the drug most often used first was nicotine, through cigarette smoking.[88] Nicotine is the number-one gateway drug for the majority of drug users. The second most common drug used first was alcohol.[89] Alcohol was credited with 2,371 deaths in 1998.[90]

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[81]Ibid.

[82]Australian Bureau of Statistics, *Deaths, Australia 1998* (2003) 19.

[83]Ibid.

[84]Arena, above n 39, 97.

[85]Ibid.

[86]Ibid.

[87]Ibid 444.

[88]Leroy C. Gould, et al, 'Sequential Patterns of Multiple-Drug Use Among High School Students' (1977) 34 *Archives of General Psychiatry* 216, 221.

[89]Ibid.

[90]Ridolfo and Stevenson, above n 80, 98.

Over 250,000 Australians can be classified as alcoholics and an equal number of families are affected by the abuse of alcohol.[91] In Australia, alcohol is involved in the majority of criminal offences, particularly offences of non-lethal violence. Alcohol was consumed prior to the commission of 73% of violent assaults;[92] 67% of convicted rapists in Victoria reported drinking prior to the commission of the offence;[93] alcohol was present in 50% of homicides nationally.[94] Of men convicted of car theft, 46% had consumed alcohol prior to committing the offence[95], and 42% of domestic violence incidents in Western Australia involved alcohol.[96] As the research shows, there is a link between alcohol and crime. Research (based on Victorian prisoner surveys undertaken by Bartholomew[97] in 1968) found that from 1,836 prisoners surveyed, just over 59% had consumed alcohol before committing the offence for which they were charged.[98] When this research was repeated in 1983, the rate had increased to 81%.[99] It was also found that over 82% of prisoners who committed offences of personal violence either had a drinking problem, or had

[91]Gail Mason and Paul R Wilson, 'Alcohol and Crime (April 1989), Trends & Issues in Crime and Criminal Justice No. 18' *Australian Institute of Criminology* 2.

[92]Ibid.

[93]Ibid 3.

[94]Ibid.

[95]Ibid.

[96]Ibid.

[97]A. Bartholomew, Alcohol, Drugs and Crime (May 1985) *Police Life* 82, 82.

[98]Ibid.

[99]Mason and Wilson, above n 91, 2.

been drinking at the time of the offence, in comparison to 53% of property offenders.[100] Later research conducted in Tasmania[101] reported similar findings and it is likely to be the same in most states.

Behaviour that may fall short of constituting a criminal offence, but that can be characterised as anti-social or deviant, is also closely correlated with alcohol consumption. The survey research indicates that 46% of a national survey sample in 1993, and 41% in 1995, reported experiencing alcohol-related disorder at least once in the previous twelve months, most commonly in the form of verbal abuse, or being put in fear.[102]

Despite the serious social problems and the high death rates caused by alcohol, it has never been prohibited or criminalised in Australia; yet the rate of consumption has been in decline since the 1970s.[103] In 1975, Australia was tenth in the world in total absolute alcohol consumption – then Australia dropped to thirteenth by 1985, and continues to drop.[104] In contrast to nicotine and

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[100]Bartholomew, above n 97, 82.

[101]R. White and K. Boyer, 'Alcoholism amongst the Tasmanian Population: Research Note' (1985) 18 *Australian and New Zealand Journal of Criminology*, 109, 110.

[102]Commonwealth Department of Health and Family Services, 'National Drug Strategy Household Survey Report, 1995' Commonwealth Department of Health and Family Services, 1996.

[103]Department of Community Services and Health, Statistical Services Division, *Alcohol in Australia: A Summary of Related Statistics* (1988) 41.

[104]Ibid.

alcohol, only 357 opioid-related deaths were recorded in 2003,[105] and in 1988 only four deaths were recorded where the underlying cause was cocaine.[106]

These statistics are not presented in order to support an argument that alcohol and tobacco should be criminalised, but to demonstrate two things. Firstly, on almost any comparative basis the regulated drugs are as bad for the user and society as the criminalised and prohibited drugs. Secondly, to show that education and regulation are a valid alternative to prohibition and criminalisation. The above research shows that alcohol and nicotine consumption have declined over time, at least partly due to better education and regulation.

> Following the decline in per-capita alcohol consumption over the past 20 years, alcohol-related mortality fell substantially during the 1990s. Alcohol-related brain damage declined after the introduction of thiamine-fortified flour in 1991. Tobacco-related deaths have fallen considerably among men and levelled off in women, reflecting the steady decline in smoking prevalence and per-capita tobacco consumption in recent decades. Anti-smoking campaigns have played a small part in this decline, with other factors including increased prices, reduced advertising, and restrictions on smoking in public places.[107]

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[105] L. Degenhardt, A. Roxburgh and E. Black, 2003 'Australian Bureau of Statistics Data on Accidental Opioid Induced Deaths (2004)' *National Drug and Alcohol Research Centre* 1.

[106] Ridolfo and Stevenson, above n 80, 98.

[107] Alex D. Wodak, 'Alcohol and drugs' (2002) 176 (1) *Medical Journal of Australia* 5, 5.

It is likely that illicit-drug consumption would also decline under a properly designed regulatory regime. Other researchers support this view and have argued that the laws and culture governing these drugs have a direct affect on the rates of addiction.[108]

> Alcoholism in Arabia, for instance, is rarer than in Scotland ... For example, among 50 million English ... there are about 500,000 alcoholics – 1% rate.. Among 40 million Siamese ... there are an estimated 400,000 addicts – 1% rate ... The prevalence of addiction to a particular drug is critically affected by its availability and acceptability. Both of these are controlled by laws and mores.[109]

So, in view of the fact that drug usage and addiction rates are culturally related, how have drug users in western society fared? This question is best answered by considering how governments in Australia, the United Kingdom, and particularly the United States of America chose to deal with drugs in their modern societies. The first country to consider is the United States of America and the most significant response to drugs in the USA was prohibition. The history of governmental responses to drugs in society starts with the first era of prohibition.

III. PROHIBITION AND CRIMINALISATION

The next part of this paper will consider the history of prohibition and criminalisation. The most famous era of prohibition occurred in the USA in the early 1900s and was directed at the drug

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[108] John Marks, 'Point of View – Opium, the Religion of the People' (22 June 1985) 325 (8443) *The Lancet* 1439, 1439.

[109] Ibid 1440.

ethyl alcohol. Despite the USA having experienced the disastrous effects of the prohibition and criminalisation of alcohol, as this era came to an end the USA commenced a new era of prohibition against a new range of drugs. Not surprisingly, similar consequences arose – but this time they were far more extreme.

III A. Prohibition and the Rise of Organised Crime

Before alcohol prohibition, western criminal gangs had limited means of making money. They could steal, fence stolen property, commit fraud offences, extort money, or provide prostitution, pornography and illegal gambling. In western countries, these informal gangs exercised limited geographical control of local areas and had limited means at their disposal. Some of these activities were more lucrative than others, and they presented varying degrees of risk to the perpetrators. The limited income provided from these common criminal activities also left limited resources and motivation for these criminals to corrupt officials, obtain assistance for their activities, or to protect themselves from detection and prosecution. It also left them with more limited means with which to retain various professionals, such as lawyers and accountants, to advise them.

Once alcohol prohibition was introduced, all of this changed. Organised crime was able to prosper and gain strength and influence. The money that could be made from supplying alcohol was far greater than any previous sources of income. Almost everything was now within the reach of organised crime. At the same time these criminals prospered, large cross-sections of the community, often for the first time in their lives, began to commit criminal offences by

consuming criminalised substances, or attending 'speakeasies'. This only served to undermine the rule of law and corrupt people who would otherwise have remained generally law abiding. This was another highly undesirable consequence of prohibiting a drug that had been voluntarily consumed for thousands of years by the vast majority of people.

Criminals like Al Capone quickly expanded their organisations and hired other petty criminals to do their bidding. These organised crime networks now had the resources and motivation to corrupt businessmen, police officers, prosecutors, politicians, judges, and other public officials.[110] This ensured that, at every step of the way, organised crime was protected from detection or prosecution. Corruption was present prior to prohibition, but with the influx of even larger amounts of cash into the crime networks, these types of activities occurred more frequently.[111] Robert Marks refers to the 'extraordinary incentive'[112] that high prices create and the consequences that flow from those high prices in a black market.[113]

Eventually, alcohol prohibition was recognised as a failure and was repealed in favour of regulation. Other drugs were then prohibited, and the problems associated with drug consumption and organised crime became much worse. The wealth, prosperity, and influence of

[110]Zayler, above n 10, 404.

[111]Engelsman, above n 29, 214.

[112]Robert Marks, 'Prohibition or Regulation: an Economist's View of Australian Heroin Policy' (June 1990) 23 *Australian & New Zealand Journal of Criminology* 65, 77.

organised crime then increased exponentially as drug prohibition provided unprecedented financial opportunities to a range of criminal organisations.

With the failure and repeal of alcohol prohibition and the subsequent introduction of drug prohibition in the USA, the world was at a crossroads. It could proceed with regulation in response to the perceived drug problems, or it could follow the USA and try drug prohibition. The international treaties of the time certainly did not call for or require prohibition. Those treaties were largely directed at the control of production and distribution. At the start of regulation under the international treaties there was a significant and desirable effect on the production of heroin as the following research indicates.

> The Geneva Convention of 1925 imposed a set of strict regulations on the manufacture and export of heroin, and the Limitation Convention of 1931 stipulated that manufacturers could only produce enough heroin to meet legitimate "medical and scientific needs." As a result of these treaties, the world's total legal heroin production plummeted from its peak of nine thousand kilograms in 1926, to little more than one thousand kilos in 1931.[114]

Despite this initial success and despite the previous failure of alcohol prohibition, the USA (and later Australia) turned to the full prohibition and criminalisation of certain drugs.

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[113]Ibid 66.

[114]Alfred W. McCoy, Cathleen B. Read and Leonard P. Adams II, *The Politics of Heroin in Southeast Asia* (1972) 5.

III B. International Drug Treaties

Over the twentieth century, international treaties and agreements on drugs were formulated in 1912, 1926, 1953, 1961, 1971 and 1988. Each of these treaties has escalated the levels of criminalisation and prohibition of drugs.[115] Prior to ratifying particular UN treaties,[116] Australia also had a history of medical usage of diacetylmorphine. In Queensland, dangerous drugs were regulated under Part IV Division IV of the *Health Act 1937 (*Qld*)*, and within that part, section 130 of the *Health Act 1937 (*Qld*)*[117] defined a dangerous drug. At that time, opium, morphine, heroin and cocaine were all defined as dangerous drugs, and section 30 also provided for the regulation of their possession and supply. Subsequently, Part IV Division IV of the *Health Act 1937 (*Qld*)* was amended many times until it was eventually repealed. It was then replaced by the *Drugs Misuse Act 1986* (Qld).

In Australia, we gradually followed the USA's lead, and in 1954 the Federal government banned imports of heroin and the Queensland government prohibited the drug.[118] None of the international treaties up to that point had called for full criminalisation or prohibition. In fact, the earlier treaties were directed at imposing restrictions and limitations on the production, trade and use of opium (i.e. regulation). These treaties recognised that opium has valid and important

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[115]Engelsman, above n 29, 214.

[116]*Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production Of, International and Wholesale Trade in and Use of Opium*, (New York 23 June 1953) and *Single Convention on Narcotic Drugs*, (New York 30 March 1961).

[117]See Appendix D.

[118]Marks, above n 6, 142.

medical and scientific uses. As Article II of the *Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in and Use of Opium* provides: 'The parties shall limit the use of opium exclusively to medical and scientific needs.'[119] The later treaty, the *Single Convention on Narcotic Drugs*, also similarly provides:

PREAMBLE

The Parties,

Concerned with the health and welfare of mankind,

Recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes ...

Article 4

GENERAL OBLIGATIONS

1. The Parties shall take such legislative and administrative measures as may be necessary:

(a) ...

(b) ...

(c) Subject to the provisions of this Convention, to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs.[120]

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[119] *Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production Of, International and Wholesale Trade in and Use of Opium*, (New York 23 June 1953), 62.

[120] *Single Convention on Narcotic Drugs*, (New York 30 March 1961) 204, 216.

The Single Convention on Narcotic Drugs also called for treatment of drug addicts:

Article 38

TREATMENT OF DRUG ADDICTS

1. The Parties shall give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts.

2. If a Party has a serious problem of drug addiction and its economic resources permit, it is desirable that it establish adequate facilities for the effective treatment of drug addicts.[121]

These more rational approaches seem to have been abandoned over time.

III C. Consequences of Alcohol and Drug Prohibition

In the initial periods of prohibition, some western democracies had zero tolerance and life imprisonment (or death) for certain drug offences. In the USA, in 1956, the Boggs-Daniel Act provided for a minimum penalty of 10 years and maximum of death to anyone selling heroin to a minor,[122] and some states carried penalties of life imprisonment for possession of cannabis.

One example of the extensive harm inflicted on drug users and the community from prohibition and criminalisation is demonstrated by a comparison of a range of crime statistics compiled before and during drug prohibition. One researcher compared the homicide rates in the United States of America using the introduction of alcohol prohibition and criminalisation and its repeal,

[121]Ibid 254.

[122]Caplehorn, above n 1, 356.

followed by the introduction of drug prohibition and criminalisation as a reference point, and found the following.[123] The United States of America began prohibiting and criminalising alcohol in 1907 and the national homicide rate was 1 per 100,000 people per annum.[124] Alcohol was prohibited nationwide by 1919, and by that time the homicide rate had increased to 8 per 100,000.[125] By the repeal of prohibition in 1933, the rate had peaked at 10 per 100,000. [126] The rate then shrunk to 5 per 100,000 and remained constant until 1964 when the USA reintroduced prohibition aimed at certain drugs.[127] From 1964 to 1970, the homicide rate returned to 10 per 100,000.[128]

Over time, successive governments have offered increased law enforcement as the solution to the crime problems associated with drug prohibition.[129] This approached has failed in all countries in which it has been adopted. Not only has it failed but in Australia and in the United States of America it has created some serious consequences for the community – including a significant increase in the number of state prisoners jailed for drug offences, in fact in the United States of

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[123] Kirby R. Cundiff, 'Crime and the Drug War' (August 1994) *Claustrophobia* 1, 1.

[124] Ibid.

[125] Ibid.

[126] Ibid.

[127] Ibid.

[128] Ibid.

[129] Ibid.

America the number increased from 3,079 in 1964 to 90,000 in 1989.[130]

> Prohibition and criminalisation so severely distorted the price of drugs that huge increases in crime rates followed. At the turn of the century, both heroin and aspirin were legally available and sold for approximately the same amount. Today aspirin can be purchased ... for 20 cents per gram; heroin costs $50 per gram. The price of heroin rose drastically after it was made illegal ... Dealers are willing to kill each other for profits ... junkies are willing to rob and kill for money to support their habit-money, if drugs were legal ... that they could easily obtain by working at McDonald's ... During prohibition, "liquor-store" owners murdered each other ... just as drug dealers do today. Today, liquor-store owners are generally peaceful. Eliminating the enormous profits involved in black-market businesses eliminates the motive for violent crime ...[131]

Similarly, in Great Britain in 1968, in response to the recommendation of the Brain Committee, the *Dangerous Drugs Act 1967* came into effect.[132] This act provided that only doctors specially licensed by the Ministry of Health could prescribe drugs to addicts.[133] Only psychiatrists working in public hospitals were given licences, and this caused a shortage of heroin.[134] Between 1969 and 1970, the price of heroin increased by 600%, and heroin importation was

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[130]Ibid.

[131]Ibid.

[132]Caplehorn, above n 1, 354.

[133]Ibid.

[134]Ibid.

estimated to have increased from 29.5kg in 1968 to between 240–550kg in 1978.[135] Many causes other than drug prohibition have also been nominated to explain the crime rates in the USA, but none have proved to be supported by independent evidence.[136]

Most governments respond to the drug problem by claiming that more law enforcement is the answer. However, the statistics from both Australia and the USA clearly show that law enforcement is unable to deal with the problem of drug abuse. Alcohol prohibition created an environment where organised crime could flourish and prosper. This created a highly successful, wealthy and powerful organised crime network that is still operating in the USA and other countries around the world. When prohibition was applied to drugs, a second era of organised crime and corruption commenced.

The rise of organised crime as a result of, firstly, alcohol prohibition, and then the later drug prohibition, is discussed in the following quote that outlines the direct link between prohibition and the rise of organised crime.

> At first the American Mafia ... left the heroin business to the powerful Jewish gangsters – such as “Legs” Diamond, “Dutch” Schultz, and Meyer Lansky ... in 1930–1931, only seven years after heroin was legally banned, a war erupted ... [with] more than sixty gangsters dead came a new

[135] Ibid.

[136] Cundiff, above n 123, 1.

> generation of leaders ... Salvatore C. Luciano, known to the world as Charles "Lucky" Luciano ... one of the most brilliant criminal executives ... outlined his plans for a modern, nationwide crime cartel ... within a few months the National Commission was functioning smoothly.[137]

To this day the USA has not regained control over organised crime networks, or any of the problems associated with them. Similar rises in organised crime occurred in all countries that prohibited these substances, or became involved in manufacturing them. Production moved to places like China and Europe, where local organised crime networks benefited and prospered from the criminalisation and prohibition of drugs.[138]

Meanwhile in the USA, criminals like Charles 'Lucky' Luciano restructured, developed and managed organised crime's international heroin trade in the 1930s.[139] The organised crime networks that operated during the alcohol prohibition now had more incentive and motivation than ever to promote and distribute prohibited drugs – and they proved to be highly motivated, capable and successful.

> The narcotics syndicate Luciano organised after World War II remains one of the most remarkable … For more than a decade it moved base from the Middle East to Europe, transformed it into heroin, then exported it in substantial quantities to the United States – all without ever suffering a

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[137]McCoy, Read and Adams, above n 114, 17.

[138]Ibid 5.

[139]Ibid 147.

> major arrest or seizure … within the United States, increased the number of active addicts from an estimated 20,000 at the close of the war to 60,000 in 1952 and to 150,000 by 1965.[140]

These rates of usage translate into massive profits for organised crime who strongly encouraged the usage of these drugs to maximise their profits.[141] The effect of prohibition became clear overtime – as Chesher says: 'Marketplace harms (crime, corruption, and social costs) are a consequence of, and not a reason for prohibition'.[142]

III D. Rates of Usage of Heroin and Cocaine and the Profits Reaped by Organised Crime

The amount of money that is generated from the sale of cocaine and heroin shows how powerful and successful organised crime is now. According to the conservative estimates of the Executive Office of the President of the United States – Office of National Drug Control Policy (ONDCP) – Americans spent $35.3 billion on cocaine in 2000 and consumed 259 metric tons of cocaine in 2000.[143] The ONDCP also estimates that in 2000 Americans spent approximately $22 billion on heroin and consumed 13.3 metric tons.[144] Based on the figures above, these two drugs reaped an estimated $US55.3 billion for organised crime in America in 2000. These levels of consumption

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[140]Ibid 24.

[141]Alex D. Wodak, 'The Never-ending Story' (1990) 9(4) *Drug and Alcohol Review* 346, 348.

[142]G. B. Chesher, 'Controlled Availability as an Alternative' (1990) 9(4) *Drug and Alcohol Review* 369, 369.

[143]Jennifer Lloyd, 'Cocaine - November 2003 Fact Sheet' (2003) Executive Office of the President of the United States - *Office of National Drug Control Policy, Drug Policy Information Clearinghouse* 1,1.

[144]Jennifer Lloyd, 'Heroin - June 2003 Fact Sheet' (2003) Executive Office of the President of the United States - *Office of National Drug Control Policy, Drug Policy Information Clearinghouse* 1,1.

and profit have been broadly similar for decades.

IV. NATURE OF DRUGS AND DRUG USE

In view of the information above, it is clear that many people chose to use drugs. The research shows that there are many different reasons for using drugs[145] and that drug users view their drug usage and treatment differently. Research indicates that users take drugs 'because they like the effects', are risk takers, self-medicate for past and current painful situations, and because they are addicted.[146] Not every drug user is dependent and those who are will not always want or seek treatment.[147]

Some users form dependencies, or addictions, and some do not. Persons with addictive dysfunctional personalities are the ones most at risk and those most in need of counselling and support to deal with their behaviours. When a person is able to manage their drug use and remain a contributing member of the community, the intervention of the criminal justice system is not required and any harm to the drug user or the community is minimised, if not eliminated. Problems arise when a person's drug use negatively impacts on them and the community in ways that result in significant harm to the user and the community. This is the point at which drug use becomes drug abuse and the point at which a drug user is no longer capable of managing their

[145] D. Hawks,'Why Any War Against Drugs Will Fail' (1991) 155 *The Medical Journal of Australia* 38, 39.

[146] Toni Makkai, 'Substance Use, Psychological Distress and Crime' (2003) 179 (8) *Medical Journal of Australia* 399, 399.

[147] Ibid.

drug use. It is then that the community cannot tolerate drug abuse.

When drug use becomes drug abuse, stronger intervention is needed, including intervention by the criminal justice system. Such intervention is then fully justified and appropriate if carried out with a view to addressing the addiction in a way that ultimately enables the drug users to mange his or her drug abuse problem and function in society. Under the current system, most of these people are simply dealt with under the criminal law and do not receive the support of a comprehensive system of supervised drug rehabilitation. While there is some drug court-based drug diversion,[148] it is extremely limited in its scope and operation. A person with a dependency or addiction is likely to continue to offend where rehabilitation is inadequate and drugs remain expensive.

Some drugs have the potential to be addictive as a result of chemical processes, as is the case with nicotine or heroin, while others merely foster psychological dependence, as is the case with amphetamines or cocaine. Drug users themselves – and their motivations or reasons for using – are more complicated. 'In this complex environment, public policy responses, such as drug courts and court diversion systems, need to be cognisant of what drives behaviour and develop appropriate responsive systems (of which levels of dependency will be only one factor)'.[149]

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[148] *Drug Rehabilitation (Court Diversion) Act* 2000 (Qld), *Drug Rehabilitation (Court Diversion) Regulation* 2000 (Qld).

[149] Makkai, above n 146, 399.

Where a person is abusing drugs as a result of an addiction or dependence on that drug, and the drug is also prohibited and criminalised, the cost of the drug will leave most users with no choice but to commit offences to afford the drug. Criminalising heroin is unlikely to make a difference to that person's drug use. Addicted drug abusers will do whatever they have to do to obtain and use their drug, whether the drug is legal or illegal – just the same as a smoker and an alcoholic do. If the drug abuser was able to make a choice about whether or not to use the drug, they would probably not take it – but at that time they are unable to make that choice, despite knowing that it is causing them harm and that they have a drug-addiction problem.

In contrast to this, persons with a dependency on a recreational non-addictive drug like amphetamine can be far more easily treated through good regulation and education. A drug user in this category can exercise choice, but criminalising these drugs still creates an additional set of problems and consequences that are a barrier to the effective management and control of the problem and minimisation of the harm.

V. DRUG USAGE IN MODERN SOCIETY

Despite prohibition and criminalisation, a number of people have made contributions to society while using various drugs. This fact supports the idea that persons with a drug problem can still function in society and fulfil responsible occupations.[150] As far back as 1919 'over 20% of

[150] Caplehorn, above n 1, 355.

addicts in the New York City narcotic clinic were in occupations where human safety depends on perfect sobriety'.[151] Testing of heroin users in 1940s also showed that 'the chronic administration of opioids caused little or no impairment in intellectual or psychomotor function'.[152] Further testing of heroin addicts in the 1960s also found 'an initial non-significant decrease in performance which disappeared by the 28th day'.[153] People who use drugs can continue to participate in and contribute to society if the drugs are not prohibited and criminalised. The following persons were known to use drugs by their own admission, from eyewitness accounts, or through their biographies. The list is not meant to be comprehensive.

NAME	**OCCUPATION**	**DRUGS USED**
Lewis Carrol	Mathematician and author	Psilocybin, LSD
Sarah Bernhardt	Actress	Cocaine
Elizabeth Browning	Author	Opiates
William S Burroughs	Author and historian	Cocaine and opiates

[151] Ibid.

[152] Ibid.

[153] Ibid.

Winston Churchill	Prime Minister of Great Britain	Alcohol
Samuel Coleridge	Poet	Opiates
Salvador Dali	Artist	Hashish
Charles Dickens	Author and philanthropist	Opiates
Thomas Edison	Inventor	Cocaine and alcohol
Professor Timothy Leary	University lecturer	LSD
Ulysses S Grant	Army general	Cocaine
Aldous Huxley	Author	Mescaline
Pablo Picasso	Artist	Opiates
Sir Walter Scott	Poet, author, barrister, politician	Opiates
Jules Verne	Author	Cocaine
Robert Louis Stevenson	Author	Cocaine and morphine
Peter Fonda	Actor	LSD

It is clear that people at all levels of society have used drugs. It is also clear that many people have been able to function in society despite their drug usage. So, after decades of prohibition, criminalisation and law enforcement, it is necessary to establish the current rate of drug usage in Australia.

V A. Current Drug Use

The following research provides an estimate of the current level of illicit drug use in Australia:

> Results from the 2001 National Drug Strategy Household Survey indicate that an estimated 2.6 million Australians, or 16.9 % of people aged 14 years and over, had used illicit drugs in the previous 12 months. Cannabis was the most prevalent drug used (by 12.9% of total people in this age group) ... Amphetamines were used by 3.4% of people aged 14 years and over, ecstasy by 2.9% and heroin by less than 1%.[154]

It should be noted that these figures are formulated relying on voluntary and untested admissions from respondents and the actual rates may vary. However, even these figures show that a large number of Australians continue to consume a wide range of illegal drugs. Drug use is not new; it has been around for thousands of years – but policies of prohibition and criminalisation are new. The next issue to consider is the effect of prohibition and criminalisation on crime rates.

VI. CRIMINALISATION, PROHIBITION, HARM AND CRIME RATES

Research indicates that the overall cost to the community of drug-related crime is $1,960 million dollars per annum[155] and does not include numerous intangible costs such as mental health costs, drug users' services, treatment programs, or the costs of government initiatives.[156] Research also

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[154] Australian Bureau of Statistics, '*Drug Induced Deaths'* 2003 1.

[155] Pat Mayhew, 'Counting the Costs of Crime in Australia' Trends and Issues in Crime and Criminal Justice No. 147, *Australian Institute of Criminology* (April 2003) 1, 5.

[156] Ibid.

shows a link between drug use and property crime in up to 52% of all adult male prisoners in Australia.[157] In 1990, one researcher estimated that in 1984–5 thefts to finance opiate purchases were responsible for approximately 33% of all stolen property in Australia, at a value of $1,800 million dollars.[158] This situation exists largely because of the artificially inflated cost of procuring illicit drugs under prohibition and criminalisation. This is a link that was recognised by the Prime Minister, John Howard, on the 16th March, 1998, at the launch of the Australian National Council when he said: 'Research shows that more than half, and possibly up to 80%, of property offences have some drug involvement. Between 45% and 60% of convicted offenders committed property crimes to support drug habits'.[159]

Research as far back as the 1980s found high rates of drug related crime, particularly crime related to heroin. One study found that between 76% and 86% of drug-related crimes committed between 1977 and 1981 were associated with heroin use.[160] In the 1990s, Marks found: that 80% of inmates in NSW were incarcerated for drug-related crime; that drug use was involved in 50% of break and enter offences in NSW and 63% of Victorian burglaries; and that 46% of armed

[157] Toni Makkai and K. McGregor, 'Drugs and Crime: Calculating Attributable Fractions from the Duma Project' in D. Collins and H. Lapsley (eds) *Counting the Cost: Estimates of the Social Costs of Drug Abuse in Australia in 1998–9* (2002) National Drug Strategy Monograph Series No 49 Australian Department of Health and Ageing.

[158] Marks, above n 6, 148.

[159] The Prime Minister Honourable John Howard, 'The Prime Minister, Honourable John Howard's Announcement of the Australian National Council on Drugs' (Speech delivered at the launch of the Australian National Council on Drugs), Brisbane, 16 March 1998.

[160] Marks, above n 6, 145.

robberies in NSW were committed by drug-addicted persons.[161] Despite this, and despite the fact that prohibition is a failure, the state and federal governments maintain policies of prohibition and criminalisation. In considering alternatives, Wodak, amongst others, supports the proposition that controlled availability of illicit drugs is likely to reduce property crime.[162] To illustrate these points, compare the following scenarios that offer a clear choice between two very different future societies. In the first scenario, a youth (referred to as Joe (gender neutral)) has a dependency on heroin in a society where heroin is prohibited and criminalised. In the second scenario, society has legalised and regulated heroin.

Scenario One: Joe associates with criminals to get the drug. Joe takes the drug partly because during his or her rebellious stage its illegality makes it seem fun, fashionable and daring. As a dependency develops, Joe needs to start committing crime to pay for the drug as it is very expensive under this regime. Joe turns to property crime, prostitution, or fraud to pay for the drug. It is necessary for Joe to inject the drug because, as a result of criminalisation, the drug is of poor quality, the dosage is uncertain,[163] and the drug has been adulterated with noxious substances. Joe contracts various diseases and illnesses as a result of his or her unsafe drug use. The diseases include hepatitis and AIDS as a result of sharing needles. Joe's health deteriorates and he or she accumulates a lengthy criminal history. Joe ends up serving one or more periods of imprisonment. Joe is estranged from his or her family and cannot gain any employment as a

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[161] Marks, above n 6, 155.

[162] Wodak, above n 141, 348.

[163] Chesher, above n 142, 369.

result of his or her poor health and criminal record. Eventually, though a combination of all of these circumstances, Joe dies.

Scenario Two: One of the reasons that Joe took the drug was that he or she has personality tendencies towards addictive behaviours and risk taking. Joe finds that he or she has a problem with the drug and visits the doctor. The licensed doctor has qualifications, experience and knowledge with this type of problem, and Joe begins treatment. Joe, in the meantime is provided with a prescription for heroin and buys pharmaceutical-grade heroin in a measured dosage from the chemist for a nominal cost. Joe takes the drug orally rather than by injection and is also able to take it home to use. Joe's family assist Joe to work on his or her drug problem and Joe receives counselling, education and rehabilitation. Joe retains his or her employment – or course of study – and remains in the community and in contact with family. Joe does not contract any diseases and does not commit any criminal offences to get the drugs. Joe does not serve any periods of imprisonment and does not acquire a criminal record. After a period of rehabilitation, Joe moves on from drug use.

In scenario two, society experiences a much lower property crime rate and a lower infection rate for drug use related diseases, such as AIDS. There is a greatly reduced risk of persons stepping on needles as they are rarely used – and if they are used, then that use occurs in appropriate places and the needles are disposed of properly. The cost to the community from drug abuse is also significantly lower. Organised crime is deprived of its major sources of income and some civil rights are restored.

Currently, the state and federal governments outlaw particular drugs and enact laws containing extremely harsh criminal penalties of up to 25 years imprisonment[164] and life imprisonment[165] for some drug offences. Governments spend hundreds of millions of dollars investigating those offences and prosecuting drugs users, suppliers and addicts with no real effect on drug use or abuse rates. As Caplehorn says: '… the experience of the last seventy years indicates that it is futile to attempt to control individual, private behaviour by legislation'.[166] Marks put it in these terms: '… the social cost of "the insanely expensive and damaging" policy of prohibition far outweigh the social benefits of the policy'.[167]

All of these consequences arose after governments chose, for the first time in thousands of years, to totally prohibit and criminalise certain drugs. The USA's decision was especially surprising given that they had already experienced the prohibition of alcohol and knew that prohibition was a disaster. In America during the 1950s, numerous experts and authorities – including the Yale Law Journal, the New York Academy of Medicine, Marie Nyswander, the American Medical Association and the American Bar Association – all argued against the continuation of prohibition.[168] Despite all this, Australia chose to follow America, even when other countries, such as the United Kingdom and various authorities within the USA, were taking a more

[164] *Sections 5(a), 9(a)* of the *Drugs Misuse Act 1986* (Qld).

[165] *Section 235* of the *Customs Act* 1901 (Cth).

[166] Caplehorn, above n 1, 351.

[167] Marks, above n 6, 150.

[168] Caplehorn, above n 1, 353.

moderate and reasonable approach.

Australia did so with undue haste and without any proper debate or consideration of the matter. The Menzies government criminalised and prohibited heroin within one month of McCarthyists from the USA lobbying for the change.[169] According to Zayler, the change was motivated by moralistic and paternalistic social attitudes from the Judaeo-Christian philosophy.[170] In Australia, just prior to criminalisation, addicts were committing very few crimes under the influence of drugs, unlike consumers of alcohol, and they maintained fairly low profiles within the community.[171] By the late 1980s it was estimated in the research that up to 80% of all criminal behaviour was heroin related.[172]

VII. TREATMENTS, CRIME RATES AND HARM MINIMISATION

Rates of drug abuse and crime prompted a search for solutions. One of the alternatives promoted as a solution to heroin addiction was to provide methadone, which is chemically similar to morphine and heroin. Methadone is a synthetic opiate invented by German chemists during the Second World War as a substitute for heroin.[173] Methadone was first proposed as a substitute for

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[169] Zayler, above n 10, 404.

[170] Ibid.

[171] Ibid.

[172] Ibid.

[173] Peter Edwards, 'They Don't Become Angels: Part 1' (1997) Drug Policy Alliance Library 1, 14.

heroin by Dole and Nyswander[174] in 1965/66. It was thought that methadone would assist a heroin user to develop a cross tolerance to heroin[175] and reduce the user's 'craving' for heroin[176]; this would enable the heroin user to reduce or eliminate their intake of heroin. A dose of methadone also lasts for a longer period of time than heroin.[177] However in Britain, researchers have found that methadone is far more addictive than heroin and the withdrawal symptoms far more severe.[178] These factors have contributed to an increase in the incidence of methadone being sold on the black market.[179] Other research shows that methadone not only has a wide range of serious health effects, but a higher death rate than heroin.[180] In one study in 1994, the death rate from heroin was found to be 1 in 2,582 , while the death rate from methadone was 1 in 134 – making methadone 19 times more toxic than heroin.[181] It also found that the prescribing of methadone syrup by doctors was ineffective in stopping illicit drug use.[182] Methadone was also

[174] See Vincent P. Dole and Marie E. Nyswander, 'A Medical Treatment for Diacetylmorphine (Heroin) Addiction' (1965) 193 (8) *Journal of American Medical Association* 80 and Vincent P. Dole, Marie E. Nyswander and M. J. Kreek, 'Narcotic Blockade' (1966) 118 *Archives of Internal Medicine* 304.

[175] Lewis and Chesher, above n 55, 219.

[176] Ibid.

[177] Ibid.

[178] Australian Bureau of Criminal Intelligence, above n 53, 33.

[179] Ibid.

[180] J. A. Marks, 'Deaths from Methadone and Heroin' (16 April 1994) 343 (8903) *The Lancet* 976, 976.

[181] Ibid.

[182] Ibid.

found to cause ‘disturbances of weight, sweating, sleep and dysphoria’.[183]

As one researcher said: ‘Given the dangers of methadone and its apparent ineffectiveness, perhaps the current vogue for methadone in the management of addiction should be reviewed’.[184] After decades of methadone programs, the research indicates that it will not solve the problem of heroin addiction and that methadone is not the lesser of two evils.

Research comparing drug-trial schemes with heroin addicts in the United Kingdom showed that 95% of heroin users prefer to use heroin in those trials.[185] Despite this, while heroin remains prohibited, there is a place for methadone trials for the small minority of people who would prefer to use it rather than heroin. Over the past decades many countries have held heroin trials and, in Britain, these trials have been reviewed by Dr Cindy Fazey, who has extensive experience in drug research. Dr Fazey found that:

> “... what works for drug addicts is giving them what they want, in quantities which keep them from withdrawing for as long as they believe that they need it. It works in the sense that they stay alive, do not spread HIV, lead more stable lives, do not commit as much crime, are less a burden to the state ... Criminal activity is not eliminated, but it is considerably reduced.”[186]

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[183]Ibid.

[184]Ibid.

[185]A. Parry, ‘*UK Methadone Programmes: A Public Health Disaster?*’ (1995) 3,3.

[186]Fazey, C.S.J., ‘*What Works: An Evaluation of Drug Treatments for Illicit Drug Users in the United Kingdom and Europe’ (*Paper presented at the NDRI What Works? Conference, New York, USA, October 22-25).

A review of these programs concluded that there was a place for both heroin and methadone treatment programs and that they complement each other.[187] That study also concluded that success depends on assessment of the individual addict,[188] and that the supply of heroin to addicts in the long term has positive effects on their addiction, overall health, rates of offending and recovery. However, while drugs remain prohibited and criminalised, rehabilitation will always be fraught with problems. Despite this, under either system rehabilitation as a priority still provides a better alternative to the current situation and is likely to reduce drug harm and crime rates.

Research on criminality indicates that heroin treatment programs reduce the crime rates[189] of drug addicted individuals. In one study of 144 heroin maintenance scheme patients, the conviction rates for those persons were compared against the rates prior to commencement of the program and then 18 months after the program started.[190] The study found that 'prior to entering the scheme the conviction rate was 6.88 crimes per person and this reduced to 0.44 crimes per person for the 18-month period after they commenced on the heroin maintenance scheme'.[191]

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[187]Edwards, above n 173, 20.

[188]Ibid.

[189]Edwards, above n 173, 9 and Engelsman, above n 29, 214.

[190]Edwards, above n 173, 11.

[191]Ibid.

It is likely that if drugs remain prohibited and criminalised, then any benefits that an addict may gain from being on a heroin trial will be diminished. Ideally, drug trials should be conducted in an environment of regulation and rehabilitation with ongoing support and self-development. Under these conditions, the majority of addicted users are likely, at some point, to choose to lead a drug-free life – or at least learn to manage their drug use sufficiently to function in society. The alternative is to continue the war on drugs.

VIII. DRUG LAW ENFORCEMENT AND THE 'WAR ON DRUGS'

Having considered the current rates of drug usage in both Australia and the United States of America and the profits gained by organised crime, the policy approach of the governments of Australia and the United states can now be considered.

VIII A. The 'War on Drugs' in the United States of America

Successive Presidents of the USA have declared war on drugs: Lyndon Johnson did so in the mid-1960s, followed by Richard Nixon in 1971, Gerald Ford in 1976, Jimmy Carter in 1980,[192] – then Ronald Reagan in 1982, followed by George Bush Senior in 1988, and now George W Bush Junior since the late 1990s. As Caplehorn says: 'Unfortunately, it seems that little has been learnt from this experience. The Bush administration persists in its "war on drugs" with the twin policies of international agreements/interdiction and harsh punishments for drug users'.[193] Prime Minister John Howard has taken the same approach to the drug problem.

[192] Wodak, above n 2, 37.

[193] Caplehorn, above n 1, 356.

In the USA, the ‘war on drugs’ has been fought using the combined resources of its army, navy and airforce; the Drug Enforcement Administration (DEA); the Bureau of Alcohol, Firearms, Tobacco and Explosives (AFT); the Coast Guard; the Federal Bureau of Investigation (FBI); the Central Intelligence Agency (CIA); the National Security Agency (NSA); US Customs and Border Protection; all the state and local police services and numerous other agencies. Collectively, these agencies have spent hundreds of billions of dollars and many of their members have been killed in the process. One of the justifications used by American politicians for such a massive commitment of resources, (American morality aside), is that national security may be at stake.[194] However, the more realistic threat to national security and stability is the threat from organised crime and corruption that has flourished under prohibition[195] within the USA.

Despite this massive effort and the incredible expenditure that has continued for decades, the number of people regarded as heroin addicts in the USA in 2001 is estimated by one researcher to be between 750,000 and 1,000,000.[196] Research by the US Department of Health and Human Services (HHS) also found that ‘in 2001, approximately 3.1 million Americans (1.4%) 12 years old and older had used heroin at least once in their lifetime. Persons ages 18 to 25 reported the

[194]Marks, above n 6, 163.

[195]Ibid.

[196]Lloyd, above n 144, 1.

highest percentage of lifetime heroin use with 1.6% in 2001'.[197] The rate of cocaine use in the USA was even higher, with an estimated 2,707,000 persons using cocaine chronically and 3,035,000 using occasionally in 2000.[198] The U.S. Department of Health and Human Services also found that, in 2002, more than '33 million people aged 12 and older (14.4%) reported that they had used cocaine at least once in their lifetime' and more than 8 million Americans (3.6%) aged 12 and older had used crack cocaine at least once.[199]

VIII B. Australia's 'War on Drugs'

Australia has acted in much the same way as the USA over the past decades. The Australian Federal Police (AFP) made drug law enforcement its number one priority in the 1980s. In the 1990s, the AFP was given a further boost in funding and resources for drug law enforcement.[200] With increased funding and a priority on drug law enforcement in 2003, the AFP reported that

they had seized approximately 2,467 kilograms of heroin in the past six years compared to 931 kilograms the six years prior to that.[201]

To place this seizure rate in some perspective it is worth estimating the percentage of heroin that

[197] Ibid.

[198] Lloyd, above n 143, 1.

[199] Ibid.

[200] Australian Federal Police, '*Research Note 7: The impact of AFP drug law enforcement on the availability of heroin'* (September 2004) 1,2.

[201] Ibid.

is seized compared to the total amount imported over the past six years. The only way to do this is to estimate the total usage. In order to calculate the percentage of heroin that is seized from the total amount that is imported, the following assumption is relied upon:

> The best estimates of the number of dependent heroin users in Australia in 1997–1998 from the three methods of estimation were between 67,000 and 92,000 and the median estimate was 74,000. The population prevalence was 6.9 per 1000 adults aged 15–54 years. The prevalence of heroin dependence in Australia is the same as that in Britain (7 per 1000) and within the range of recently derived estimates in the European Union (3–8 per 1000 adults aged 15–54 years).[202]

At the current population of approximately 20 million, the number of dependent users based on the above rate of 7 per 1000 is 140,000. This does not include recreational users and an allowance must be made for them as the research shows that they are a significant group.[203] Estimates of daily average rates of usage are further complicated by the fact that the research indicates that while the average user does use everyday, not all addicts do so.[204] The research by Dorn *et al*. indicates that '... the average dependent heroin user in Britain uses 0.33 grams of heroin a day for 228 days in a year'.[205] A further problem is the fact that the Australian research

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[202] Hall, above n 26, 528.

[203] Ibid.

[204] Ibid.

[205] N. Dorn, 0. Baker and T. Seddon, '*Paying for Heroin: Estimating the Financial Cost of Acquisitive Crime Committed by Dependent Heroin Users in England and Wales*' (1994) London Institute for the Study of Drug Dependence 1, 9.

shows that the purity of heroin – and therefore the actual amount –bought and used in Australian varies. Between July 1999 June 2003 the purity of police seizures of heroin varied between over 60% and under 20%, with purity generally below 30% from March 2004.[206]

Based on the above facts, and in view of the wide variations in some of the key elements, the estimate of the total amount of heroin consumed in Australia per annum is made conservatively and within an upper and lower range. To include the number of casual users it will be assumed that there are 150,000 users in Australia at the upper end of the range (about 0.75% of the population) and 125,000 at the lower end. It is also assumed that, at the higher end of the range, these users take an average of 0.200 grams per day, 250 days of the year (again to include casual users), and 0.150 grams of heroin per day at the lower end[207].

Based on these conservative figures, the average yearly consumption of heroin in Australia would be somewhere between 4,687.5kg and 7,500kg per annum. Thus, the range for the total amount of heroin imported into Australia over the past six years (including seizures) would be 28,125 to 45,000 kilograms. Given that the Australian Federal Police seized 2,467 kilograms over the past six years, this means that, in the best-case scenario, they have seized less than 10% of the heroin imported into Australia over that period. In the worst-case scenario they have

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[206] Louisa Degenhardt, et al, 'Evaluating Explanations of the Australian "Heroin Shortage"' (2005) 100 (4) *Addiction* 459, 461.

[207] Marks, above n 6, 146.

seized just over 5% of total imports. This level of seizure is consistent with estimates made by researchers in 1990s.[208] It is also similar to estimates of seizures rates made in 1985 by the head of the Federal/NSW Joint Task Force on Drug Trafficking, Detective Chief Superintendent Jim Willis, who stated that 4–7% of illegally imported drugs were being seized.[209]

The largest seizure of heroin ever recorded by the Australian Federal Police was 390 kilograms and that was made on October 14, 1998.[210] Even in the years when the largest seizures have been made, there has been no significant effect on price, purity or availability of heroin. This may support the proposition that the seizure rates are more likely to be closer to 5%.

There is a very high direct financial cost to the taxpayer of funding drug law enforcement. The Australian Federal Police alone in 2003–4 were budgeted $586,741,000, which represented an increase of $26,992,000 – or 4.8% on the 2002!03 budget.[211] The Australian Federal Police also work closely with a range of state, federal, national, international and foreign organisations to achieve those seizures – and they all have taxpayer-funded budgets. Despite high levels of expenditure across most western democracies, no country is succeeding in preventing drugs from entering its borders or being distributed to its population, but the harm associated with this approach continues. As one researcher suggests: ‘The effects of repressive law enforcement

[208]Chesher, above n 142, 369.

[209]Marks, above n 6, 152.

[210]Australian Federal Police, *‘Major AFP Heroin Seizures’* (2004) 1.

[211]Australian Federal Police, *Australian Federal Police 2003 – 2004 Agency Budget Statement* (2004) 3.

towards drug users and illicit traffickers influence the nature and the magnitude of the health and social problems of drug addicts to a large extent'.[212]

Given the poor seizure rates by our drug law enforcement bodies, the hundreds of millions of dollars spent on drug law enforcement are not well spent and the taxpayer is not getting value for money. A number of experts in this field hold the view that the 'war on drugs' has failed[213] and cannot be won.[214] In contrast to this, supplying heroin to users at near production cost would not burden taxpayers financially, and rehabilitation services would only cost a small fraction of the total amount currently spent on law enforcement. Rehabilitation services could be funded from the revenue raised from drug sales and the revenue saved as a result of reduced law enforcement. This massive effort seems hard to justify considering that it is directed at the eradication of the voluntary consumption of intoxicating substances by individuals in a democratic society. Substances which, if properly manufactured and distributed and taken in safe environments, are no more harmful or debilitating than lawful substances. Even if that person is suffering from an addiction or dependence, the use of these substances does not prevent a person from functioning within society, provided they can obtain the drug they are dependent on.

If the objective of the 'war on drugs' was to eradicate drug use, it has failed. If the objective of

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[212]Engelsman, above n 29, 212.

[213]Wodak, above n 2, 38.

[214]Hawks, above n 145, 38.

the ‘war on drugs’ was to severely limit drug use, it has failed.[215] If the objective was to deter drug use through punishment – then it has failed.[216] If the objective was to ensure that youths did not use or become addicted to drugs – it has failed. If the objective was to make drugs unavailable to the general population, it has failed.[217] If the objective was to ensure that people do not suffer harm as a result of drug abuse – then it has failed. By almost any objective measure, prohibition and criminalisation have failed. What it has succeeded in doing is declaring war on drug users and rendering addicts liable to arrest, conviction and incarceration, merely for being addicts.

IX. REFORM

A significant change to the current approach is clearly needed and the next segment provides an outline of the changes required. This segment will not repeat the research and information presented above, but does rely upon that research and information in formulating the proposals.

IX A. Overview of Reform

Having considered the past and the present, it is now appropriate to consider the future. Given the current situation and the current approach taken by the state and federal governments, the future is not promising – as one researcher says:

> ... the implementation of real harm-reduction measures can hardly be described as “Olympian”

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[215]Chesher, above n 142, 369.

[216]Ibid.

[217]Ibid.

> under the current administration. Real Australian successes [218] in the area of harm reduction have arguably occurred despite federal and state policy rather than because of it ... The sad reality is that the "Tough on drugs" approach currently pursued in Australia seems doomed to soon fuse with the Americans' globally denounced "War on drugs".[219]

Clearly, this must change: and one of the barriers to change is public opinion, which is largely based on misinformation. When debates about the removal of the prohibition of drugs occur, two fears are often cited by opponents of reform. Firstly, that if drugs are decriminalised, a significantly larger number of people will become drug addicts; secondly, that more people will die as a result of drug abuse. The research on these matters indicates that it is unlikely that a disproportionately larger number of deaths would occur in an environment of education, regulation and rehabilitation. One of the reasons for this is that drug harm is the biggest cause of drug-related deaths – and drug harm is significantly reduced in an environment of regulation.

There are also three arguments against the proposition that the number of addicts will increase substantially or disproportionately. Firstly, across the spectrum of drug users, usage rates are skewed towards the lighter end and, also, this is the case with the total spectrum of heroin users when recreational users are included.[220] So while there may be more users, it is unlikely that there will be a disproportionate increase in users at the heavy-use end of the spectrum. Secondly,

[218] Alison J Ritter, Alex D. Wodak and J. Nick Crofts, 'Reducing Drug-related Harm: Australia Leads the Way' (2004) 181 (5) *Medical Journal of Australia* 242, 242.

[219] David G. E. Caldicott and Cameron Duff, 'Reducing Drug-related Harm: Australia Leads the Way' (2005) 182 (3) *Medical Journal of Australia* 140, 140.

[220] Marks, above n 6, 166.

the repeal of alcohol prohibition in the USA did not result in widespread ongoing inebriation.[221] Thirdly, in countries where opiates have been used traditionally (Pakistan, Turkey, India and Thailand), only a small percentage of the population use the drugs[222] – and in Pakistan and Thailand, that percentage is lower than in Australia.[223] There is also no evidence to support the proposition that non-drug using citizens will suddenly decide to commence drug use in a destructive way under a regulatory regime.[224]

It has been also been argued by those opposed to decriminalisation that it is better to have less people using drugs with a higher rate of death than it is to have more people using drugs and a lower death rate. Not only is there no evidence to support the argument that more deaths will occur, but there is support for the proposition that there will be less deaths due to reduced drug harm. In any case, such an argument overlooks all the other harm to drug abusers and the wider community that occurs under criminalisation and prohibition. None of the above issues provide a persuasive basis for rejecting a system of regulation.

Any system of regulation that seeks to manage drug use in society and to deal with the problems of drug use and abuse, must start from the point that history shows that people use drugs whether those drugs are legal or illegal and despite the health risks. The next important point is that –

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[221]Ibid 165.

[222]Ibid 166.

[223]Ibid.

[224]Chesher, above n 142, 370.

regardless of the drug in question and whether it is currently legal or not – a majority of drug users are able to manage the drug of their choice without it causing serious or debilitating problems in their lives[225] or to the community. These people should not be the subject of excessive government control or criminalisation unless their conduct transgresses laws, or has a significantly negative impact on the community. It must also be recognised that prohibiting and criminalising drugs does not stop drug use or abuse – but it does increase drug harm. As Englesman said: 'The penal approach should be left aside as much as possible and ought to be substituted by other methods of prevention, such as health education'.[226] Regulation and education have a positive impact on rates of usage and drug harm.

In attempting to reform the current legislative system, the most important goal is to design a system whereby, over time, a drug abuser can either become drug free, or at least able to manage his or her drug problem and function at a lawful level in society. Any system should also ensure that people, at the end of their addictive or dependent phase, have not been left with extensive criminal histories and permanent injuries to their health and well-being. A system must avoid streaming drug users into criminal activity and contributing to a loss of the capacity to live, work and function in society.

This proposal argues for change in three areas: education, regulation and rehabilitation. Each of these elements deals with a discreet part of the problem, but they all overlap and enhance the

[225]Mugford and O'Malley, above n 9, 28.

[226]Engelsman, above n 29, 213.

operation of the others. Each part of this process includes the wider community, drug users and drug abusers. Each element is dependent on each other for success and therefore all elements need to be implemented simultaneously. While education and rehabilitation are essential parts of any system of reform, they are separate areas of expertise and I only intend to touch briefly on those areas in my proposal for reform.

Drug use and abuse are social, medical and psychological issues and, therefore, these problems cannot be dealt with primarily by the criminal justice system. However, the criminal justice system has two secondary roles to play. The first is in enforcing the regulation of drugs in society; the second is in enforcing rehabilitation processes for drug abusers who resist dealing with their problem. These measures need to be supported by public education and information campaigns that will aid in the introduction of these reforms.

X. LAW REFORM/REGULATION

X A. Law Reform and Regulation

The state and federal governments of Australia, like the USA, have chosen to throw a blanket of criminality over the whole drug problem rather than develop a more sophisticated and humane approach. Like alcohol or nicotine abuse, the abuse of illicit drugs can only be dealt with effectively by qualified experts who are properly trained to treat people suffering from a drug addiction or dependency.[227] The availability and use of drugs in society needs to be regulated

[227] Ritter Wodak and Crofts, above n 218, 242.

and managed to ensure that this occurs. As Mugford and O'Malley state: 'regulatory strategies ... have generally proven more effective ... than prohibitory strategies for minimisation of harms flowing from the pleasurable commodities'.[228]

The challenge then is to create a legislative system that balances all of these matters, while managing and discouraging drug use and without creating more harm. The current legislative system does not achieve these objectives.

X B 1. Current Legislative Systems

Under this proposal for reform, it is necessary to remove the total prohibition and criminalisation of particular drugs from the legislative system and to replace that legislation with a system of regulation. As far as possible, the new system would utilise the existing frameworks while enhancing and broadening them so that they properly prioritise the new objectives.

There are two possible courses of action that can be undertaken to achieve this reform. The first is for the state and federal governments to reform the legislative systems in cooperation with each other. A joint process of reform is preferable, as the laws in this area are a mixture of state and federal statutes and there is already a system in place that could be utilised. Unfortunately, at this time it is unlikely that both the state and federal governments would agree on this type of the reform or cooperation in this process given that the current conservative federal government supports the 'war on drugs' approach to the problem.

[228] Mugford and O'Malley, above n 9, 32.

The second course – assuming that the current federal government is unwilling to undertake reform – is for the state government alone to undertake the entire task. Both approaches are considered below and it is noted that, in general terms, criminal law is largely and primarily the responsibility of the state government under its plenary state constitutional power.[229] Under the current state and federal systems, the importation and the regulation of licit drugs are largely the responsibility of the federal government. Licit drugs are regulated through a federal system of classification, overseen by the National Drugs and Poisons Schedule Committee. This process and this committee are provided for under the *Therapeutic Goods Act 1989 (*Cth*)* and the *Therapeutic Goods Regulation 1990 (*Cth).

In considering the first course of action (whereby reform is undertaken jointly with the federal government), the overall approach would be to remove the current state laws that prohibit and criminalise a range of drugs – and then classify those drugs under the federal *Guidelines for the Classification of Medicines and Poisons*, thus bringing those drugs within a system of regulation largely carried out by the medical profession. It would also be necessary to introduce or modify a range of state and federal offences to deal with any drug-related conduct that falls outside the boundaries of the new system of regulation. The second course of action would necessitate the state government formulating legislation to control the production, distribution, retailing and prescription of those drugs through licensed and trained doctors and chemists, independent of the

[229] Section 2 of the *Constitution Act 1867* (Qld), Section 8 of the *Constitution of Queensland 2001* (Qld).

federal system. The current state system of drug diversion and rehabilitation would also need to be reviewed to achieve a broadening of its current application and powers.

X B 2. Current Laws

X B 2(a).Other Laws

The legislation mentioned in this part of the paper includes only the Acts that are relevant to the reform proposal made in this paper. The regulation of licit drugs (such as ethyl alcohol and nicotine) is provided for primarily in the *Liquor Act 1992* (Qld), *Tobacco and Other Smoking Products Act 1998* (Qld) and the *Tobacco Products (Licensing) Act 1988* (Qld) – but these laws will not be further considered.

X B 2(b).Prohibition and Criminalisation

In order to propose appropriate modifications to the current state and federal systems of prohibition and criminalisation, it is necessary to outline the relevant state legislation that is currently in place. The most important Acts are the *Drugs Misuse Act 1986* (Qld), the *Drug Misuse Regulation 1987* (Qld) and the *Customs Act 1901* (Cth). The *Drugs Misuse Act 1986* (Qld) and the *Drug Misuse Regulation 1987* are the laws that must be amended to repeal drug prohibition and modify the system of criminalisation. Sections 5–12[230] of the *Drugs Misuse Act 1986* (Qld) currently prohibit and criminalise all conduct associated with the possession, use, supply, production (including cultivation) and trafficking of all of the of the drugs listed in

[230] See Appendix A.

schedules 1, 2, and 2A[231] of the *Drug Misuse Regulation 1987* (Qld).

Sections 5–12 of the *Drugs Misuse Act 1986* (Qld) must be amended so that those sections operate to criminalise the conduct only where a person carries out that conduct outside of the regulatory system. The drugs nominated in schedules 1, 2, and 2A of the *Drug Misuse Regulation 1987* (Qld) must then be classified under the federal system, or alternatively – if only the state is participating in the process – new laws providing for the regulation of the cultivation, production, distribution, prescription and retail of these drugs would need to be formulated and included in the *Drugs Misuse Act 1986* (Qld). The next section will outline the current system of regulation.

X B 2(c). The Regulatory System

The current regulatory system includes *inter alia* the following state and federal acts: *Therapeutic Goods Act 1989* (Cth), *Therapeutic Goods Regulation 1990* (Cth), *Health Act 1937* (Qld), *Health Regulation 1996* (Qld) and the *Health (Drugs and Poisons) Regulation 1996* (Qld). Chapter 6, Part 6–3 of the *Therapeutic Goods Act 1989* (Cth) provides for the establishment of a National Drugs and Poisons Schedule Committee. That committee is responsible for providing the guidelines for the National Drugs and Poisons Schedule Committee. Chapter 3 of that document contains the *Guidelines for the Classification of Medicines and Poisons*.[232] A drug or poison can be classified into one of eight different schedules. The

[231] See Appendix B.

[232] See Appendix C.

different schedules provide for escalating levels of monitoring and control that can be imposed upon a particular therapeutic good (drug). Together, the above group of Acts, *inter alia*, provides the system whereby drugs are classified and distributed through medical practitioners under prescription. These Acts also seek to define what a drug is and section 5 of the *Health Act 1937* (Qld) defines a drug in the following terms:

> ***drug*** without limiting the ordinary meaning of the term, means any article used for or in the composition or preparation of medicine for internal or external consumption or use by humans, and includes disinfectants, germicides, antiseptics, pesticides, detergents, preservatives, deodorants, anaesthetics, tobacco, narcotics, soaps, cosmetics, dusting powders, essences, unguents, and all other toilet articles, and also includes goods for therapeutic use within the meaning of the ***Therapeutic Goods Act 1989*** **(Cwlth)**, and an article or substance declared under a regulation to be a drug.[233]

Unfortunately, the *Health Act 1937* (Qld) does not define medicine. However, the *Therapeutic Goods Act 1989* (Cth) does define therapeutic goods by *inter alia* referring to goods that are for therapeutic use and this is defined as:

> … use in or in connection with:
>
> (a) preventing, diagnosing, curing or alleviating a disease, ailment, defect or injury in persons or animals; or

[233]Section 5 of the *Health Act 1937* (Qld)

(b) influencing, inhibiting or modifying a physiological process in persons or animals; or

(c) testing the susceptibility of persons or animals to a disease or ailment; or

(d) influencing, controlling or preventing conception in persons; or

(e) testing for pregnancy in persons; or

(f) the replacement or modification of parts of the anatomy in persons or animals.[234]

It can be seen from both of the definitions above, substances like diacetylmorphine, cocaine, marijuana, ethyl alcohol and nicotine all fall within those definitions. As demonstrated in Part II of this paper, almost all of the drugs mentioned therein have been used as medicine at one time or another, whether or not the drug has at other times also been used for religious, cultural, social or recreational purposes. These definitions reflect the objective fact that the currently criminalised drugs are not a specific, separate and substantially different category of substance from all other drugs. Previously, drugs like morphine and diacetylmorphine were once within the operation of acts like these and were regulated rather than criminalised.

X B 3. Reform of Legislative System

While it is necessary to repeal prohibition and to decriminalise drugs, it is not necessary or desirable to leave a legal vacuum – or to tolerate an anarchic utopia for drug users and abusers. Thus, a statutory system that regulates and manages drug use, and provides for the rehabilitation of drug-addicted or dependent person where appropriate, is proposed. Some aspects of the statutory system that regulates alcohol and nicotine can also be adopted *mutatis mutandis* for

[234] Section 3 of the *Therapeutic Goods Act 1989* (Cth).

drug regulation. The very first step in this process is to repeal the prohibition on diacetylmorphine and to decriminalise this drug. This would be the most important step forward in drug-law reform and make the most difference in the short term.

In this regard, like other all drugs (including nicotine and alcohol), diacetylmorphine should not be available to persons under 18 at all, unless they have a clinically diagnosed addiction that is being treated in rehabilitation. The age limit of 18 is recommended, as it is consistent with the current age limit set for most adult-related activities. A further exemption to the age limit would also apply where a person, under medical care, is terminally ill.

To achieve decriminalisation and the revocation of prohibition, sections 5–12 of Part 2 of the *Drugs Misuse Act 1986* (Qld) should be amended so that they only apply to the conduct specified therein where the accused has obtained the drugs unlawfully – such as where the drugs have not been obtained from a medical practitioner under a prescription, or where the drugs have not been produced or cultivated under licence and sold through authorised outlets.

Except for cannabis, all the drugs that are currently prohibited – such as cocaine, amphetamine and its derivatives like methamphetamine (speed) and methdioxymethamphetamine (ecstasy) – should be available on prescription from a medical practitioner and sold only at pharmacies. The drugs could be regulated and pharmaceutical companies would be required to research recommended dosages and control the strength of their products. The cost of the drug would also be carefully controlled. It would also be mandatory to supply all relevant information in the

accompanying literature including health information, health warnings and guidelines on the safe usage and effects of the drug. The manufacturers would also be required to include health warnings on the outside of the packaging.

Doctors would be specifically licensed to prescribe these drugs and the licences should be issued only to doctors who have additional approved expertise and training in managing drug-addicted or dependent persons.[235] Medical practices and pharmacies should be centrally linked by computer[236] to a database that monitors who is writing the prescriptions, as well as who is obtaining them and the amounts prescribed.

Any sale, importation, or production of drugs outside this system should carry penalties that are directed at rehabilitating the offender where they have a drug problem, or more punitive measures where the person is carrying out the activity merely for profit. However, it is unlikely that such activity would be profitable under this system as any drug users could obtain pharmaceutical-grade drugs from an authorised outlet (such as a pharmacy) with a doctors prescription for a nominal cost.

Under regulation, the price of the drug would be carefully controlled. The price could be set high enough to discourage drug use, but not high enough to present a problem or encourage a black market: just as cigarettes are now. It would also be an offence: to use the drug intravenously,

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[235] Caplehorn, above n 1, 357, 358.

[236] Ibid 358.

except when administered by a nurse or doctor and to inject the drug in a public place. It will continue to be an offence to fail to properly dispose of used syringes, as is currently the case. These measures will ensure that users are taking pharmaceutical-grade heroin under the supervision and care of medical practitioners or nurses and that their drug use occurs safely and in private. For users who breach these provisions, the penalties can be directed at rehabilitation with escalating levels of incarceration during rehabilitation for repeat drug abusers. This is discussed further below.

Under a system of regulation, all drugs will be of pharmaceutical grade and the users will be under the management of a medical practitioner. Users would be fully informed of the risks and effects of the drug and can discus their reasons for wanting to take the drug. All advertising aimed at sales would be totally banned and none of these products could be placed on display. In addition to these measures, drug companies would be required to fund advertising that is directed at informing people of the health risks and consequences of taking drugs, as well as funding advertisements aimed at discouraging drug use and abuse and promoting rehabilitation.

All decriminalised drugs that are currently subject to abuse in society and associated with addiction can be classified under the federal regulatory scheme as Schedule 8 substances if the federal government was participating in the reform process. Schedule 8 is directed at allowing '... potent medicines to be available for medicinal use with restrictions on manufacturing, trade, distribution, possession and use to prevent abuse, addiction and dependence.'[237] Drugs such as

[237] Department of Health and Ageing Therapeutic Goods Administration, *Interim Guidelines for the National Drug and Poisons Schedule Committee* (March 2003) 35.

opium, morphine, diacetylmorphine, cocaine, ecstasy and methylamphetamine should all be reclassified into Schedule 8. All of these measures would not only considerably reduce the harm associated with taking such drugs, but enable qualified medical practitioners to monitor a person's drug use and determine if they are developing a problem that may require greater medical intervention such as rehabilitation. It will also assist in disassociating those drugs from glamorous activity[238] that you indulge in with exciting, rebellious figures like drug dealers, members of organised crime syndicates, or outlaw motorcycle gangs.[239] Most importantly, decriminalisation will remove the profit from drug sales and this will severely undermine organised crime.

There are already a range of laws that prohibit persons who are under the influence of a drug from doing certain things: such as being unsafe at work; driving or operating machinery; and behaving in certain ways in public. All of these laws apply to persons who are under the influence of a drug, whether the drug is lawful or unlawful. Any persons convicted of these offences where drugs are involved would be liable, if the sentencing court thought it appropriate, to undertake rehabilitation, voluntarily or otherwise.

In addition to these measures, police would retain search and seizure powers in relation to all drugs where they have grounds to suspect that the regulatory regime has been breached. Police would also retain powers to demand confirmation of a person's source for the drugs that they

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[238]Engelsman, above n 29, 215.

[239]Ibid.

have been using, or which are found in their possession. A person must be able to produce a valid script and receipt for their drugs or the drugs can be confiscated and destroyed by the police. If a person has been using drugs in these circumstances, then they can then be ordered by the courts to undertake either voluntary or involuntary drug rehabilitation. The money raised from the lawful drug sales can be directly channelled into education and rehabilitation programs.

XI. EDUCATION

The first priority of education should be to accurately inform the community about drugs, drug use and drug abuse with the aim of discouraging drug use and encouraging safety, self-care, self-respect, self-esteem and self-development. Education not only involves providing information and courses on drug use and abuse to users, but also to the wider community. Drug abuse would be defined in the community as a treatable, medical problem, while the true risks of drug use should be presented to enable people to make better choices. All drug abuse should be portrayed as occurring as a result of treatable medical or psychological conditions. This would remove some of the glamour or fun associated with drug abuse and could be done through widespread public advertising prior to decriminalisation. Accurate and credible presentations of the actual short- and long-term negative effects of drug use and abuse would make these messages more effective. If the messages about the short-term negative effects of drug use and abuse matched the user's early experiences, then they would be more likely to take cognisance of them.

The first group that should be discouraged from drug use should be preschoolers. They can be taught simple, accurate messages about drug use and abuse, self-esteem and living skills. These

lessons can be reinforced and followed up as the children progress through the different stages of school. The message can be expanded upon and additional, accurate and credible, information can be supplied. Even with drugs like cannabis, previous messages have been widely inaccurate and thus have lacked credibility. The heavy-handed use of fear and exaggeration has resulted in official messages losing credibility amongst persons who are interested in drug experimentation. The next step in the education process is to educate the wider public about drugs, drug use and drug abuse. This can build on the previous messages and provide a wide range of information that can be presented in more complex and detailed terms to older and more educated audiences. Misinformation may cause youths who are curious about drugs to wonder what the truth is and what the drug is really like. This may heighten their curiosity and encourage experimentation[240] rather than discourage it. The presentation of incontrovertible medical facts that will be confirmed by the drug users themselves – either through their own experience or from the experience of others – would provide more powerful, credible messages.[241] Such information also demystifies and debases drug experiences and assists in discouraging drug use.

Education also has a role in teaching drug users self-esteem, living skills and in providing courses to teach people how to think, (like the courses run by the De Bono Institute).[242] Education overlaps with rehabilitation, but its most important function is in discouraging or

[240]Ibid 216.

[241]Ritter Wodak and Crofts, above n 218, 242.

[242]Edward De Bono, Effective thinking (2005) http://www.edwdebono.com/course/index.htm at 4 April 2005.

preventing drug use. Where these processes are unsuccessful in discouraging drug use, education then becomes a crucial part of rehabilitation. Once a solid foundation of education has been laid, the next step is to commence a process of legalisation and regulation.

XII. REHABILITATION

It is now recognised that, regardless of the drug in question, there are people who are capable of using that drug without developing dependencies, addictions, self-destructive or antisocial behaviour – whether the drug they choose to use is alcohol, licit drugs or illicit drugs, including heroin. These people may use their drug of choice irregularly and are capable, without external assistance, of remaining contributing members of society. Those types of drug users, regardless of the drug they choose to use, should not be subject to either criminal sanction or involuntary rehabilitation. In direct contrast to this is the category of persons who will not participate in any treatment and who prefer to live outside mainstream society and commit criminal offences regardless of their drug usage. Those persons are unlikely to respond to rehabilitative processes. Any drug management system should be aimed at the people who are between these two extremes (i.e. people in the community who use drugs and find themselves with either an addiction or a dependency). Many of these people will come to the attention of authorities for a variety of reasons associated with their drug use. These persons have a negative impact on the community as a whole, but they are not well served under a system which criminalises drugs and treats them as criminals.

For the majority who would respond to treatment, the final element in the system would be a comprehensive process of rehabilitation designed to assist them to manage their drug use and their lives and, if possible, recover from their addictions or dependencies. Some of these people will recognise that they have a problem and others may need legal intervention before they will accept assistance. Many in the latter category come to the attention of authorities as a result of their drug abuse before they ever voluntarily chose to seek assistance. The legislation could provide that a court, when sentencing a person for any offence where drug usage was directly or indirectly involved, can order that the person undertake rehabilitation. A court can decide whether or not to order rehabilitation after the court receives a report on the matter, or with the consent of the person being sentenced. The alternative would be a term of actual imprisonment.

In Queensland, there is already a system of court-based diversion for drug dependent offenders and this is provided for in the *Drug Rehabilitation (Court Diversion) Act* 2000 and the *Drug Rehabilitation (Court Diversion) Regulation* 2000. This system is limited in scope and application and needs to be widened to include a wider range of offences, offenders and escalating forms of diversion. All drug-dependent persons who have committed property offences should automatically be eligible for drug rehabilitation. Offenders who have committed a range of other offences – including all assaults below the level of grievous bodily harm and unlawful wounding – should also be eligible. Offences like attempted murder, murder and sexual assaults would be excluded. Where a person is drug dependent and has committed a crime, as opposed to a misdemeanour or simple offence, that person should be required to undertake rehabilitation after serving the relevant period of imprisonment and before being released back into the

community.

The resources supporting rehabilitation also need to be significantly enhanced to ensure that there are multiple levels of rehabilitation available and that they are sufficient to provide proper programs to individuals that properly address their particular needs. This will increase the drug abuser's chance of success in rehabilitation. People who elect to undertake rehabilitation could, on the first occasion, be placed under the control of a rehabilitation centre. These centres could provide people with planned programs of drug rehabilitation. When a person participating in such a program is assessed as having succeeded, they would then be released from further obligation. A person who fails or re-offends would then be subject to a further rehabilitation order and required to either undertake the first program again, or undertake a full-time, live-in course at a rehabilitation facility. This would have the desirable effect of removing the person from the environment that is influencing or encouraging their drug abuse, as well as immersing them in a rehabilitative environment.

Refusal to participate and cooperate could result in imprisonment, and performance during rehabilitation would be monitored. Release from the program would be conditional on performance and progress as assessed by specialists in the field. The next level would be involuntary rehabilitation involving incarceration in a secure facility, preferably within a purpose-built, secure facility and not within an existing prison. The final level for a person who fails or refuses the entire rehabilitation process would be a term of imprisonment in a mainstream

prison. The overall process could be based on a similar system to the current community-based sentences which are supervised by the courts (including the drug courts).

Rehabilitation would be comprehensive and tailored to suit the needs of individuals. The process should include counselling, participation in support groups and courses on living-skills, self-esteem and thinking. A person would also be required to undertake formal education or training at the level best suited to them, including vocational training and educational courses that range from basic literacy and numeracy to tertiary studies. The rehabilitation could be funded by a combination of money raised from lawful drug sales, government funding and, where appropriate, contributions from the drug abuser – either during or after their rehabilitation. As property crime decreases and organised crime is weakened, the amounts currently spent on drug-law enforcement will be significantly reduced. These funds can then be spent on rehabilitation.

One of the focuses of the rehabilitation process should be self development. It is central to a drug abuser's personal development to address his or her reasons for using drugs and developing a drug abuse problem; it must deal with the personal circumstances that led to the problem. This approach is better for the community. Incarcerating a drug addict without assistance, support or rehabilitation means that when that person is released back into the community, they are often in a worse mental state and social position than when they were first imprisoned. This means that the drug abuse cycle recurs and the risk to the community from that offender is increased. Prisons are often referred to as the universities of crime and once a person has been imprisoned they learn a great deal about methods of offending. Prisoners are also exposed to new criminal networks as a result of the contacts they establish in prison.

XIII. CONCLUSION

After decades of prohibition and criminalisation there is overwhelming evidence to show that this approach has had disastrous effects on the community and drug users. Overall, the negative effects of the current system far outweigh the positive ones and the current system fails to achieve any of its aims. The minor reforms of harm minimisation have little impact on the major problems associated with drug abuse or the wider range of serious problems that currently exist in society, like organised crime and corruption.

Society is far better served providing proper care and support to persons with a drug-abuse problem than it is criminalising drug-dependent and drug addicted people. The era of prohibition and criminalisation has been given ample opportunity and resources to succeed – but ultimately it has been a failure and has no prospect of succeeding in the future.

In Australia, harm minimisation is slowly gaining more recognition in the wider community and at state government level but not as yet at federal government level. This limited recognition is a step forward, but this advance will make little difference in an environment of prohibition and criminalisation. Any reform needs to go much further if it is to make a real difference to drug users, drug abusers, society and the problems surrounding those activities. The only realistic, rational and effective way forward is to abandon prohibition and criminalisation in favour of an approach based on regulation, education and rehabilitation.

Andrew Swindells, October, 2005

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