

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

committed to preventing tragedy that arises from illicit drug use

PO Box 36, HIGGINS ACT 2615, Telephone (02) 6254 2961

Email mcconnell@ffdlr.org.au Web <http://www.ffdlr.org.au>

NEWSLETTER

April 07

ISSN 1444-200

NEXT Meeting Thursday 26 April 2007 at 7.30pm

Venue: St Ninian's Uniting Church, cnr Mouat
and Brigalow Sts, Lyneham.

Refreshments will follow

Editorial

The Federal Parliamentary Impact of illicit Drug use on Families is well underway. Readers can access some of the Hansard transcripts of proceedings and some of the submissions at the following web address:

<http://www.aph.gov.au/house/committee/fhs/illicitdrugs/hearings.htm>.

It is clear from the transcripts that have been published so far and from reports from those who have attended hearings (most hearings are open to the public) that some members of the committee have a predetermined agenda.

The Chair is Bronwyn Bishop and here is an early statement taken from Hansard in an exchange with the Department of Health:

CHAIR—*I might begin by asking you the way in which your department plans to deliver—or is in the process of delivering—its strategy with regard to drugs ... which is in accordance with the Prime Minister's statement. The statement that he made on 3 February 2004 on zero tolerance is a good starting place. ...He says that the people around Australia have found it to be a good policy, and he says:*

... it has never ceased to amaze me how people can question the doctrine of zero tolerance towards commencement of drug taking in the first place or indeed dealing with the problem.

He makes several more very strong statements saying that zero tolerance is our policy.

Despite having it explained how the National Drug Strategy (a whole of Australia strategy supported by all states) and Prime Minister Howard's Zero Tolerance fit together, that explanation was not accepted by the chair. Those that did not agree with the Chair's view were described thus:

CHAIR—*... But then you have other people, lower down the food chain, who say it is not. I am a bit worried that your questions might be reinforcing what the people lower down the food chain say rather than what the Prime Minister says is the policy.*

And Professor Margaret Hamilton came in for special attention:

CHAIR—*I am going to ask my committee for questions in a minute, but first I want to ask this: the Prime Minister has been absolutely uncompromising in what he believes is the policy.*

The Deputy Chair of the Australian National Council on Drugs, Margaret Hamilton, has written that it was unfortunate that the Prime Minister has a zero tolerance approach to drugs, but we have managed to handle him by saying that it only applies to education. How dare she? How can we have an effective policy when the Prime Minister has spelt out the policy and the deputy chair says, 'We have handled the Prime Minister; he was a bit of a problem for a while'? How dare she?

This attack on Professor Hamilton was uncalled for and simply wrong. The ANCD is a body that advises Prime Minister Howard on drug policy. There would be little value in having an advisory body that did not give frank and fearless advice to Prime Minister Howard— even when the Prime Minister is wrong.

However the Chair is not alone in her views:

Mr CADMAN [speaking to the Department of Health]—*As a member of the former committee [actually it was the same committee but a previous inquiry – the "Inquiry into substance abuse in Australian communities", Ed], I have to say I was pretty disappointed with the long delay we had in receiving a response to our report and with the quality of the response. That is my own opinion. Having taken evidence for two years and having seen providers and gone around Australia—going to areas that I do not know whether or not you visit—the committee had formed a view on behalf of the people we represent, and it appeared to us that the department had a view which was superior, in their opinion, to ours. We are very determined to see that there is a change to the process and philosophy that you are adopting—I am, anyway.*

I have searched your website and I cannot find the words 'tough on drugs' anywhere on the department of health's website. Is that right? You used the words today. That is the first time I have heard an official from the department of health use those words. Others use them.

Readers might recall that the previous inquiry into this same subject was seriously flawed and did not provide a balanced representation of the submissions or the evidence presented. That there were minority reports and that there was a serious and heated debate in the parliament about the final report was enough reason for the government not to take the report seriously.

But the bias of the inquiry is likely to go much further.

FFDLR has been identified as being one of "*the pro-drug lot*". Readers will of course know that is not true.

Some concerning themes are emerging from the committee.

- The imposition of zero tolerance and replacement of harm minimisation,
- The denigration of those that hold different views and that support the harm reduction element of harm minimisation, including suggestions of withdrawal of government funding,

- Scare tactic advertising and education campaigns to be adopted in an effort to prevent the uptake of drugs.

There is little balance in these themes. Zero Tolerance was zealously pursued in some schools when first announced by Prime Minister Howard. The result? Students found using drugs were expelled, potentially leaving them outside of their community and undereducated. That part of the policy was quickly withdrawn.

The committee was presented with information from the 2004 Household Survey by the Australian Institute of Health and Welfare. The committee took particular notice of the data about what influenced first use of illicit drugs. Here 77% of respondents to the survey said it was “curiosity” and 54.5% said it was “peer pressure”. (Obviously this was a multiple choice question because the total is greater than 100%.)

The committee went little further than being shocked about this revelation and concluded a shock advertising/education campaign was needed.

What they failed to do was to delve further into the data. For example a further 20.7% of survey respondents said it was “to do something exciting”. But it should also be remembered that those responding to this question represent only those who have used illicit drugs and they represent less than 15% of the population. Of the remaining 85% of the population who had never used illicit drugs about 75% said they were “just not interested” in using illicit drugs.

But the important piece of information for the committee from survey respondents who had never used illicit drugs was that a mere 1.3% said “education/awareness” had caused them to not use illicit drugs.

This then raises some questions that the committee should be asking itself: Would funds be best spent on a program of which only about 1% of the population took any notice? How could we take the “curiosity” factor or the “peer pressure” factor out? What would happen if the use of illicit drugs was seen as boring or no longer exciting?

If the committee is serious about making a difference in drug usage and the impact of drug use on families then some changes need to occur.

First, preconceptions and biases need to be put aside in search for the best possible advice. Second, all who have a significant and serious contribution to make to the committee should be heard and should be treated with respect during that process. Third, the committee needs to promote evidence based policies over faith based policies. And finally policies should not just simply be imported from other countries (whether that be the USA, Sweden or any other country) without careful examination of their effectiveness and of their consequences for the community, drug users and their families.

Recreational drugs: a harm scale

by Peter Lavelle

Published 05/04/2007, <http://www.abc.net.au/health/thepulse/s1884640.htm>

What's worse – heroin or amphetamine? And are they worse than alcohol and tobacco, which affects the health of far greater numbers of people.

In fact, how do you measure the harm of a drug? That's a question UK researchers found themselves asking when they set out to rate a range of commonly used recreational drugs – some legal, others not – to rate them in order of the harm they cause to users and to those around them.

They looked at 14 compounds: heroin, cocaine, alcohol, barbiturates, amphetamine, methadone, benzodiazepines, solvents, buprenorphine, tobacco, ecstasy, cannabis, LSD, and steroids.

They asked a range of experts – doctors, psychiatrists, chemists, police, lawyers and others – to rate these drugs individually in various categories of harm. The first was physical harm to the user – whether they caused illness and disease. The second was whether the drug would lead to addiction and dependence; and the third was the capacity for harm to others; family, community, and society.

Varieties of harm

Those drugs that are injected like heroin, amphetamines cause a lot of physical harm because of the risk of overdose and spread of blood borne viruses like HIV, hepatitis B and C. Other drugs like alcohol and tobacco don't have an overdose or HIV risk, but caused physical harm over the long term. Some of the newer party drugs such as ecstasy or MDMA are so new their long term health effects aren't known.

With some drugs, the physical harm is compounded by the fact that the drug is addictive and the person keeps using it. Some require higher and higher doses to achieve the same effect, and/or cause withdrawal symptoms when the drug is stopped; heroin, benzodiazepines and nicotine were in this category, while LSD was much less addictive.

Drugs also vary in their capacity to cause harm to others. Alcohol often leads to violent behaviour, injuries and accidents and is a major cause of damage to family and social life. Alcohol and nicotine, being so widely used and so destructive to health over long periods of heavy use, are immensely costly to society. (Tobacco and alcohol together account for about 90 per cent of all drug-related deaths.) Illegal drugs like ecstasy, amphetamine and heroin may involve the user in criminal activity and its consequences.

And the winner was..

Rating these drugs wasn't easy because of the wide variations of degrees of harm in different categories – some drugs caused a lot of harm in one category but not another.

But when it came to all the harm factors considered together, heroin and cocaine were right at the top of the list; alcohol, tobacco, amphetamines and benzodiazepines fairly high; cannabis further down; and LSD and ecstasy towards the bottom.

So what's the point of all this?

The researchers weren't trying to justify the use of one drug over another. What they were trying to do was encourage police and law-makers to be a bit more rational about

Membership Renewals

Thank you to all those people who have renewed their membership in the last month. Thank you also to those who have included an additional donation. The membership renewal and donations will certainly assist in the work of FFDLR.

For those of you who may have been busy and put aside the renewal until there is enough time, can we please offer a gentle reminder not to forget to do it. Perhaps now while you think of it?

classifying drugs on the basis of harm (they found there wasn't much rationale in existing 'dangerous drugs' classifications in the UK at least).

But the findings are also a useful guide for doctors, counsellors, family and others working in drug treatment to help them devise harm minimisation strategies, especially when there's a scarcity of one type of drug and users switch to another with a different set of risks.

A startling injection of common sense

http://comment.independent.co.uk/leading_articles/article2341316.ece,
Published 9 March 2007

"The report from the Royal Society of Arts Commission on Drugs tells us what most thoughtful people have known for some time: Britain's drug laws have been shaped by moral panic, rather than a rational analysis of the problem of substance abuse.

The two-year study argues that the focus of government policy should be on harm reduction. In common with last year's report by the Parliamentary Science Select Committee, it recommends that the existing "ABC" classification system be scrapped in favour of an "index of harms", which would extend the definition of drugs to include alcohol and tobacco.

It also argues that there should be an emphasis on "medicalising" the problem of heroin abuse, urging the roll out of "shooting galleries" for heroin users and wider prescription of the drug by doctors.

The report's authors feel addiction should be seen as a health and social problem rather than simply a criminal justice issue. If drug taking does not harm anyone, criminal sanctions should not be applied. Jail should be reserved for only the most serious drug-related crimes.

They also correctly identify the major reason why this is not already happening: politicians. The response of the former Home Secretary, David Blunkett, to the proposals yesterday sums up the problem. He rejected the arguments of the RSA in favour of reform and argued that the present approach by the Government is working perfectly well. Meanwhile, the former Tory leader, Iain Duncan Smith, who is shaping the Conservative Party's own policy on drugs, was also critical of the RSA recommendations. Mr Duncan Smith does at least have a strategy for improving on the present situation.

He stresses the need for residential rehabilitation for addicts. But by arguing that getting people off drugs altogether should be the only objective of government policy, he too demonstrates why politicians are failing on this crucial issue. Too many in Westminster feel it is their responsibility to stigmatise addicts, rather than help them."

Sweden's drugs policy

A letter to the editor of The Advertiser, Fri 16 Mär 2007

CAN we please correct, once and for all, the ongoing assertions about how "good" the Swedish system is with drugs policy?

According to a United Nations report, so frequently quoted by Drug Beat and its ilk, three times as many people die from acute drug overdoses as do in Holland, a country with far less draconian policies.

The rate of hepatitis C, a close correlate of intravenous drug use, is higher in Sweden, and these are in a country almost half the population of Holland.

What a brilliant result that would be for Australia; slightly fewer people using drugs, and yet far more young, misguided Australians dying in the streets, or contracting a chronic infectious disease. Why don't these policies have the support of the Australian medical profession or, indeed, just about any professional medical body?

For the record, there just isn't "ample" research supporting coercive drug treatment, just the research produced by those behind such treatment regimes, and therefore standing to financially gain from them.

Research never lies, just the people who misrepresent it, generally for political or financial gain.

(Dr) DAVID CALDICOTT, Registrar, Emergency Department, Royal Adelaide Hospital, Adelaide.

Crackdowns failing in battle on drugs in jail

Matthew Moore Freedom of Information Editor, Sydney Morning Herald, April 10, 2007

THE battle against drugs in NSW jails has fizzled into an uneasy truce, with about one in seven prisoners testing positive to unauthorised drug use in each of the past five years.

Figures provided by the Department of Corrective Services under freedom of information laws show repeated crackdowns on drugs in jails have had no significant effect on the number of positive tests results.

A huge random and targeted drug testing campaign each year consistently finds between 12.5 and 14.5 per cent of prisoners' urine samples test positive for "non-authorised drugs".

Last year 2459 of the 18,401 urine samples - 13.36 per cent - tested positive to a range of illegal drugs including cocaine, cannabis and methamphetamine (ice). Prisoners also tested positive to the unauthorised use of prescription drugs.

Although the Herald asked for a breakdown, the department did not reveal the positive results for each drug. Nor did it provide information on which prisons had the highest levels of unauthorised drug use. The figures do not include tests for alcohol because the department says it does not have them.

The department also said it had produced no assessments or reports of the urine testing program despite recording about 2000 positive results tests each year.

But a departmental report in 2004 comparing saliva testing with urine testing said the level of illegal drug use may be much higher than the new figures show.

It found that of 315 urine tests carried out in prisons and community institutions, 37 per cent tested positive for cannabis, heroin, cocaine, amphetamines and benzodiazepines (such as Valium).

A University of NSW academic with an interest in prisons, Eileen Baldry, said it is impossible to know what was really happening, because the department did not publish the results of its urine tests nor reports produced using the data.

"It's unconscionable to spend all that money and not make the information available," she said. "Dr Baldry said such

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Contact Prashant for information 4782 9222

data was published as a matter of routine in the US and it should be the same here.

A spokeswoman for the department, Candace Sutton, said it was impossible to keep all drugs out of jail but said drug use plummeted when people entered prison.

On arriving in jail, 43 per cent of inmates tested positive for alcohol or drugs. That figure dropped to about 13 per cent, she said. "The drop in drug use from the time of reception is greatest for illicit drugs, such as heroin, amphetamines and cocaine," Ms Sutton said.

Victoria's prisons department recently released figures which showed 3.6 per cent of 4600 random urine tests were positive, but Ms Sutton warned against comparisons.

"It is not possible to compare Victoria to NSW, as Victoria did not publish its counting rules and its statistical methodology is unknown," she said.

What Does It Mean to Decriminalize Marijuana? A Cross-National Empirical Examination (an extract)

Center for the Study of Law and Society Jurisprudence and Social Policy Program, University of California, Berkeley Year 2004 Paper 25

Prepared for 24th Arne Ryde Symposium in Lund, Sweden, The Economics of Substance Use, August 13-14, 2004

Rosalie Liccardo Pacula, RAND and NBER, Robert MacCoun, UC Berkeley, Peter Reuter, U. of Maryland, Jamie Chriqui, The MayaTech Corporation, Beau Kilmer, Harvard University, Katherine Harris, SAMHSA, Letizia Paoli, Max Planck Institute, Carsten Schaefer, Max Planck Institute

Although widely used in discussions regarding alternative marijuana policy regimes, decriminalization is a policy that to date has gone largely undefined in the international policy arena. The term literally implies a reduction in the criminal status of marijuana possession offences; however, numerous countries and sub-jurisdictions that are recognized as having decriminalized marijuana in fact merely reduce the penalties associated with possession of specified amounts. Hence, the term marijuana depenalization has evolved in the scientific literature as a more accurate term reflecting the diversity in policies that exist across countries. Decriminalization, nonetheless, remains a common term used in policy discussions and debates.

Although all developed countries today prohibit in some fashion the possession, use, cultivation, distribution and/or sale of marijuana and marijuana products, the countries differ tremendously in the types of behaviours that are allowed, the resources devoted to enforcing the laws, the penalties that are imposed on those who break these laws, and their citizens' knowledge of these policies. Variations in laws, how they are enforced, and the penalties imposed together determine the policy and the public's understanding of the policy. Hence, those interested in evaluating the impact of specific policies like marijuana decriminalization need to consider more than just the law and a simple binary label for its penalty structure. They must also consider how and to what degree specific policies get enforced in relevant jurisdictions.

Decriminalization: A Form of Depenalization

Decriminalization and depenalization are both terms that represent a range of policies targeting marijuana users in

countries where the supply of marijuana for the purpose of recreational use is statutorily prohibited. Hence, these policies do not relate to how the suppliers of marijuana get treated in specific countries. They only differentiate how those caught in possession (with the intent to use) get treated.

Just as apples are a type of fruit, decriminalization is a specific type of depenalization policy. In this paper, depenalization refers to any policy that reduces the penalties associated with possession or use of marijuana. The penalties that get reduced can be criminal or civil in nature. For example, policies that retain the criminal status of possession offences but remove or reduce the amount of incarceration imposed as a penalty would be examples of depenalization policies. Decriminalization, on the other hand, refers specifically to depenalization policies that

change the criminal status of possession offences from that of a crime to that of a non-criminal offence. Because penalties are usually graduated with the level of crime, a change in the criminal status of an offence will also imply a reduction in the level and type of penalties imposed with that offence, which is why decriminalization policies may be viewed as a special form of depenalization policies.

A country (or smaller jurisdiction for that matter) that is interested in reducing the criminal justice burden associated with marijuana possession offences could do so in one of at least two ways: (1) retain the criminal status of the offence, but remove any jail time imposed for these offences (depenalization), or (2) eliminate the criminal status of the offence, which will also eliminate the jail time imposed with this offence (decriminalization). The first method results in an incremental reduction in the burden for the criminal justice system mainly due to reduced incarceration costs, as court resources may still be required to adjudicate cases depending on the legal structure of the jurisdiction. The second method also generates savings due to incarceration, but may produce larger savings if the resources involved in enforcing and processing civil offences are less intensive than those used to enforce and process criminal offences. If this is not the case, then the non-incarceration savings associated with a change in the criminal status of marijuana would simply reflect a redistribution of these costs from the criminal justice system to another government (or quasi-government) agency.

Fundamentally, the primary difference between these two methods has to do with the outcome for users. Although the specific penalties imposed on users in each of these cases could be structured identically (e.g. a fine of \$1000 and no jail time), depenalization retains the criminal status of the offence while decriminalization does not. The importance of a criminal charge depends on the jurisdiction. In some jurisdictions, criminal charges can influence an individual's ability to obtain and/or retain work, student loans, and public assistance; hence decriminalization can substantially reduce the personal cost associated with getting charged with possession offences. In other, more rehabilitative jurisdictions, criminal charges do not impose these sort of additional personal burdens.

More at: <http://repositories.cdlib.org/cgi/viewcontent.cgi?article=1041&context=csls>

<p>Family Drug Support Volunteer Training Program – ACT</p> <p>A 2 day program to train volunteers for the FDS telephone support line</p> <p>Sat 5 & Sun 6 May 2007</p> <p>Contact: 4782 9222</p>
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