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

committed to preventing tragedy that arises from illicit drug use

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SUBMISSION OF FAMILIES AND FRIENDS FOR DRUG LAW REFORM TO THE INQUIRY OF THE HUMAN RIGHTS AND EQUAL OPPORTUNITY COMMISSION AND THE MENTAL HEALTH COUNCIL OF AUSTRALIA INTO THE HUMAN RIGHTS OF PEOPLE AFFECTED BY MENTAL ILLNESS INCLUDING THE NEED FOR BETTER MENTAL HEALTH CARE

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I. INTRODUCTION

A. Summary

1. Families and Friends for Drug Law Reform urges the Human Rights and Equal Opportunity Commission and the Mental Health Council of Australia to pay close attention to the links between drug policy and mental health.

2. There is a large overlap between those using illicit drugs and those with a mental illness. To take heroin dependency as an example, "research has repeatedly shown that heroin users experience high levels of psychological distress" (Ward *et al.* 1998, 80-82 &, generally, 419-36).

3. Drug dependency and mental illness or disorders work on each other. The difficulties flowing from one – the distress, economic hardship, stigma and shame – magnify the difficulties of the other. The scarcity and inadequacy of services for one are even more so for people with both conditions. The predicament of families known to Families and Friends for Drug Law Reform where a member is dependent on illicit drugs is often desperate. Their predicament is aggravated more than twofold where comorbidity with a mental illness or disorder is involved. The mental illness or disorder we refer to is over and above that of substance dependence that is regarded as a mental disorder (Ward *et al.* 1998, 419; FFDLR 2004, para. 6).

4. What is more, all the evidence points to a high and still increasing level of comorbid substance abuse and mental illness or disorders.

> "The use of illicit drugs such as cannabis and psychostimulants such as amphetamines and cocaine is . . . higher amongst young adults with severe mental illness compared to either the general population or to other psychiatric comparison groups" (Baker *et al.* 2004, 155).

This is putting more pressure on the health system and families than they can bear.

> "Hospital morbidity data show a dramatic rise in the number of psychotic disorders due to psychostimulant use from 200 in 1998-99, to 1,028 in 1999–2000 and a further but smaller increase to 1,252 in 2000-01" (*ibid*., 156).

5. In order to cope with crises, scarce resources are being siphoned away from already chronically underfunded services providing low and medium level interventions – that is, from most cost effective to least cost effective interventions. Of course, this deprivation of resources from where needs are low or medium leads more people into crisis thus compounding the health, social and fiscal problems.

6. The link between drug dependence and mental illness or disorders is not confined to the pharmacological effects of the drug concerned. The Commission and

the Council should not therefore rest content with a platitudinous recommendation that illicit drugs, because they have deleterious effects, should be made less available.

7. Mental illness or disorders are also brought about or aggravated by the stresses on dependent users associated with existing steps to make them less available. Furthermore, there are other less direct but still potent links. The ineffectiveness of drug treatments leaves an increasing number of children exposed to greater risk of becoming mentally ill or disordered themselves by virtue of the addiction of their parents, other adults or their peers. In particular, the substance dependence of parents is a risk factor directly associated with their children developing a mental illness or disorder. It also contributes to other recognised risk factors of mental illness or disorder such as low birth weight, neglect and school drop out (Dept. of Health and Aged Care 2000, 16).

8. This examination of the various links between mental health and abuse of illicit substances should not lead to a defeatist conclusion that treating effectively and humanely those with comorbid conditions is incompatible with policies that effectively reduce supply of dangerous drugs to young people. The Commission and Council, therefore, should consider what measures can reasonably be expected to make dangerous drugs associated with a mental illness or disorder less available.

9. After considering the negative impacts of current illicit drug policy on mental health, this submission examines three main obstacles to securing improvement. These is, firstly, a moral belief of dominating influence, though probably not widely shared, that overcoming addiction should take precedence over all other issues. Secondly, there is a fear that existing policies, whatever their negative effect, have worked to make dangerous drugs less available. In fact the net effect of existing policies is most probably to promote the distribution of illicit drugs among vulnerable populations. The third obstacle examined is the failure to be guided by the best available evidence in formulating measures to give effect to drug policy.

10. The submission concludes by looking at the current National Mental Health Plan and Drug Strategy. These peak policy documents fail in any meaningful way to address the links between mental health and illicit drug substance abuse. The *National Mental Health Plan 2003-2008* passes responsibility for drug and alcohol problems to the national drug strategy. *The National Drug Strategy: Australia's integrated framework 2004-2009* makes the platitudinous point that there should be strong partnerships with the treatment services and integration of policies and programs.

B. About Families and Friends for Drug Law Reform

11. Families and Friends for Drug Law Reform was formed in April 1995 around a group of people in the Australian Capital Territory who had a child, relative or friend who had died from a drug overdose death. Its membership now extends across Australia. The grief that all shared turned to frustration and anger that those lives should have been lost: all would be alive today if drug use and addiction had been treated as a social and medical problem and not a law and order one. The criminal law and how it was enforced contributed to the death of these young Australians.

12. Since then the group has been intent on reducing the tragedy from illicit drugs, reducing marginalisation and shame, raising awareness of the issues surrounding illicit drugs and encouraging the search for and adoption of better drug policies. The increasingly evident links between mental health and substance abuse has led it to make submissions that deal with mental health as well as substance abuse (e.g. FFDLR 2003 & FFDLR 2002).

13. Families and Friends for Drug Law Reform does not promote the view that all drugs should be freely available. Indeed it believes that they are too available now in spite of their illegality. Experience points to reliance on the criminal law to control their availability being ineffective and, in fact, counterproductive.

II. PHARMACOLOGICAL LINKS BETWEEN MENTAL ILLNESS OR DISORDERS AND ILLICIT DRUGS

14. There are reports of use of illicit drugs causing mental illness or disorders and that many people who have a mental illness or disorder use illicit drugs as self medication. The inquiry should be guided by the best expert advice about whether pharmacologically the use of particular illicit drugs causes or aggravates mental illness or disorders. There is particular concern about possible links between cannabis use and schizophrenia and between potent methamphetamines and psychoses. We will refer briefly to these two issues.

15. Families and Friends for Drug Law Reform understands that there is no strong evidence that cannabis use causes schizophrenia but that there is epidemiological evidence pointing to cannabis use triggering latent schizophrenia and some suggestion that it may even cause this psychotic illness. According to a recent Dutch review of five longitudinal studies "using cannabis doubles the risk of developing the disease" (Sheldon 2003). Having said that, even if there is a causative link between cannabis use and developing schizophrenia, it is not strong. Cannabis is the most widely used of illicit drugs yet only a very small proportion of the population develop schizophrenia. Reflecting figures comparable to that of Australia, "by the age of 18 years half of Dutch men and a third of Dutch women have used cannabis at least once" yet in that country just "five in 10,000 adults a year develop schizophrenia" (*ibid*.).

16. While studies have yet to document fully the connections, it seems that there is a much stronger link between consumption of methamphetamines and serious mental illness or disorders than the link with cannabis. Potent methamphetamines have become widely available in recent years. An Australian text published this year on intervention and care for psychostimulant users states that:

> "It is well established that a psychostimulant-induced psychosis may occur following either prolonged use of the psychostimulant or after binge use. The symptom profile is similar to that found in other non-drug induced psychoses and typically the psychostimulant-induced psychosis resolves after discontinuation of psychostimulant use. Psychosis is higher among psychostimulant users than amongst the general population and is higher after amphetamine use than after cocaine use.

> "The emergence of more pure forms of crystalline methamphetamine 'ice' and the so-called 'base' methamphetamine product (poorly purified crystalline methamphetamine), has been associated with an increase in psychotic behaviour among methamphetamine users in Australia. Psychotic symptoms can be induced in healthy subjects with no history of psychosis or substance use and in patients previously dependent on amphetamines. Psychostimulant use can exacerbate psychotic symptoms in people with schizophrenia" (Baker *et al.* 2004, 156)

17. An American text, referring to the base form of methamphetamine which can be smoked (and known there as ICE), states:

> ". . . prolonged cocaine use can result in psychoses resembling paranoid schizophrenia. A similar pattern of acute delusional and psychotic behavior occurs after smoking ICE. However, unlike cocaine, ICE-induced psychosis can persist for days or weeks and can occur much earlier" (Julien 1998, 143).

It is particularly worrying that the onset of serious psychiatric problems is so rapid as a result of heavy use of potent methamphetamines. According to workers in the field

> "It was . . . unanimously agreed that the users of the more potent forms of methamphetamine reached these states of chaos far more quickly into their use careers than do users of methamphetamine powder. It was perceived by [key informants] that users of the more potent forms start to experience serious physical and psychological side-effects after only a few months of heavy use, and therefore tend to present requesting help after a relatively short period of time. Users of methamphetamine powder may take some years of heavy chronic use before they reach such states of disorder" (Darke *et al.* 2002, 33).

18. These accounts correspond with the impressions that Families and Friends for Drug Law Reform has gained from its membership that the severity of behavioural problems experienced by families trying to cope with a member who has been heavily using the new forms of methamphetamine exceeds the still distressing ones associated with heavy cannabis usage.

III. NEGATIVE IMPACT OF DRUG POLICY ON THE MENTAL HEALTH OF ILLICIT DRUG USERS

19. The link between illicit drugs and mental illness or disorders arises not only from their pharmacological effect but from the very strategies that are adopted to counter their availability. The strategies designed to deter illicit drug use bring about risk factors that are known to influence the developmental of mental health problems.

A. Criminal processes creative of mental health risk factors

20. The criminal law is the overriding characteristic of current drug policy. Even if use itself is not a criminal offence in some jurisdictions, activities intimately associated with use uniformly are – activities such as possession and supplying drugs to fellow users. In some respects with drugs the rigour of the traditional processes of the criminal law have been ameliorated in recognition that the problem has a health

dimension. Thus the distribution of sterile syringes is permitted, some states have set up drug courts and police have ceased, as a matter of course, attending non-fatal overdoses. Even so, the essentially criminal character of the policy response to drugs has serious impacts on the mental health of users by virtue of:

(a) the stresses and dangers associated with securing and using illicit drugs;

(b) the ease with which criminal peer groups associated with drugs can lead astray young people with or prone to a mental illness or disorder;

(c) the rigours of imprisonment brought about by offences linked to their drug use.

21. The harms to drug users associated with the criminal processes and their associated illicit status have been extensively documented. The report of a committee inquiring into serious drug offences contains as good a summary as any:

> ". . . it has become increasingly apparent that significant elements in the harm which results from habitual use of illicit drugs are a consequence of criminal prohibitions and their effects on the lives of users. Quite apart from the risks of arrest and punishment, there are risks to health or life in consuming illicit drugs of unknown concentration and uncertain composition. The circumstances in which illicit drugs are consumed and the widespread practice of multiple drug use add to those risks. Medical intervention in emergencies resulting from adverse drug reactions may be delayed or denied because associates fear the criminal consequences of exposing their own involvement. The illicit consumer's expenditure of money, time and effort on securing supplies may lead to the neglect of other necessities. It will often impose substantial costs on the community, and the user, if the purchase of supplies is funded from property crime. Further social costs result from the stigmatisation of habitual users as criminals and their alienation from patterns of conformity in employment, social and family life.
>
> "Risks are inherent, of course, in habitual use of most, if not all, recreational drugs. But criminal prohibitions amplify those risks. They amplify, for example, the risk of death from overdose" (SCAG 1998, 6-7).

22. In addition to the literature mentioned in that report, the inquiry is referred to the following examples of more recent literature documenting the harms:

Campbell Aitken, David Moore, Peter Higgs, Jenny Kelsall & Michael Kerger, "The impact of a police crackdown on a street drug scene: evidence from the street" in *International journal of drug policy*, vol. 13, pp. 193-202 (2002)

J.L. Fitzgerald, S. Broad & A. Dare, *Regulating the street heroin market in Fitzroy/Collingwood* (Issues series) (Department of Criminology, University of Melbourne & VicHealth, 1999)

Maher *et al.* 1998: Lisa Maher, David Dixon, Michael Lynskey and Wayne Hall, *Running the risks: heroin, health and harm in south west Sydney* (NDARC monograph no. 38) (National Drug and Alcohol Research Centre, University of New South Wales, 1998)

Maher 2002: Lisa Maher, "Don't leave us this way: ethnography and injecting drug use in the age of AIDS" in *International journal of drug policy,* vol. 13, pp. 311-25 (2002)

23. The stresses of criminal prohibitions and their effects on the lives of users themselves constitute known risk factors potentially influencing the development of mental health problems and mental disorders. One can pick out many from the list, particularly relating to children, in the National mental health strategy monograph on promotion, prevention and early intervention for mental health. A selection of these factors include:

- alienation and social isolation
- experiencing rejection
- lack of warmth and affection,
- deviant peer group,
- physical illness/impairment
- unemployment, homelessness
- poverty/economic security; and
- neighbourhood violence and crime (Dept. of Health and Aged Care 2000, 16).

B. Relative harm of cannabis control: prosecution compared to expiation notice system

24. Research on different strategies used to counter the availability of cannabis show that different strategies can have different impacts on mental health. The standard processes of the criminal law have been varied in some jurisdictions (most recently in Western Australia) for minor cannabis offences to provide for an expiation notice process similar to on-the-spot parking tickets.

25. A comparison was made between South Australia which has long had an expiation system and Western Australia before a similar system was introduced there. The study found that those prosecuted in Western Australia were more likely to report negative employment consequences than those who received an expiation notice in South Australia. The difference was marked. Of the Western Australia group 32% identified at least one negative employment consequence and 16% of these were sacked as a result of the offence. In South Australia only 1.7% reported such a negative consequence.

26. In personal relationships only 5% of the South Australian group reported negative consequences compared to 20% of the Western Australian group. Whereas 16% of the West Australian group reported negative consequences in their accommodation, none of the South Australian group did so.

27. In contrast to the marked negative impact of the application of the traditional criminal processes in Western Australia compared to South Australia, the Western Australian process did not appear to serve as a stronger deterrent against actual cannabis usage. This aspect is mentioned further below (Lenton *et al.* 1998, x).

28. The study thus found that the different strategies used to combat cannabis usage had significantly different incidental impacts on cannabis users – impacts that heighten known risk factors for mental illness or disorders such as unemployment, poverty, homelessness, insecurity, divorce and family break-up.

C. Incarceration

29. There is no more cogent indicator of the negative impact on mental health of current strategies to combat illicit drug use than the high proportion of the population of Australian prisons who have a mental illness or disorder associated with the use of illicit drugs. Imprisonment is also a potent aggravating experience for those with a mental illness or disorder.

30. Dr Richard Matthews, Chief Executive Officer of the NSW Corrective Health Service gave evidence in 2002 to a House Representative Committee that 90.1% of women on reception in NSW have some form of mental illness or disorder as do 78.2% of men. On substance abuse he reported that compared to 2.8% in the general community, 74.5% of women on reception in NSW corrective institutions are dependent on or abuse alcohol or another drug. For men the figures are 7.1% and 63.3%. The drugs concerned are interesting. 20.5% of the men were dependent on or abused cannabis, 35.2 % on an opioid, 11.9% on a sedative, 30.8% on a stimulant and 22.4% on alcohol. The levels of dependency or abuse by women was much higher for all categories of drug.

NMHI – Drug & Alcohol

12 Month prevalence dependence/abuse (DSM-IV)

Receptions (n = 756m/165f) Community (n = 6,627m/6,837f)

		Male %		Female %	
		Reception	Community	Reception	Community
Alcohol	Dependence	19.2	5.2	16.4	1.8
	Abuse	3.2	4.3	1.8	1.8
Cannabis	Dependence	18.1	2.4	22.4	0.7
	Abuse	2.4		2.5	
Opioid	Dependence	33.3	0.2	53.4	0.2
	Abuse	1.9		0.6	
Sedative	Dependence	11.6	0.4	28.6	0.3
	Abuse	0.3		0.0	

Stimulant	Dependence	27.9	0.3	47.8	0.1
	Abuse	2.9		2.5	
Any disorder		63.3	7.1	74.5	2.8

SOURCE: Overheads shown by Dr Richard Matthews during his evidence to House of Representatives Standing Committee on Family and Community Affairs at *Committee Hansard*, Friday, 16 August 2002, pp. FCA 1,230-1,238

31. An even higher percentage of those sent to prison had a mental illness or disorder on reception. Compared to 0.43% in the community, 10.7% of men had a psychosis, 16.0% depression compared to 3.4% in the community, 33.9% an anxiety disorder compared to 7.1% and 39.9% a personality disorder compared to 6.83%. All told 78.2% of men had a mental illness or disorder. The extent of mental illness or disorders among women was even higher. Over half suffered from an anxiety or personality disorder and 90.1% had one or another mental illness or disorder.

NMHI – Mental Health

Receptions (n = 756m/165f) Community (n = 6,627m/6,837f)

	Male %		**Female %**	
	Reception	Community	Reception	Community
Psychosis	10.7	0.43	15.2	0.41
Depression	16.0	3.4	23.6	6.8
Anxiety	33.9	7.1	55.8	12.1
Personality	39.9	6.83	56.4	6.13
Any Mental disorder	78.2		90.1	

SOURCE: Overheads shown by Dr Richard Matthews during his evidence to House of Representatives Standing Committee on Family and Community Affairs at Committee Hansard, Friday, 6 August 2002, pp. FCA 1,230-1,238

32. It is evident that prisons have become receptacles for people with a mental illness or disorder or substance dependence. What is more, the existence of a mental illness or disorder and substance dependence are not independent factors associated with imprisonment. The coexistence of substance abuse, including abuse of alcohol, with other mental illness or disorders dramatically increases the risk of offending behaviour. Whatever the myth, schizophrenia is not particularly associated with violence or other offending behaviour. It is substance abuse that makes a difference. This is shown in a survey of the literature by Dr Paul Mullen, clinical director of the

Victorian Institute of Forensic Mental Health and Professor of Forensic Psychiatry at Monash University (Mullen 2001). For example, in an Australian study that traced the criminal histories of just over 1,000 people with a diagnosis of schizophrenia: "Over 20% of males with schizophrenia had been convicted of a criminal offence with over 10% having a conviction for violence compared to 8% of controls who had a recorded offence with 2% violent convictions. A co-existing diagnosis of substance abuse was significantly associated with the chance of acquiring a conviction (49% vs 8.6%) including convictions for violence (17% vs 2%)" (Mullen (2001) p. 8) "In those with schizophrenia who did not have a problem with substance abuse, there was only a modest increase in offending" (VIFMH 2000, 407). Another recently published Victorian study found that if a person had schizophrenia their chances of attracting a criminal conviction was 11.7%. If they had schizophrenia and a substance use disorder their chance of obtaining a criminal conviction rose to 68.1% (Wallace *et al.* 2004, 721).

33. The association with crime of the combination of mental illness or disorders and substance abuse is a growing problem. As Dr Paul Mullen has written:

> "The evidence is mounting that the frequency with which those with mental disorder are resorting to the abuse of drugs and alcohol is increasing. In one of our own studies the rate of recorded problems with substance abuse among first admissions increased from 10% in 1975 to 35% in 1995" (Mullen 2001, 17).

34. In the more recent study, known substance abuse problems among persons with schizophrenia increased from 8.3% in 1975 to 26.1% in 1995 (Wallace *et al.* 2004, 721).

35. It is reasonable to conclude that many with a mental illness or disorder find themselves in prison as a result of their drug problem. The prison environment is about the worst environment they could be in. Families and Friends for Drug Law Reform can do no better than quote the words of Professor Paul Mullen, Professor of Forensic Psychiatry at Monash University and Clinical Director of the Victorian Institute of Forensic Mental Health, which attest to this:

> "The correctional culture and the physical realities of prisons are rarely conducive to therapy. Rigid routines, the pedantic enforcement of a plethora of minor rules, the denial of most of that which affirms our identity, add to the difficulties of managing vulnerable and disordered people. Separation and seclusion are all too often the response of correctional systems to troublesome prisoners, irrespective of whether those difficulties stem from bloody mindedness, distress, mental disorder or even suicidal and self damaging behaviours. Hierarchy and coercion which tends to rule in the official structure is often mirrored in the subculture of the prisoners. Mental disorders and intellectual limitations are frequently constructed by staff and prisoners alike as a sign of vulnerability and vulnerable is not a safe label to wear in prison. Those who do seek mental health treatment are at risk of being seen by staff as attempting to evade the rigours of prison, and by fellow prisoners as weak and unacceptably alien. Prisons and jails are intended to be punishing

> and they provide hard and unforgiving environments which often amplify distress and disorder. Equally however they provide remarkably predictable environments with clear rules and limited but well delineated roles. Some mentally disordered individuals thrive in this world stripped of the contradictions and complexities of the outside world. Sadly thriving in total institutions is rarely conducive to coping in the community" (Mullen 2001, 36)

36. It is a measure of the desperation of families and the lack of support in the community, that some have greeted with relief or even sought the arrest of a family member, as a means of securing care for them. The notion that remand centres and prisons are safe and caring drug free places for mentally disturbed people or indeed any young person addicted to drugs amounts to a cruel hoax. Nothing is further from the case.

> "Contact with the criminal justice field . . . exposes the vulnerability of mentally disordered people. A large majority of forensic mental health patients and clients have had substantial contact with the criminal justice system, which generally, as a matter of course, brings them into contact with other substance abusers. These contacts are often retained when they are released into the community. There is also the ever-present danger that the mentally disordered in the criminal justice system, and to a lesser extent in the community, will fall victim to the stand-over tactics of drug dealers" (VIFMH 2000, 412-13).

D. Confirmation that the response to drug dependence more than the dependence itself is a potent risk factor for mental illness or disorder

37. It is clear from research such as that mentioned above that the responses to drug users consistent with existing drug policy create known risk factors for mental illness or disorder. In other words, the risk factors arise from these responses independently of the direct pharmacological effect of the drugs concerned. This distinction is supported by the experience of maintenance treatment of dependent users. At least with an opiate like heroin, it is established that those who have been leading seriously dysfunctional lives replete with risk factors associated with mental illness or disorders can regain much of their functionality while being prescribed maintenance doses of methadone (which maintains their opiate addiction) and even heroin itself.

38. A survey of research on methadone maintenance concluded that:

> ". . . a high proportion of methadone maintenance patients experience psychological distress, and [that] high levels of distress may impede treatment outcome. The research . . . indicates that methadone maintenance treatment may itself contribute to an amelioration of patients' symptoms of depression and anxiety" (Ward *et al.* 1998, 82).

Randomised controlled trials have shown striking improvements for those on methadone maintenance compared to those on control groups that did not receive that treatment. To take one example, "six of the 12 men who entered methadone

maintenance were employed or in school, and three had been gaoled, whereas all 16 of those in the control condition had returned to gaol" (Ward *et al.* 1992, 15).

39. Similarly there were marked improvements in the social functioning and health of those on the trial of heroin prescription in Switzerland. As well as big reductions in their criminal conduct, improvements in employment, housing and social relationships (all signifying big reductions in risk factors for mental illness or disorders) there was a direct improvement in their psychological health. The following were the findings for three surveyed groups:

Psychological health: Swiss heroin prescription

of patients in heroin prescription treatment

Psychological health	Patients in treatment for less than 2 years (n=269)		Patients in treatment from 2 to 3 years (n=291)		Patients in treatment for more than 3 years (n=144)	
	on entry	1997	on entry	1997	on entry	1997
very good	3%	4%	3%	6%	1%	9%
good	58%	77%	61%	74%	53%	76%
bad	36%	18%	34%	17%	45%	15%
very bad	2%	1%	3%	3%	1%	1%

SOURCE: Swiss Federal Office of Public Health 1999, pt VII, para. 2.2.

It was noted in the Swiss report containing this table that after only a short time nearly 90% of those being prescribed heroin were in good physical health and more than 80% in good psychological health. It cautioned that the state of health of these people should take into account the fact that they had been selected for their severe and intractable heroin dependency (Swiss Federal Office of Public Health 1999, pt VII, para. 2.2).

IV. NEGATIVE IMPACT OF DRUG POLICY ON THE MENTAL HEALTH OF THOSE ASSOCIATED WITH ILLICIT DRUG USERS

40. Particularly in the case of their children, illicit drug users often can have negative impacts on the mental health of others. Drug abuse is a particularly potent element in the transmission and magnification of risk factors from one generation to another because of its close association with many other potent risk factors for mental illness or disorders. Family violence and disharmony, long term parental unemployment, abuse and neglect of children, low birth weight and school failure are among the risk factors that are often associated with parents whose life is out of control because of their illicit drug use. It is easy to see how a downward spiral through several generations can occur.

41. Imagine generation one being brought up in a low risk family. While the risks of drug abuse among the children may be low, drugs are potentially attractive to a wide range of perfectly normal young people – from among those who have a normal risk taking personality or who have low self esteem. The attractiveness of illicit drug abuse to a large proportion of normal young people appears from the following table from the 2001 household survey of the factors why people first used illicit drugs (AIHW 2002b, 40 and further discussion in FFDLR 2003 pt II(B).

Factors influencing first use of any illicit drug, lifetime users aged 14 years and over, by sex, Australia, 2001			
Factor	*Males*	*Females* (per cent)	*Persons*
Peer pressure	54.8	54.5	54.7
Curiosity	81.9	83.0	82.4
To feel better	8.0	9.8	8.8
To take a risk	9.9	11.1	10.4
To do something exciting	21.6	22.9	22.2
Family, relationship, work or school problems	6.2	8.8	7.4
Traumatic experience	3.1	5.1	4.0
Other	2.2	4.1	3.0

Notes

1. Base equals used an illicit drug in lifetime.

2. Respondents could select more than one response.

SOURCE: Australian Institute of Health and Welfare, *2001 National drug strategy household survey: detailed findings* (Drug statistics series no. 11) (Canberra, December 2002) table 6.2, p. 40.

Through drug abuse, some from this low risk environment can have their life chances and those of their own children badly degraded. There may be capable grandparents to help out. A further generation on and this family support will no longer exist. To quote the then Director of Marymead, an ACT family and children's service:

> "[W]e're now certainly seeing second generation families. Of course, there are children who are resilient, who will break out of the lifestyle of drug abuse but there are others who have not been able to escape that and it's really quite difficult to imagine how they're going to find their way out of that" (address of Sue Mickleburgh at FFDLR 2001)

42. It is generally not for want of love from their drug dependent parents that risk factors are heaped upon children but incapacity to reconcile the demands of bringing up children with those of drug dependency.

43. Once more the point needs to be stressed that the dependency itself does not necessarily lead to social dysfunction of parents. Of greater influence are the responses called for by existing drug policy to make those drugs less available and to motivate users to give them up. This is shown by the clinical experience referred to by which many severely dependent users of at least some illicit drugs can regain functionality in their lives while still addicted.

V. ATTITUDES OBSTRUCTING IMPROVEMENT

44. The nub of this submission of Families and Friends for Drug Law Reform is that the inquiry needs to look at the negative impacts on mental health of existing drug policy responses. It is not enough to point to the obvious correlation between illicit drug use and mental illness or disorders and observe that there would be less mental illness or disorders if there was less such use. A recommendation that ignores the impact of existing responses and urges intensification of those responses will only intensify the mental health crisis that so many families are going through.

45. At the same time Families and Friends for Drug Law Reform appreciates that there may be political obstacles in taking the approach it urges. It therefore concludes this submission with some observations on the following key points:

(a) whether overcoming addiction should take precedence over all other problems in the life of those addicted;

(b) whether existing policies make illicit drugs less available; and

(c) whether policy should be based on the best available evidence.

A. Whether overcoming addiction should be the overriding objective of drug policy

46. At the heart of the greater part of the sensitivity about drug policy are opposing moral positions about addiction and the consumption of mind altering drugs. On the one hand, some regard a person who is addicted as deprived of their essential humanity. They see the consumption of mind altering drugs that may lead to this as wrong. Certain quarters of the Christian church urge this. According to it, the overriding obligation is to help those who are addicted to overcome their addiction. From this point of view the indefinite maintenance of people on methadone, a synthetic opiate, is unacceptable because to do so maintains their addiction. The medical prescription of heroin as a drug treatment (which is possible in at least the United Kingdom, Switzerland and The Netherlands) is completely ruled out. That such treatments may allow people on maintenance treatments to improve their general level of health and regain control of their lives is discounted. Every effort including coercive ones should be made to free a person from addiction. If in the end the person dies, so be it.

47. An opposing view that receives support from both secular and other Christian quarters also regards addiction as undesirable and something which people should be assisted to overcome. This viewpoint differs from its opposition in rejecting the view that an addiction deprives people of their essential humanity. Addiction is a disability which, like any other disability, a person should be helped to live with if they are unable to overcome. Alternatively, if addiction is considered an illness the standard approach of treating illness should be followed: seek a cure but, if a cure is not possible, mitigate the symptoms. The paramount issue is to maximise the capacity of a human being to live a rewarding life and not to focus on the addiction alone. Overcoming addiction is not more important than life itself.

48. This latter viewpoint is probably most widely held. It is certainly more widely held than a traditional libertarian view that regards it wrong to interfere with the right

of anyone to act in a way that may cause harm to themselves. Such a view is often wrongly attributed to those who favour a change of drug policy.

49. Families and Friends for Drug Law Reform holds to the middle position. It totally rejects the absolutist view that puts greater store on becoming drug free than on life itself. Many of our members have lost children and other family members. They have every reason to dislike the drugs themselves that led to this. To maintain, though, that these people who have become entangled with illicit drugs are better off dead than still alive and addicted is hurtful and offensive in the extreme. Whether any of the drugs that are presently illegal should join the socially acceptable drugs like alcohol (that also lead to enormous harm) is a separate question and distinct from the moral acceptability of existing drug policies.

50. The absolutist view that addiction is the paramount evil is also inconsistent with the values reflected in human rights instruments. Given the recognised links that exist between measures taken to implement existing drug policies and poor physical and mental health, aspects of such policies would seem to be inconsistent with art. 12 of the International Covenant on Economic and Social Rights which obliges parties to "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and to take steps necessary for "the creation of conditions which would assure to all[,] medical services and medical attention in the event of sickness." Even more explicit provisions are found in art. 24 of the Convention on the Rights of the Child. It refers to "the enjoyment of the highest attainable standards of health and to facilities for the treatment of illness and rehabilitation of health". Drug policy bears heavily on children because a high proportion of children use illicit drugs. The 1999 national survey of secondary students found that 50% of 17-year-olds had used cannabis at least once and 12% used it weekly (White 2001). Over the years drugs have become more and more available to young people and more and more are using at a younger age.

51. The ethical issues involved in drug policy are discussed in more detail in Bush & Neutze 2000a with an abbreviated version in their 2000b. Discussion of discrimination and the views of church leaders is found in the submission of Families and Friends for Drug Law Reform to the Inquiry into the provisions of the Disability Discrimination Amendment Bill 2003 by the Senate Legal and Constitutional Legislation Committee (FFDLR 2004).

B. Whether existing policies make illicit drugs less available

52. That measures taken in accordance with existing drug policies do themselves cause harm may seem to place the welfare of people who do not use illicit drugs in conflict with those who do. Are the interests of one set of people at odds with the interests of others? In the context of mental health, is there a conflict of interest between measures taken to reduce the risk factors of mental illness or disorders of young people who do not use illicit drugs and measures that would reduce risk factors for people who are already using? This conceivable dilemma is most often raised in the context of cannabis where one hears objection to relaxation of controls on cannabis (as in the adoption in some jurisdictions of a system of expiation notices for minor cannabis offences in place of standard criminal prosecution) on the ground

that this will lead to more children taking that drug. Proposals to test party drugs (which often do not contain what they are passed off as) is another situation where the dilemma may be thought to arise.

53. There are persuasive reasons to believe that the interests of the non-using children are not at odds with measures to minimise the harms and otherwise assist people who do use. These reasons include:

- the level of illicit drug use in various countries bears no direct relationship to the repressiveness of measures against that use;
- in Australia where relaxation of laws regarding cannabis has occurred, the level of cannabis usage has not risen significantly compared to other jurisdictions;
- measures that reduce the commercial incentive to provide illicit drugs are likely to make them less available.

Each of these reasons is now examined.

1. The level of illicit drug use in various countries bears no direct relationship to the repressiveness of measures against that use

54. The degree of repressiveness of anti-drug measures varies greatly between countries. The relationship between the repressiveness and drug usage is often hard to gauge because of different survey methodologies of drug usage but in 1999 a survey was made of tenth graders in the United States and 30 European countries using methods designed to produce comparable results (SUNY 2001). The United States is generally very repressive. Most European countries are less so. The survey found that usage rates varied widely:

> ". . . 41% of 10th grade students in the United States had used marijuana or cannabis in their lifetimes. . . . [A]n average of 17% of 10th grade students in the 30 participating European countries had ever used marijuana or cannabis (19% in Northern Europe, 14% in Southern Europe and 16% in Eastern Europe). This proportion varies among European countries from 1% in Romania to 35% in the Czech Republic, France and the United Kingdom. All the participating European countries had a lower rate of lifetime cannabis use than did the United States."

55. 16% of 10th grade students in the United States had used amphetamines compared to an average of 2% for amphetamines across the European countries surveyed. The highest European rates of amphetamine use was 8% in the United Kingdom and 7% in both Estonia and Poland. The only countries with a rate of drug injection over 1% were Russia (2%) and the United States (3%).

2. Relaxation of cannabis law enforcement in Australia has not led to a significant increase in usage

56. The introduction in 1987 of the expiation notice system in South Australia has not led to any significant increase in cannabis consumption to counter balance the benefits already mentioned. According to a study made of usage between 1985 and 1995 the rate of increase in lifetime cannabis use in South Australia "has been marginally greater than the average rate observed in the other jurisdictions over the

same period." The study added that "there was as much variation in rates of cannabis use between jurisdictions that retained criminal penalties as there was between these jurisdictions and South Australia." If the expiation system ". . . has any effect, it has been a small increase in the number of adults, who are prepared to try, (or prepared to *report* that they have tried), cannabis."

57. Of most significance was the finding that:

> "There is no evidence to date that the [expiation] system in South Australia has increased levels of regular cannabis use, or rate of experimentation among young adults" (Donnelly *et al.* 1998, 13).

58. According to the household surveys of 1998 and 2001, across Australia there has been a decline from 21.3% to 18% of the population that had used cannabis recently (AIHW 2002a, 3; Makkai & Payne 2003, 5). This trend was also reflected in the 1996 and 1999 survey of secondary students: "among 16-17-year-olds the proportions using cannabis recently had decreased from 27% to 20% in 1999" (White 2001, 32). Over this time both law enforcement effort and price seem to have declined. Between 1995-96 and 2001-02 there was a decline of 30% in arrests and expiation notices for cannabis related offences (AIC 2003a, 93-94; AIDR 2002, 94). In that time a gram of cannabis head seems to have declined from mostly $30 or more in 1995-96 to between $20 and $25 in 2001-02 (AIDR 1996, 228-30; AIDR 2002, 106; AIDR 2003, 145). Data like this suggest that trends in drug consumption are only weakly correlated with either price or law enforcement effort and that some other factors are more influential.

3. Measures that reduce the commercial incentive to provide illicit drugs are likely to make them less available

59. The illicit drug market is organised as a pyramid selling system. The grass roots distribution of drugs is overwhelmingly in the hands of user-dealers. For addicted users without private income, dealing is a means of raising the substantial funds required to maintain a habit and is seen by many as preferable to the other main sources of finance: ripping off family and friends, property crime or prostitution. It is the pyramid structure that makes the illicit drug market so resistant to law enforcement. The vulnerable low level dealers are rapidly replaced. Those higher in the pyramid are very hard to catch. Stress imposed at the user-dealer level thus has little or no impact on the overall drug market while at the same time having those negative impacts that have already been described on the mental health and general welfare of the people involved.

60. Attractive treatments reduce both demand and availability – demand from those who are in treatment and availability in that they no longer need to deal in drugs to support their treatment. Surveys undertaken of those on methadone maintenance show dramatic reductions in criminality generally (which would include drug dealing) by those on the programme (Ward *et al.* 1992, 34ff).

61. There was a huge reduction in the prevalence of dealing by those on the Swiss heroin prescription programme and an even more striking reduction in the incidence of dealing. In other words, in addition to the high proportion who stopped dealing entirely, those who continued dealing did so far less.

Drop in prevalence and incidence rates of self-reported criminality, after one year of treatment in the Swiss program of heroin prescription, compared to the time before admission (reference period of 6 months, N=319). Unless otherwise indicated, all changes are significant at the .05 level at least.		
Offense type	*Prevalence rates*	*Incidence rates*
. . .		
Selling "soft" drugs	– 50 %	– 70 %
Selling "hard" drugs	– 82 %	– 91 %

SOURCE: Martin Killias, Marcelo Aebi and Denis Ribeaud, "Summary of Research Findings concerning the Effects of Heroin Prescription on Crime" (paper delivered at international symposium on heroin-assisted treatment for dependent drug users, 11 March 1999)

Such data holds out the prospect that measures other than repressive law enforcement bearing on users are capable of making drugs less available. Indeed, the very success of law enforcement in raising the price of drugs many, many times above the cost of production would seem to outweigh any dampening effect on demand that high prices have: the high profits are an incentive to supply a market that because of addiction or otherwise is willing to pay inflated prices.

62. The inefficacy of law enforcement is illustrated by the surge in supply of the imported potent methamphetamines – drugs that appear to have such serious effects on mental health – at the same time as Australia was experiencing an unprecedented heroin shortage. The bulk of the drugs came from the same Asian suppliers. Several years before it occurred, this change was forecast by the Office of Strategic Crime Assessment on the ground, firstly, that new markets in China for illicit opiates would outstrip supply from the Golden Triangle (notably Burma) and, secondly, the boom in manufacture of the new methamphetamines (Wardlaw 1999, 5). It is beyond reasonable doubt that these factors plus a series of poor opium harvests in Burma were principally responsible for the heroin shortage in Australia, not law enforcement. An analysis of the evidence is at Bush *et al.* 2004.

C. Whether policy should be based on the best available evidence

63. On a sensitive subject such as drug policy, "facts" are often in contention. It is imperative that rational standards be applied in formulating what should be done to achieve desired goals.

64. Families and Friends for Drug Law Reform urges the inquiry to formulate a set of measures based on the best available evidence that can reasonably be expected

to minimise the harmful consequences for mental health arising from illicit drugs including policies to combat them.

65. In this process the inquiry should be aware that those who take the moral position that freeing people from addiction is the overriding imperative, will often deny evidence that may seem to undermine support for their position. This includes evidence that people on maintenance treatment are able to regain functional lives while still addicted. Similarly, they tend to dismiss evidence of the negative effects of measures of which they approve. Examples are evidence of the negative impacts of coercive drug treatment or higher death rates and other harms as a result of more intense law enforcement.

66. One frequent technique used to undermine such evidence is to point to the uncertainty of research. Criticism of the evaluation of the trial of heroin prescription in Switzerland is an example of this. Because the trial proceeded without a control group it could not be said that the spectacular improvements in the health and welfare of those on the trial arose from the heroin prescription rather than the psycho-social support that accompanied it. The criticism is correct in that the trial did not prove that the heroin had these beneficial effects even though it greatly strengthened the evidence in favour of that conclusion (WHO 1999; Uchtenhagen 1997). The uncertainty of the Swiss trial was addressed in a subsequent trial in The Netherlands where the efficacy of different therapies, including heroin prescription, was compared (Netherlands 2002).

67. The sensitivity of the subject matter and the fact that funding of drug research agencies is overwhelmingly from government, leads to timidity on the part of researchers in speculation on the implications of their findings. Speculation about the implications of research results and robust debate about them by those with relevant expertise is an important part of the scientific process. Speculation looks beyond narrow conclusions based on findings to likely broader links. Such speculation normally shapes the direction of future research. Without freedom to range over all likely possibilities because of fear of getting into political hot water, comments are often limited to calls for more research along the same lines. Because, in the social sciences, proof in the strict sense is elusive, further similar research is never likely to eliminate uncertainty but at best reduces it. Policy makers, normally prepared to adopt measures supported by far weaker evidence, can use lack of proof as a pretext for inaction. In this way endless calls for further research may be no more than a camouflage for their procrastination.

68. Families and Friends for Drug Law Reform urges the inquiry to base recommendations on what are the conclusions to be drawn from the best available evidence.

VI. FAILINGS OF NATIONAL MENTAL HEALTH AND DRUG STRATEGIES TO ADDRESS THE PROBLEM

69. In this submission Families and Friends for Drug Law Reform is calling on the Commission and Council to examine the link with mental illness or disorders of both illicit drugs and the measures taken in accordance with existing drug policy against those drugs. The evidence is there that the worsening crisis in mental health is largely contributed by this link. The demand for treatments and services is continuing to outstrip what is available. The suffering of those with mental health problems and their families intensifies.

70. The easiest course is, of course, to pass over the difficult question of illicit drug policy. The Australian Law Reform Commission and Human Rights and Equal Opportunity Commission in their report *Seen and heard: priority for children and the legal process* (1997) regarded "the problems of drug abuse among young people [as] beyond the terms of reference" of their inquiry (ALRC & HREOC 1997, 13). It came to this conclusion even though it is directly or indirectly through drugs that most children get entangled with the processes of the criminal law and those processes often have such detrimental effects upon them.

71. Federally, the overlap of the problems of mental health and drug abuse is falling between stools. The *National Mental Health Plan 2003-2008* shoves responsibility for drug and alcohol problems to the national drug strategy. For example, it states that:

> "In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system and have a separate, but linked, national strategy" (AHM 2003, 5 &, similarly, 36).

72. The current National Drug Strategy 2004–2009 subtitled *Australia's integrated framework* states the platitude that mental health and drug services should work together:

> "During this phase of the National Drug Strategy, action will be taken to . . . build strong partnerships between drug treatment services and mental health services to enhance responses to co-existing drug and mental health problems" (MCDS 2004, 7)

and that "policies and programs" under the strategies be "integrated":

> "There will also be integration between the National Drug Strategy and other relevant strategies, for example, the National Supply Reduction Strategy for Illicit Drugs, the National Hepatitis C and National HIV/AIDS Strategies, the National Mental Health Strategy, the National Suicide Prevention Strategy, and the Aboriginal and Torres Strait Islander Peoples Complementary Action Plan. Such integration will ensure relevant trends in these areas are incorporated in the development of policies and programs under the National Drug Strategy" (MCDS 2004, 11)

73. It is clear that much still needs to be done to "build strong partnerships" between treatment services but however well mental health and drug treatment services work together there is only so much that they can do. For one thing the demand on resources to fund the ever increasing demand for services is already becoming unsustainable. Therefore, an important focus of the Council's and Commission's inquiry should be how policies and programs should be integrated so as to minimise the distress that is already so evident of mental illness or disorders associated with drug abuse.

22 October 2004

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