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 SENATE SELECT COMMITTEE ON MENTAL HEALTH INTO THE PROVISION OF MENTAL HEALTH SERVICES IN AUSTRALIA

Families and Friends for Drug Law Reform has just one plea to make to the Committee. That is for it to recognise that the response in Australia to illicit drugs contributes to the worsening crisis in mental health far beyond the adverse effects of the drugs themselves. In particular, we call on the Committee to reject the current disempowering mindset that insists first and foremost that people should overcome their addiction before addressing other problems in their life.

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I. INTRODUCTION

A. Summary

1. Families and Friends for Drug Law Reform urges the Committee to acknowledge the contribution of existing drug policy to the increasing level of mental illness and disorders in Australia and the worsening plight of those who suffer from them and of their families. Great improvements are possible if the National Mental Health and Drug Strategies were integrated rather than passing off the problem to one or other set of service providers as the strategies presently do.

2. This submission covers the links between drug policy and:

(a) social and other risk factors known to be associated with mental illness and mental disorders;

(b) the pressure on the mental health system which is seeing more and more resources demanded for crisis interventions and less available for more cost effective early, low and medium level interventions;

(c) over representation of people with a mental illness in the criminal justice system and in custody; and

(d) the ready availability since the end of the 1990s of new potent methamphetamines which lead to severe mental health problems.

There is a large overlap between people using illicit drugs and those with a mental illness. In the words of the National Comorbidity Project: "Comorbidity of mental disorders and substance use disorders is widespread and often associated with poor treatment outcome, severe illness course, and high service use" (Teesson & Burns 2001, 1). 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). "Comorbidity is of particular concern for young adults aged 15-24 years. The recent Australian burden of disease and injury study found that nine out of ten leading causes of burden in young males and eight out of ten leading causes in young females were substance use disorders or mental disorders" (Teesson 2001, 9).

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 itself 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. Professor Kavanagh of the Mental Health Centre at the Royal Brisbane Hospital has warned that "effective management of comorbidity is likely to be critical to the cost-effectiveness of services." There are, he has written, "particularly high proportions [of comorbidity] seen in services for more serious problems (such as in-patient wards) and in younger patients. If these patients are not effectively treated, this will have a substantial impact on the overall effectiveness of the service. In practice, management of comorbidity becomes 'core business' for the service, whether or not this is recognised" (Kavanagh 2001, 64).

6. In order to cope with crises, scarce resources are being siphoned away from already chronically under funded 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.

7. The link between drug dependence and mental illness or disorders is not confined to the pharmacological effects of the drug concerned. The Committee should not therefore rest content with a platitudinous recommendation that illicit drugs, because they have deleterious effects, should be made less available.

8. 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 (DHAC 2000, 16).

9. 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 Committee, therefore, should consider what measures can reasonably be expected to make dangerous drugs associated with a mental illness or disorder less available.

10. After considering the negative impacts of current illicit drug policy on mental health, this submission examines three main obstacles to securing improvement. These are, firstly, a moral belief of dominating influence, though probably not widely shared, that overcoming addiction must 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, existing policies, by their net effect, 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.

11. 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 between the treatment services. It also specifies that there should be integration of policies and programs without indicating what this involves.

B. About Families and Friends for Drug Law Reform

12. 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.

13. 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).

14. Families and Friends for Drug Law Reform does not promote the view that currently illicit drugs should be freely available. Indeed it believes that they are too available now in spite of their illegality. Their distribution is in the hands of organised crime deriving wealth from them that can corrupt or influence all levels of society and government. Illicit drugs are an industry beyond the capacity of democratic governments to control. 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

15. There are reports of the 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 and the apparent tendency of those with a mental illness or disorder to use illicit drugs as self medication.

A. Illicit drugs and self medication

16. In 2001 the then Minister for Health, citing a National Survey of People Living with Psychotic Illness, said that "people currently living with long-term psychotic illness are: ten times more likely to abuse street drugs, four times more likely to abuse alcohol, and almost three times more likely to smoke than the general

population" (Teesson & Burns 2001, 5). "Having emotional problems (that is, anxiety and depression) is associated with at least a three-fold increase in lifetime incidence of substance use disorder" (Dadds 2001, 43). "Persons who have comorbid substance use and mental disorders have poorer outcomes than those who have a single disorder. This has been well demonstrated in schizophrenia but is also the case in depression and anxiety" (Hall *et al.* 2001, 15).

17. Whether motivated by an attempt at self-medication or otherwise (Dadds 2001, 44-45), it is clear that illicit substances have a big attraction for many people with a mental illness or disorder. As discussed below, when considering why so many people with a mental illness or disorder find themselves in prison (page 12), the proportion of such people resorting to these substances has been increasing alarmingly. It is known that ". . . some mental disorders may increase the risk of substance use disorders. One example of this is when persons with anxiety and affective disorders use alcohol and other drugs to self-medicate" (Hall *et al.* 2001, 11). A researcher at the Centre for Mental Health Studies at the University of Newcastle has described how it is that many people with depression come to use illicit drugs:

> "People with depression often respond to everyday situations with a negative interpretation. Symptoms of depression also include low mood, loss of interest in activities, people or places and loss of energy which makes them feel terrible about themselves and the world they live in. Many people then turn to alcohol and drugs for temporary relief" (Kay-Lambkin 2004).

B. Cannabis

18. 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 that cannabis use possibly triggers 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*.).

C. Methamphetamine

19. 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 from just before the 2001 heroin drought.

20. An Australian text published in 2004 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" (Baker *et al.* 2004, 156)

21. 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).

22. Increased mental health problems have dominated comments about the potent stimulants. Across Australia ". . . there has been a dramatic rise in the number of psychotic disorders due to stimulant use from 200 in 1998-99, to 1,028 in 1999-00 and a further but smaller increase to 1,252 in 2000-01" (McKetin & McLaren 2004, 14).

23. 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).

Similarly, another account states:

> "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).

24. In a 2001 survey in South Australia, many health workers and others of the key informants "spoke of the increasing emergence of mental health problems, including psychosis, depression, anxiety and violent behaviour. These adverse effects may be a result of increased use of much stronger forms of the drug, and they are manifested at a more rapid rate in users. The drug and alcohol workers noted a high incidence of clients with depression or bipolar disorders, as well as low self-esteem, suicidal impulses and self-destructive behaviour patterns" (Longo *et al.* 2002, 44). Added to similar reports from Queensland was the comment that: "Some Accident and Emergency departments reported between 2-12 people presenting a night with problems associated with amphetamine use. Another comment by key informants was that paramedics, health staff and police were experiencing abuse and violence and situations where it was difficult to handle someone because they were on high doses of amphetamine or methamphetamine" (Rose & Najman 2002, 67). A survey carried

out the following year (2002) found that "there does seem to be a link between regular methamphetamine injection and mental health problems" (Kinner & Fischer 2003, 64 & similarly Kinner & Fischer 2004, 43-44).

25. 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 use.

26. Reflecting the assessment of law enforcement agencies, the 2000-01 Illicit Drug Report stated that:

> "The demand for amphetamine-type stimulants in Australia is on the increase. The prevalence of tablet-form methylamphetamine being marketed as ecstasy further generates a whole new market and user group for the drug. In Queensland alone, the amphetamine-type stimulant market has evolved to the extent that its consumers outnumber those in the heroin market and cross a variety of licit and illicit drug markets via polydrug usage" (AIDR 2002, 48).

'Base' and 'ice' or crystal methamphetamine - potent forms that are typically imported - became "relatively commonplace among the dance party scene since 2001" (McKetin & McLaren 2004, 27). Moreover, analysis of seized samples shows the extent that methamphetamine tablets were often passed off as ecstasy. New South Wales police reported that in 2001-02 something over half the tablets sold as ecstasy contained methylamphetamine and not the active ingredient of ecstasy, the phenethylamine known as MDMA. The proportion had been 3:1 in favour of methylamphetamine in 2000-01 (AIDR 2003, 80).

27. In the light of the widespread practice of passing off these potent stimulants as ecstasy the sizeable increase in "ecstasy" use revealed in the 2004 household survey is therefore of particular concern. Between 2001 and 2004 there was a 23% increase from 6.1% of the population to 7.5% who had ever used ecstasy. Moreover, the survey probably conceals a substantial shift to the potent methamphetamines within the category of "Meth/amphetamine (speed)" – a category that would include old powdered speed.

Table 1: Summary of selected drugs ever used/tried: proportion of the population aged 14 years and over, Australia, 1993 to 2004

	Ever tried			*Ever used*	
Drug/behaviour	***1993***	***1995***	***1998***	***2001***	***2004***
Meth/amphetamine (speed)[(c)]	5.4	5.7	8.8	8.9	9.1
Ecstasy[(e)]	3.1	2.4	4.8	6.1	7.5[#]

(c) For non-medical purposes.
(e) This category included substances known as "Designer drugs" prior to 2004.
2001 result significantly different from 2004 result (2-tailed $\alpha = 0.05$).
Source: Extracted from AIHW 2005, 4.

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

28. 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

29. 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.

30. 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).

31. 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)

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)

32. 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 includes:

- 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 (DHAC 2000, 16).

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

33. 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. Under this system the drug remains prohibited but minor offences incur a civil rather than a criminal penalty.

34. 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.

35. 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.

36. 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 serve as a stronger deterrent against actual cannabis usage. This aspect is mentioned further below (Lenton *et al.* 1998, x).

37. 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

38. 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.

39. 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.

Table 2: 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

40. 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.

Table 3: 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

41. 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 only modestly associated with violence or other offending behaviour (according to one big study 11.7% of those with schizophrenia without a substance abuse problem compared to 7.8% of a comparison group that did not have schizophrenia) (Wallace *et al.* 2004, 722). In fact:

> "When the rate of offending in persons with schizophrenia is compared to that in persons with other forms of mental disorder, particularly severe personality disorders, schizophrenia may appear to actually be protective against violent offending and other types of offending" (Wallace *et al.* 2004, 724).

42. 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 chance 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).

43. 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).

In the more recent study of those treated for schizophrenia for each of five years between 1975 to 1995, known substance abuse problems among persons with schizophrenia increased from 8.3% in 1975 to 26.1% in 1995 (Wallace *et al.* 2004, 721). The authors of that study added that "had we examined a 2000 cohort, the rate would have been well over 30%" (*ibid.*, 725).

44. In summary, one can draw the following conclusions from these studies about schizophrenia:

> (a) substance abuse greatly magnifies the risk of those with schizophrenia offending;
>
> (b) the proportion of those which schizophrenia who are abusing substances is increasing; and
>
> (c) having schizophrenia "is associated with increased rates of substance abuse" (*ibid.*, 725).

Families and Friends for Drug Law Reform understands that the same could be said for many other mental illnesses and disorders.

45. 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 in which they could be. 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 [construed] 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)

46. 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

47. 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. The continued use on maintenance programmes of depressants like the opiate heroin is consistent with a two-fold improvement in the mental health of those on the programmes. In the first place the mental health of those still receiving the maintenance drug is shown to improve directly and, in the second place, risk factors associated with mental illness or disorders of those on such programmes are shown to diminish. In particular, maintenance programmes are shown to reduce greatly the involvement in crime and resulting imprisonment and other stresses of the criminal justice processes that are particularly potent risk factors for mental illness or disorders of both drug users and those dependent on them.

1. Direct improvements in mental health of those on maintenance programmes

48. Experience of maintenance treatments shows that the mental health of people receiving those treatments can be improved while being maintained on an addictive substance. Direct improvements observed in the large trial of medically prescribed heroin in Switzerland are reported in the following terms:

> "The general state of mental health improved on average, and the need for treatment was estimated to be slightly lower compared to the status on admission . . . .

Table 4: Medical rating of mental health on admission and during treatment

	On admission %	*After 18 months* %
Mental status	(n = 217; md = 20)	z=3.94; p ≤0.001
Good	64	82
Poor	36	18
Need for treatment	(n = 208; md = 29)	z = 1.89; n.s.
No or slight	32	38
Moderate	47	46
Major	21	16

"In particular, depression and other affective disorders became less frequent, which is not the case for schizophrenic conditions. Of the schizophrenic psychoses diagnosed at the outset (n = 8), 5 stayed on the programme for at least 18 months. This matches the mean retention rate in the programme, in contrast to high drop-out rates of dual diagnosis patients in general.

"Affective disorders required psychiatric treatment considerably less often after the second month on the programme. The same applies to personality disorders and other behavioural disturbances. The corresponding data for schizophrenia show no reduced need for treatment.

"During the admission and in-treatment interviews, patients were also investigated about psychological morbidity. 62 psychological items from the SCL-90 symptom checklist were used. Three syndromes were extracted on the basis of factor analysis. The three syndromes concerned depression, anxiety/ delusion and aggressive acting-out.

"The follow-up analysis over 18 months showed a reduction in depressive syndromes. Anxiety and delusional syndromes also diminished markedly, as did aggressive acting-out.

"The decrease in depressive symptoms occurred primarily in the first 12 months of treatment and then remained stable.

"The decrease in anxiety and delusional symptoms was continuous and extended beyond the first 12 months of treatment.

"The decrease in aggressive behaviour also showed further improvement after the 12th month of treatment" (Uchtenhagen *et al.* 1999, pp. 51-53).

49. The following table surveys the psychological health of those on the programme for longer periods than the 18 months mentioned in the foregoing reports – those in treatment for less than two years, from two to three years and for more than three years. It too confirms that positive mental health outcomes are possible for people while continuing to receive some drugs on which they are dependent.

Table 5: 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.

50. Similarly, a survey of research on maintenance with the artificial opiate, methadone, 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).

The prescription of heroin in The Netherlands to severely dependent opiate users who had not responded well to methadone also showed that improvements in mental health were possible while people continued to use addict substances:

> ". . . the supervised co-prescription of heroin to chronic, treatment-resistant methadone patients lead to improvements in all health outcome domains: physical health, mental status and social functioning. . . . The clinical relevance of the findings of the current study is illustrated by the magnitude of the improvements in the different outcome domains among treatment responders in the experimental condition. As a group, these responders showed considerable improvements in physical health and mental status, with mean [Maudsley Addiction Profile Health Symptoms Scale] and [Symptoms Checklist of psychiatric status] SCL-90 scores at the month 12 assessment, which were very similar to the mean scores in general population samples" (Netherlands 2002, 148).

2. Reduction of risk factors for mental illness or disorders of those on maintenance programmes

It is established that dependent drug users leading seriously dysfunctional lives that are risk factors for mental illness and disorders can regain stability in their life while receiving prescribed maintenance doses of opiates such as methadone and even heroin. 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).

51. Similarly there were marked improvements in the social functioning and health of those being prescribed heroin in Switzerland. Improvements in social integration was measured in terms of accommodation, employment, finances, and social contacts. The following is drawn from the findings for those who remained on the programme for 18 months.

52. *Accommodation:* Homelessness is a risk factor for mental health problems (DHAC 2000, 16). "Unstable living conditions dropped below half the initial value, while stable living conditions increased accordingly. These changes were continuous over the entire treatment period and are highly significant" (Uchtenhagen *et al.* 1999, 59).

53. *Employment:* Unemployment and job insecurity are risk factors for mental health problems (DHAC 2000, 16)."The result is impressive: despite a difficult labour market situation, there was nearly a twofold increase in permanent employment whereas unemployment dropped to less than half. The differences are highly significant. It also became evident that 28% of those unemployed on admission found regular employment and 24% of those originally working temporarily had found a permanent job. The changes occurred predominantly during the first year of treatment" (Uchtenhagen *et al.* 1999, 59-60).

54. *Finances:* Poverty and economic insecurity are risk factors for mental health problems (DHAC 2000, 16)."Financial debts constitute a serious impediment to social integration; they represent a major obstacle and have a demoralising effect. . . . Debts decreased continuously during the treatment period. After 18 months of treatment, one third of patients were debt free and a further quarter were only moderately indebted. These differences also are highly significant" (Uchtenhagen *et al.* 1999, 60).

55. *Social contacts:* Deviant peer groups and peer rejection are risk factors for mental health problems (DHAC 2000, 16). "The proportion of those who had contact with drug users several times weekly fell to less than half during the first year of treatment. Accordingly, the number of those increased who rarely or never had such contacts. . . . In addition to the analysis of social contacts, patients were asked how often they visited the drug scene. Such visits decreased dramatically" (Uchtenhagen *et al.* 1999,62).

3. Reduction in involvement in crime and processes of the criminal law for those on maintenance programmes

56. Involvement in crime, whether impelled by the need to raise funds to support a habit, by being under the influence of a drug or for other reasons, is part of the life of many (though far from all) users of illicit drugs. Criminal activity shares with mental illness or disorders a collection of risk factors such as school failure, association with deviant peer groups, socio-economic disadvantage. What is more, crime and mental illness or disorders are each potent risk factors for the other (NCP 1999, 136; DHAC 2000, 16). It is the accumulation of risk factors that is known to be behind these as well as so many other big social problems. Snowball like, crime and mental illness or disorders greatly add to the risk factors of further problems including the re-occurrence of crime (i.e. recidivism) and intensification of mental illnesses or disorders. Substance abuse, and particularly the use of illicit substances is also closely associated with these problems. What the following research shows is that this relationship is not nearly as close as is generally regarded. Evidence is clear that continuing dependence on opiates at least is not a significant risk factor for crime.

57. Research has been carried out for many years on the effect on participation in crime by dependent drug users who are receiving methadone. Most likely these people will have been dependent on heroin. Dependency continues while receiving the artificial opiate, methadone. Even so, their offending behaviour is shown to decline while in opiate maintenance treatments. Two examples of the many trials are mentioned here. The first is the Treatment Outcome Prospective Study (TOPS)

carried out in the United States from 1979 into the early 1980s. This was a large prospective study of over 11,000 illicit drug users who applied for treatment in 41 programs.

> "Criminal activity was assessed by self-reported predatory crimes such as breaking and entering and robbery. Among patients in methadone maintenance, one-third reported committing a predatory crime in the year before treatment. This dropped to 10% during the first month of treatment. . . . Methadone treatment . . . was associated with a reduction in criminal activity during treatment but did not permanently change the behaviour of the more criminally involved patients in the post-treatment period" (Ward *et al.* 1992, 31).

58. The second example is the results of a large-scale outcome study of methadone maintenance treatment involving six methadone maintenance programs, two in each of Baltimore, Philadelphia and New York, over a three-year period between 1985 and 1987. The study found that methadone maintenance had "a dramatic impact" on crime among the 388 patients who remained in treatment:

> "The reduction of crime associated with retention in methadone maintenance . . . appeared impressive. The study sample had an extensive criminal history prior to entering methadone: a total of 4,723 arrests, with a mean of nine arrests for the 86% of the sample who had been arrested. Sixty-six per cent of the group had spent some time in gaol, 36% having been incarcerated for two years or more. Although these figures indicate extensive criminal involvement, they seriously underestimate criminal activity which is better estimated by self-reported crime.
>
> "The sample admitted to 293,308 offences per year during their last period of addiction. Among those who admitted committing criminal acts, each person committed an average of 601 crimes per year (range 1 to 3,588), and had committed criminal offences on an average of 304 days per year during their last addiction period. After entry to methadone, the number of self-reported offences declined to 50,103 crimes per year and the mean number of 'crime days' per year decreased from 238 in the year prior to entry to 69 crime days during the early months of methadone maintenance. The number of crime days continued to decline with the number of years spent in treatment. In terms of the number of crimes committed, the reduction during methadone maintenance was 192,000 offences per year. As [the authors of the study] remark, such a substantial reduction in criminal activity among heroin users is usually only achieved by incarceration" (Ward *et al.* 1992, 35).

59. The cautious conclusion from a survey of all studies is that: "The relationship between methadone maintenance and a reduction in . . . criminal behaviour is, on average, a reasonably strong one" (Ward *et al.* 1998, 47).

60. The possibility of even more striking reductions in crime have been demonstrated while dependent drug users continue to receive heroin itself. Heroin prescription in The Netherlands reported "strong reductions in illegal activities" (Netherlands 2002, 148). The changes in offending measured in more detail for those being prescribed heroin in Switzerland has also shown this. Reductions that can only be described as spectacular were documented using different measurements. These measurements were:

(a) self-report by those on the programme of the extent they engaged in crime before and during treatment;

(b) self report of the extent that these same patients on the programme were themselves victims of crime before and during treatment; and

(c) the changes in offending behaviour for those on the programme as reflected in their contacts with police.

61. A summary of the outcomes for just the first year of treatment compared to the six months before are set out in the following tables. The first records a reduction of 94% in the number of patients on the programme engaged in serious property offences (the prevalence rate). It also shows an even greater reduction in the frequency with which each individual offended (the incidence rate). Such offences particularly associated with illicit heroin use. This is in contrast to the small reduction in offences such as assault which are committed relatively rarely by opiate users.

Table 6: Prevalence and incidence rates of self-reported criminality, after one year of treatment in the Swiss programme of heroin prescription, compared to the time before admission
(reference period of 6 months, N=305).

offence type	prevalence rates				incidence rates			
	before	after	p	drop	before	after	p	drop
serious property offences[1]	11.2	0.7	<.001	94%	0.388	0.007	<.001	98%
other property offences[2]	39.9	17.4	<.001	56%	7.238	0.954	<.001	87%
selling "soft" drugs	26.3	12.5	<.001	52%	8.960	2.162	0.001	76%
selling "hard" drugs	46.9	8.2	<.001	83%	25.297	2.030	<.001	92%
assault[3]	1.0	1.0	ns	ns	0.017	0.016	ns	ns

1 burglary, muggings, robbery, pick-pocketing
2 thefts, shoplifting, receiving or selling stolen property
3 with or without weapon
Source: Killias *et al.* 2005, 195.

62. Victimisation is recognised as being closely correlated with delinquency. The following table shows a particularly strong diminution in offences connected with the life of drug dependent people namely victimisation in terms of robbery, theft and fraud involved in the purchase of drugs.

Table 7: Prevalence and incidence rates of self-reported victimizations, after one year of treatment in the Swiss programme of heroin prescription, compared to the time before admission

(reference period of 6 months, N=305).

offence type	prevalence rates				incidence rates			
	before	after	p	drop	before	after	p	drop
robbery	11.5	4.7	<.001	59%	0.273	0.084	<.001	69%
assault	3.6	2.7	ns	-	0.036	0.043	ns	-
sexual offences	1.7	1.4	ns	-	0.092	0.013	ns	-
fraud with drugs	55.3	16.0	<.001	71%	4.465	0.572	<.001	87%
thefts	23.0	13.0	<.001	43%	0.792	0.180	<.001	77%
theft of bicycle	14.1	9.7	.096	31%	0.201	0.128	.063	36%

Source: Killias *et al.* 2005, 195.

63. The big drops in police contacts set out in the following table confirmed the reductions in self-reported offending.

Table 8: Incidence rates of police contacts, by offence type, for periods of 6 months before and after admission in the Swiss programme of heroin prescription (N =604).

(Incidence rates allow - by multiplying the rate by the number of individuals - to calculate the number of contacts recorded; e.g., 1162 contacts were recorded by the police for the period before admission and 370 for the period after admission.)

offence type	before	after	drop	p*
violent and sex offences	0.023	0.022	4%	ns
shoplifting	0.164	0.078	52%	<.01
burglary	0.041	0.013	68%	<.02
robbery/mugging	0.012	0.002	83%	.06
trespassing	0.028	0.007	75%	<.02
theft of vehicles	0.048	0.020	58%	<.03
other theft and property offences[1]	0.139	0.033	76%	<.01
other criminal code offences[2]	0.023	0.007	70%	<.01
traffic offences	0.040	0.013	68%	ns
use or possession of cannabis	0.131	0.056	57%	<.01
use or possession of heroin	0.689	0.149	78%	<.01
use or possession of cocaine or ecstasy	0.285	0.132	54%	<.01
use or possession of other or several substances	0.166	0.025	85%	<.02
drug trafficking	0.119	0.051	57%	<.01
offences to other law[3]	0.017	0.005	71%	.07
overall incidence rate	1.924	0.613	68%	<.01

* t test for paired samples, two-tailed significance

1 including receiving stolen property and forgery

2 including fare dodging

3 including searches

Source: Killias *et al.* 2005, 196.

64. The foregoing tables cover only the first year of treatment. The more detailed report to the Swiss Government that analyses the longer term effects of the trial has concluded that:

> "In summary, heroin treatment constitutes without doubt one of the most effective measures ever tried in the area of crime prevention" (Killias *et al.* 2002, 80).

65. The big reductions in crime that the foregoing research reveals shows that at least for the opiates concerned, addiction alone is not responsible for the high involvement in crime of dependent drug users. Since the crime reductions occur while people concerned continue to receive addictive substances, other factors associated with our response to illicit drugs must be responsible. Crime is examined in this submission on mental health because more and more people with mental illnesses or disorders are using illicit drugs and are ending up in about the worst place they could be for their condition, namely prison. In the words of one tenacious mother of a young man with schizophrenia:

> "Trauma is the Criminal Justice System. This is a major stressor especially prior to a court appearance. I find it enormously frustrating and distressing when I have worked so hard to help him reach a stable day-to-day existence only to have him psychotic again because of this stressor. We need assistance before the situation becomes this dire. The prison system need never be an option with early intervention" (testimony of Meta Ransome in Teesson & Burns 2001, 33).

66. Measures that lead to a big reduction in crime and stabilise the life of illicit drug users therefore hold out big improvements in the condition of those with a mental illness or disorder. Quite apart from crime, research on methadone maintenance and the prescription of heroin has demonstrated or, at least, pointed the way to direct improvements in the mental health of those stabilised on those addictive substances as well as improvements in other measures of social functioning such as accommodation, employment, financial position and social contacts. Deficits in these matters are all known to be risk factors for mental illness or disorders. The same is also true of the lifestyle associated with crime and imprisonment that results from crime. The reduction of those risk factors while people remain addicted therefore greatly reduces the prospect that otherwise high risk illicit drug users will develop or intensify mental illnesses or disorders.

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

67. 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.

68. 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 latest available household survey of the factors why people first used illicit drugs – that of 2001 (AIHW 2002b, 40 and further discussion in FFDLR 2003 pt II(B).

Table 9: 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.

69. 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)

70. 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 associated with their drug dependency.

71. 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. In particular surveys show that crime and resulting incarceration are not necessarily associated strongly with illicit drug dependency. Absence of a father in childhood, antisocial role models, neglect in

childhood and parental criminality, which are generally associated with the crime and imprisonment of drug users, are recognised risk factors for mental illness of children exposed to them (DHAC 2000, 16). A big reduction in crime and incarceration of those suffering from a drug addiction therefore removes very potent risk factors for mental health problems for any children that they may have.

V. ATTITUDES OBSTRUCTING IMPROVEMENT

72. 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.

73. 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) should overcoming addiction 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. Overcoming addiction as the overriding objective of drug policy

74. 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. Relapses are part and parcel of addiction hence an absolute insistence on abstinence sets people up for failure. As Professor Kavanagh has remarked of treatments and services for comorbidity : “An approach that . . . sees abstinence as the only positive goal will have limited applicability” (Kavanagh 2001, 65).

75. 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 may be regarded as a disability which, like any other disability, a person should be helped to live with if they are unable to overcome it. 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. Obstacles should not be put in the way

of people who are addicted leading a stabilised life with their addiction. Viewed in this way addiction is only one of the harms that dependent drug users should be helped to address. 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.

76. 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 everyone who favours a change of drug policy. It should be observed, though, that it is the approach expressed by the Parliamentary Secretary for Health and Ageing, Mr Christopher Pyne, in support of minimal Government intervention to combat teenage drinking:

> "It is families that bear the responsibility for preventing teenagers from engaging in problem drinking, and it is families that stand the best chance of succeeding. Like it or not, teenagers will continue to find ways to access alcohol. The question is whether they will be brought up with the self-restrain to deal with temptation. . . .
>
> "The role of government is, and will remain, one of support. Government must not usurp the role of families by substituting heavy-handed and ill-considered regulation for individual responsibility. But the ultimate responsibility for addressing the problem of teenage drinking remains with parents and the teenagers themselves" (Pyne (2005)).

77. The philosophy behind this approach to alcohol is diametrically opposite to the philosophy behind the Government's illicit drug policy. For its part Families and Friends for Drug Law Reform sees the two extremes of unfettered legalisation and strict prohibition of addictive substances as policy options that maximise harm. Both disempower parents in dealing with their children – in one case leaving children prey to advertising and other commercial pressures and in the other in putting the distribution of addictive substances into the hands of criminals and impeding the capacity of parents to support their drug using child. On the other hand, Families and Friends for Drug Law Reform believes that governments would do well to recognise the futility of seeking to legislate in opposition to market forces which is what prohibition does.

78. Families and Friends for Drug Law Reform holds to the middle moral position. It totally rejects the absolutist view that puts greater store on becoming drug free than on life itself. To maintain 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.

79. 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 2002 national survey of secondary students found that 41.8% of 17-year-olds had used cannabis at least once and 9.7% reported using it in the past week (White & Hayman 2004, 18). Over the years one or other illicit drug has become more and more available to young people and more and more are using at a younger age.

80. The ethical issues involved in drug policy are discussed in more detail in Bush & Neutze 2000a with an abbreviated version in their 2000b paper. 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

81. 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.

82. 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 Australian jurisdictions where relaxation of laws regarding cannabis has occurred, the level of cannabis usage is not significantly different to that of other jurisdictions;
- measures that reduce the profit motive incentive to sell 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

83. 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."

84. 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 were 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

85. The introduction in 1987 of the expiation notice system in South Australia did not lead to an 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."

86. 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).

87. According to the household surveys since 1998, across Australia there has been a decline of the population that had used cannabis recently from 21.3% in 1998 to 18% in 2001 and to 11.3% in 2004 (AIHW 2002a, 3; Makkai & Payne 2003, 5; AIHW 2005, 4). This trend was also reflected in the surveys of secondary students since 1996. The 1999 survey reported that : "among 16-17-year-olds the proportions using cannabis recently had decreased from 27% to 20% in 1999" (White 2001, 32). There was no statistically significant change between 1999 and 2002 of these students but a significant reduction in male students aged 16 to 17 who had used cannabis in the previous week as well as significantly fewer junior students compared to 1999 who had used cannabis in the past month or week (White & Hayman 2004, 20-21). Between 1999 and 2002 in the Australian Capital Territory (and thus before the 2004 winding back of the territory's cannabis expiation notice system):

> "There was a significant decrease in the proportion of students reporting use of cannabis in the last four weeks, between 1999 (16.2%) and 2002 (12.0%) (p=0.000)" (ACT Health 2004, 49).

88. Since 1996 both law enforcement effort and price across Australia 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 fallen 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). According to one study "the prevalence of marijuana use and the conditional demand for marijuana in the general population are responsive to changes in its money price" On the other hand, it found that while "decriminalisation is associated with an increase in the prevalence of use by males over the age of 25" it appears to have had no impact on use by young people whose consumption of the drug is the greatest cause for concern:

> "There is no evidence that decriminalisation significantly increases participation in marijuana use by either young males or females, or that decriminalisation increases the frequency of use among marijuana users" (Williams 2003).

89. In all these circumstances, the overall declines in cannabis consumption have important implications. In the first place, they point to the need for a careful assessment of the economic and other drivers influencing drug consumption for data like this indicate that trends in drug consumption are only weakly correlated with either price or law enforcement effort. It appears that some other factors are more influential. In the second place, the declines in cannabis consumption should serve as a warning against hasty moves to tighten prohibition around cannabis in the light of alarm about reports of the dangers of cannabis use. Greater law enforcement is unlikely to lead to greater reductions in use than are already occurring but will probably have harmful impacts on users caught up in the enforcement.

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

90. In contrast to recognition of the importance of working with market forces in other areas of government policy, illicit drug policy opposes those forces. As explained by a Senior Fellow with the Institute of Public Affairs, such an approach is doomed to fail:

> "A recent article in *The Economist* told us that a kilo of heroin, 40 per cent pure, sells on the streets for up to US$290,000 and that import prices are about 10-15 per cent of retail in rich countries. The more successful the authorities are in restricting supply—either by capturing shipments or scaring off illicit drug traders—the wider 'the wedge' between import and street prices becomes and the greater the potential profits. Australian authorities cite the recent hike in the price of illicit heroin as evidence of success, but such success is necessarily its own substantial undoing—it increases rewards for smuggling or manufacture, and causes addicts to take even more desperate measures.
>
> "It is virtually inevitable that such huge profits will be employed in their own preservation, by corrupting the enforcement authorities and influencing the political system. This happens in legal industries with far smaller margins of profit. Think of how the motor industry tried to preserve its 'wedge' by regaling us with the horrors that would be associated with reduced import restrictions. The horrors never did eventuate, but their improbability didn't stop the motor manufacturers. And even at the height of protection, cars sold in Australia for only about half as much again as they could be imported,

whereas drugs sell for six or seven times import parity. The last thing the drug barons want is a policy that removes 'the wedge'. In my political days I marvelled at how quickly and generously the case against drug liberalization could be financed" (Hyde 2001, 10).

91. The addictive nature of the commodities concerned lead to the illicit drug market being particularly resilient. It 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.

92. 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).

93. 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 – 92%. In other words, in addition to the high proportion who stopped dealing entirely, those who continued dealing did so far less.

Table 10: Drop in prevalence and incidence rates of self-reported drug dealing after one year of treatment in the Swiss programme of heroin prescription, compared to the time before admission

(reference period of 6 months, N=305).

Offense type	*Prevalence rates*	*Incidence rates*
Selling "soft" drugs	– 52 %	– 76 %
Selling "hard" drugs	– 83 %	– 92 %

These reductions are extracted from table 6 at page 18 above (Killias *et al.* 2005, 195).

94. Such data holds out the prospect that measures other than repressive law enforcement bearing on users are capable of making drugs less available. Indeed, evidence points in that direction (Killias & Aebi 2000). A highly regarded study on the control of cocaine undertaken by the Drug Policy Research Center of RAND in California points out the large cost-benefit of treatment over various forms of law enforcement. The benefit was measured in terms of reduction in the number of users, the quantity of the drug consumed and the societal costs of crime and lost productivity that arise from use of the drug. The study estimated that "the costs of crime and lost productivity are reduced by $7.46 for every dollar spent on treatment." Described in other terms, domestic law enforcement, the most efficient form of law enforcement,

"costs 4 times as much as treatment for a given amount of user reduction, 7 times as much for consumption reduction, and 15 times as much for societal cost reduction" (Rydell & Everingham 1994, xv-xvi).

95. High levels of drug seizures are often cited as evidence of the effectiveness of law enforcement. For example, the Attorney-General pointed out last year that "Australian law enforcement agencies have stopped more than nine tonnes of serious illicit drugs from reaching Australia's shores" (Ruddock 2004). At best this is meaningless unless set against an estimate of the size of the drug market. More likely, the level of seizures reflects the amount of drugs available with a high level of seizures pointing to greater availability. As explained in a West Australian parliamentary report: "seizures of drugs by law enforcement agencies . . . can provide an important insight into the actual trends in illicit drug production and trafficking" (WA 1997, v.1, §3.2.4, p. 61). Thus, police intelligence has acknowledged that: "While seizure rates do not necessarily correspond with production, they can be a good indicator of production trends" (Gordon 2001, 18). Research agencies regularly cite rising trends in the rate of seizure as evidence of greater availability (e.g. Topp *et al.* 2002, 67). In fact, the officially funded study of the 2001 heroin shortage acknowledges that the annual weight of heroin seized is "an indication of the amount of heroin imported" (Degenhardt *et al.* 2004, 45-46).

96. The 2001 heroin drought and its consequent drop in overdose deaths are cited as demonstrating the efficacy and benefits of vigorous law enforcement effort to reduce supply. The study on the shortage concludes that "the heroin shortage was probably caused by changes in heroin supply to Australia related to Australian drug law enforcement rather than to natural events (such as changes in heroin production)" (*ibid.,* 93). The case that it makes out for concluding that law enforcement was responsible is much the same as a conclusion that gravity was responsible for the collapse of a badly designed bridge.

97. The study identifies a unique set of circumstances in which law enforcement probably influenced a decision by drug dealers to reduce the supply of heroin to Australia. However, it is clear from the report that law enforcement was not responsible for those circumstances. It acknowledged that the circumstances may well change (if they have not done so already) and that law enforcement may again be as incapable of stemming a growth in the supply of heroin:

> (a) as it was during the 1990s when there was a huge growth in heroin supply; or
>
> (b) as it has been incapable of stemming the importation of the dangerous new methamphetamines at the same time that law enforcement was said to be successful in reducing heroin supply.

98. The study of the heroin shortage and the sister study of the methamphetamine situation in Australia identify the following unique circumstances over which Australian law enforcement had no significant influence:

> (a) Large quantities of new potent imported methamphetamines were indeed being imported into Australia during the time of the heroin shortage: "the more potent forms of 'base' and 'Ice' methamphetamine were first detected in 1999. Since 2001 all forms of methamphetamine (i.e., 'Ice', 'base' and powder methamphetamine or 'speed') appeared to be readily available to users" (McKetin & McLaren 2004, vii).

(b) The heroin shortage study records that there was a big shortfall in production of opium where Australia's heroin originates: "There was a continuing downwards trend in opium cultivation from the mid-1990s in the South East Asian cultivation regions, with more marked decreases in cultivation noted in 1998 and 1999 due to drought conditions in the area" (Degenhardt *et al.* 2004, 22). This trend was large. Production declined by about a half over this period.

(c) From this smaller harvest traffickers were supplying a new booming market in China. The study tells us that during the 1990s "the number of opiate dependent people registered in China - 80% of whom are heroin dependent – increased almost ten-fold" (*ibid.,* 57).

(d) In contrast to heroin, the same region was producing increasing amounts of potent methamphetamines. The study speaks of their production by "large-scale groups who were already involved in heroin production. These people already had connections, trafficking routes, money and power" (*ibid.,* 55).

(e) A number of heroin traffickers to Australia had switched to methamphetamines: It adds that "some traffickers previously involved in heroin production and trafficking to Australia are now involved in methamphetamine production and trafficking" (*ibid.,* 58).

99. The combination of these circumstances which law enforcement did not bring about forms the background to the reduction in heroin supply to Australia. The study does not assert that law enforcement physically prevented the import of the usual large supplies of heroin. This possibility was ruled out because methamphetamines was continuing to arrive from the same area and through the same hands as heroin had. Instead, what the study asserts is that Australian law enforcement influenced a decision by financiers of heroin to withdraw from sending large quantities:

> "[Key informants] consistently reported that a small number of key groups had traditionally financed major heroin imports to Australia in the 1990s, and these groups had withdrawn from the financing and facilitating these imports in the late 1990s" (*ibid.,* 77).

100. The study hangs upon the assessment that this decision by financiers to withdraw sending the same quantity of heroin to the Australian market was influenced by Australian law enforcement.

> "A large proportion of the heroin supply is thought to have relied on a centralised network based around a small number of key wholesale suppliers (Australian Crime Commission 2003). These wholesalers relied on large sea cargo shipments. Despite the centralised collaborative networks that provided organisational support and security, there was an increased risk of detection as a result of the coordinated action of Australian law enforcement (Australian Crime Commission 2003). It is considered likely that the 'major players' responsible for financing heroin imports to Australia may have withdrawn their involvement to some extent because of these changes" (*ibid.,* 61)

101. It is apparent that the correctness of the assessment that law enforcement was a material cause of the heroin shortage hangs on the thinnest of threads, namely a second guess of what was in the mind of certain financiers. It is a possibility that is largely undermined by the study's own conclusion:

> "The combination of low profits and increased success of law enforcement, probably led to the reduced dependability of key suppliers of heroin to Australia. This occurred against a backdrop of gradually declining production in South East Asia" (*ibid.,* 48).

The study thus admits that criminals made a commercial decision to reduce heroin supply to Australia in a context of low profits and shortage of supply. The admitted role of Australian law enforcement was thus only marginal and heavily dependent on circumstances which law enforcement had little or no capacity to bring about.

102. Probing the causes of the heroin shortage calls for a combination of judicial and intelligence assessment skills such as might be found in a Royal Commission and not the method used in the study. The study itself acknowledges that its method of approaching key informants "to analyse a reduction in heroin supply has the potential to be biased because the reduction in supply is itself an aim of drug law enforcement and is actively pursued" (Degenhardt *et al.* 2004, 6).

103. The lack of rigour of the study may flow from this. The following are some examples. It puts much store on Canada not experiencing a heroin shortage even though it too is supplied from South East Asia. There are obvious commercial reasons why traffickers would have chosen to reduce heroin supply to Australia. Something like a third less heroin is used in Canada and the market could be easily poached by traffickers with other sources.

104. In the same way the study does not take into account the probability that the 600 kg of heroin seizures in the year before the drought amounted to little more than a month's supply. Earlier seizures of similar magnitude did not reduce availability. Nor does the study explain why law enforcement was so unsuccessful in stemming the flood of stimulants through similar channels. It makes no mention of the prediction of these events 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). Nor does the study explain why the since abolished National Crime Authority with its extensive access to intelligence declared at the height of the drought that existing approaches were not reducing the problem of illicit drugs:

> "Whatever steps are taken, the scale of the illicit drug problem and its onward progression is such as to demand the highest attention of government and the community - it simply is not a battle that can be won by law enforcement alone or in partnership with the health sector. A co-ordinated and holistic approach is required, building upon and updating the foundation already established" (NCA 2001, 23).

105. In 2001 the Australian Federal Police Commissioner revealed criminal intelligence that:

> (a) drug syndicates "have their market research which tells them that these days people are more prepared to pop a pill than inject themselves" (Moor 2001); and.
>
> (b) there had been "a business decision by Asian organised crime gangs to switch from heroin production as their major source of income to the making of methamphetamine, or speed, tablets. . . . [T]he Asian drug barons would continue to supply some heroin to the Australian market, but intelligence

> suggested they were gearing up to aim for a new and much bigger market of people prepared to use methamphetamine pills" (*ibid*.).

106. The heroin shortage combined with a flood of the new potent methamphetamines is thus consistent with the business plan of criminals. It is of the gravest concern that anyone should regard this study on the heroin drought as recognising "the pivotal role of law enforcement in reducing the availability of heroin" (Ellison 2004). It did not do anything of the kind.

107. A detailed analysis of the evidence is at Bush 2004 and Bush *et al.* 2004. Annexed to this submission is a comparison between the officially sponsored study and these analyses.

108. At this point it would be well to reiterate the reasons for the inclusion in a submission on mental health of this section on the effectiveness of law enforcement to reduce the supply of illicit drugs. It is relevant because:

> (a) illicit drug policy as well as illicit drugs impact severely on the mental health of Australians;
>
> (b) although this may be acknowledged it is commonly asserted that illicit drugs would become much more available in the absence of repressive measures. There is little evidence in support of this and indeed much reason to believe that the direct opposition by law enforcement measures to market forces that repressive measures represent in fact stimulates the market;
>
> (c) in particular the 2001 heroin shortage and big fall in overdose deaths is often held up as an illustration of how law enforcement has been effective. In fact, the officially commissioned study did not recognise "the pivotal role of law enforcement in reducing the availability of heroin" but rather the reverse. There is a crying need for a probing independent assessment such as would be given by a royal commission of the causes of the upheavals in the Australian drug market;
>
> (d) the pharmacological effect of potent stimulants which have flooded the Australian market in recent years (and during the 2001 heroin shortage) appears to be much more injurious to mental health than heroin.

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

109. 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.

110. 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.

111. 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.

112. 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).

113. 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.

114. 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

115. In this submission Families and Friends for Drug Law Reform is calling on the Committee 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 while the suffering of those with mental health problems and their families intensifies.

116. 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).

117. The current National Drug Strategy 2004–2009 subtitled *Australia's integrated framework* rests content with what is virtually a 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)

Furthermore, "policies and programs" under the strategies should 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)

118. It is stating the obvious that there needs to be "strong partnerships" between treatment services. In doing so governments have also passed responsibility for what is probably the most challenging and growing aspect of both drug treatment and mental health to the already overstretched service providers. However well mental health and drug treatment services work together there is only so much that they can do. In the strategies there is:

> (a) no recognition that early intervention has a role: reference is made only to "drug treatment services and mental health services". These services are not focussed on early intervention;
>
> (b) no recognition that there is a need for governments to review policies that may contribute to co-morbidity let alone to adjust any policies;

(b) no reference to the level of resources necessary to meet the escalating needs for co-morbidity services; and

(c) no reference to support for families negotiating the nightmare of a family member with a co-morbid condition.

119. The demand on resources to fund the ever increasing demand for services is already becoming unsustainable. Therefore, an important focus of the Committee's inquiry should be how policies and programs can be integrated so as to minimise the distress that is already so evident of mental illness or disorders associated with drug abuse. The Parliamentary Secretary to the Minister for Health and Ageing, Mr Pyne, was on the right track when he wrote in his forward to the 2004 National Mental Health Report that the "need for linked initiatives extends to areas such as housing, employment, social security, crime prevention and justice" (DHA 2003, i). We must think laterally and challenge some of our fears. Drug policy must be added to the list if we are to have hope of ending so much suffering and waste.

15 May 2005

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APPENDIX

AUSTRALIAN DRUG MARKET 2000-01
COMPARISON OF STUDIES

Studies compared:

Louisa Degenhardt, Carolyn Day and Wayne Hall (eds.), *The causes, course and consequences of the heroin shortage in Australia,* NDLERF Monograph Series no. 3 (Funded by the National Drug Law Enforcement Research Fund, an initiative of the National Drug Strategy, embargoed until 12 November 2004) summary at http://www.ndlerf.gov.au/
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Bill Bush, *Upheaval in the Australian drug market: the cause and impacts of the sudden heroin shortage and increased supply of stimulants in 2000-01* (12 November 2004) at www.ffdlr.org.au.

The citation of references mentioned in the following comparison in abbreviated form are listed at the end of the foregoing paper at www.ffdlr.org.au.

An earlier shorter version of the latter study was published by the Beckley Foundation Drug Policy Programme, London, in July 2004 at http://www.internationaldrugpolicy.org/factsheet4.pdf.

Bush Study	*Officially commissioned study*	*Comments*
SHORTAGE OF OPIUM PRODUCTION		
Burma "In the lead up to 2001 there was a big decline in opium production in Burma. 'Three years of drought was followed by abnormal flooding and frost in Burma' (Gordon 2001, 20; AIDR 2001, 29). According to figures of the United Nations Office on Drugs and Crime the potential yield for 1999 was 53% of the estimate for 1997. Production increased in 2000 but was still only 65% of the estimate for 1997 (ODCCP 2002, 47). The decline was even greater according to estimates of the US Department of State. It considered that the potential yield for 2000 was only 46% of the estimate for 1997 (US, DOS, 2000; US, DOS 2001, VIII-6 & 14; Morrison 2003, 2)" (p. 9)	"1998 and 1999 saw reductions in South East Asian opium cultivation levels caused by three years of drought in the opium cultivation regions, followed by abnormal flooding (Gordon 2001). This drought had the greatest effect in Myanmar, where the area planted with opium poppies decreased by 16% to 130,300 hectares (Australian Bureau of Criminal Intelligence 2000). There were no major changes in the opium cultivation levels in either Myanmar or South East Asia during 2001, but opium cultivation in the region has shown a decreasing trend since the mid-1990s (Figure 2.4)" (p. 11). "There was a continuing downwards trend in opium cultivation from the mid-1990s in the South East Asian cultivation regions, with more marked decreases in cultivation noted in 1998 and 1999 due to drought conditions in the area. During 2001, opium cultivation in the Myanmar region showed no major changes" (p. 22) "progressively smaller quantities of heroin have been produced in the Golden Triangle over the past 15 years (Chapter 2)." (p. 56) *Speculation on impact:* "This type of explanation seems the least plausible explanation of the Australian heroin shortage, because these factors should also have affected heroin supply in other countries (trafficking and distribution levels in Figure 5.1), whereas Australia seems to be the only country affected that sources its heroin from the Golden Triangle (Chapter 2)." (p. 53). "It is an appealing hypothesis that unfavourable conditions in the main source country for Australia's	Agreement on facts However, officially commissioned study uses only data of United Nations Office on Drugs and Crime and does not also refer to U.S. data that estimates an even greater reduction. *Evaluation of impact:* Relevance of production shortage dismissed because not specific to Australia whereas shortage of product could be highly relevant as a motive for a decision of Asian syndicates not to supply one of their markets. But, in contradiction, later admits that supply shortage would have been relevant in combination with law enforcement: "The combination of low profits and increased success of law enforcement, probably led to the reduced dependability of key suppliers of heroin to Australia. This occurred against a backdrop of gradually declining production in South East Asia" (p. 48).

Bush Study	*Officially commissioned study*	*Comments*
	heroin contributed to the reduction in heroin supply. This explanation does not account for the fact that there was no heroin shortage in other countries, particularly China and Canada." (p. 54) *Contradiction*: "The combination of low profits, increased success of law enforcement, probably led to the reduced dependability of key suppliers of heroin to Australia. This occurred at a time when seized heroin was becoming more difficult to replace because of reduced supplies in the Golden Triangle. These factors may have reduced the attractiveness of Australia as a destination for heroin trafficking" (p. 64) "Opium cultivation in Myanmar was largely unchanged during this time" (p. 7).	Correct if it means 2001 but incorrect if this means "for the last decade".
Growth in S.E. Asian production of amphetamine type stimulants involving those who had dealt in heroin "There was a large growth in production of methamphetamine-type stimulants in the same region that supplied Australia with heroin (Gordon 2001; US, DOS 2001, VIII-6, 11-12). According to the International Narcotics Control Board: 'In East and South-East Asia, there has been a drastic increase in the manufacture of, trafficking in and abuse of amphetamine-type stimulants in the past few years. Illicit methamphetamine laboratories continue to operate in the border areas between Myanmar and Thailand and between Myanmar and China. Those three countries and the neighbouring countries have reported sizeable seizures, low prices and wide availability of stimulants' (INCB 2001, §330)" (p. 9).	"In 2000, the number of Chinese heroin seizures remained steady. This was accompanied by reports that narcotics traffickers had increased the production of methamphetamine and other synthetic drugs in China, suggested by highly increasing methamphetamine seizures (United States Department of State 2001)" (p. 14). "KI reported that methamphetamine production shifted from 1999 onwards from 'small time' operators in Bangkok, Thailand (who were independent of heroin production), to large-scale groups who were already involved in heroin production. These people already had connections, trafficking routes, money and power. The quantity of methamphetamine produced increased in 1999 and again in 2000. Production peaked in Thailand in 2000, as measured by arrests and seizures. In contrast to opium, methamphetamine was subject to much less policing and interdiction in Thailand/Myanmar. In particular, Thai law enforcement	Agreement

Bush Study	*Officially commissioned study*	*Comments*
	agencies reported that they did not initially detect the expansion in methamphetamine production and use in the late 1990s" (p. 55-56) "heroin producers have added methamphetamine to their production cycles" (p. 56). "Finally, heroin is produced about one month after the opium harvest, and the laboratories can then be used for methamphetamine production. Around 50% of the chemicals used in the production of heroin are used in methamphetamine production. One seizure of methamphetamine by Thai law enforcement had the same seals as were used in the packaging of heroin and some samples of methamphetamine showed traces of heroin. This suggested that heroin and methamphetamine were being produced by the same people and/or in the same laboratories. Reports suggest that even the opium farmers may also be diversifying into both heroin and methamphetamine production. In short, the producers in South East Asia appear to have diversified into methamphetamine production as well as heroin" (p. 56).	

Bush Study	*Officially commissioned study*	**Comments**
Trafficking of stimulants of various origins from S.E. Asia using routes & means similar to those for heroin "Methamphetamine-type stimulants originating either in south-east Asia or Europe were being imported into Australia via similar channels to heroin (Gordon 2001, 21-22; AFP 2001, 3, 22 & 23). The Asian group operating through Fiji that police broke up in the lead up to the heroin shortage trafficked in methamphetamine as well as heroin (Hawley 2002, 48). This action led to no reduction in availability of those stimulants" (p. 10). "Asian crime groups that had concentrated on heroin were also becoming involved in the supply of South American cocaine to Australia. 'The New South Wales Police/Australian Federal Police Joint Asian Crime Group in New South Wales obtained information from overseas agencies regarding cocaine seized within Australia, which suggested cooperation between South American cocaine cartels and individuals from Southeast Asian crime groups that had previously concentrated on heroin trafficking'(AIDR 2002, 68). The following year's report noted that: 'Southeast Asian centres, where heroin and amphetamine-type stimulants have a long history of use, are increasingly used for storage and transit of cocaine' (AIDR 2003, 90)" (p. 10)	". . . there has been a significant increase in the trafficking of methamphetamine to Australia and other countries in the Asian Pacific region since around 1996 (United Nations Office for Drug Control and Crime Prevention 2002; Australian Crime Commission 2003). It may have been that the increase in methamphetamine trafficking (Chapter 6) led to a decrease in heroin trafficking by the same individuals. "Some traffickers previously involved in heroin production and trafficking to Australia are now involved in methamphetamine production and trafficking. In September 2000, Operation Octad (in which two containers, one with heroin and one methamphetamine, were interdicted) showed that the financiers of the drugs from South East Asia were different, but the facilitators were the same individuals (Figure 5.1, trafficking level)" (p. 58). "**Evaluation** "This hypothesis could account for the fact that the shortage was unique to Australia. A shift from heroin to methamphetamine trafficking among South East Asian organised criminals supplying Australia was reported by law enforcement officials prior to the onset of the heroin shortage in Australia (Australian Bureau of Criminal Intelligence 2001; Commission on Narcotic Drugs 2001). This hypothesis also implies a high level of centralisation of the South East Asian heroin trade, which fits with previous analyses of Australia's heroin markets (Australian Crime Commission 2003)" (p. 58) "In July 2001, Operation Wahoo intercepted a small boat from Thailand, moored near to the Sunshine Coast in Queensland. Seizures were made of MDMA (2kg), MDBD 169kg), methamphetamine tablets 91kg), and	Agreement on facts Officially commissioned study puts up to dismiss an Aunt Sally proposition namely that "alternative source of income came from the importation of methamphetamine, and that the traffickers had limited importation capacity" (p. 58). I.e. that traffickers did not have the capacity to import both heroin and methamphetamine. Our thesis is simply that traffickers had another source of income which would compensate them for the reduction in availability of heroin. We have not maintained that any limitation on their capacity to import was relevant. There is generally evidence of co-shipment of heroin with the stimulants rather than just the stimulants. Officially commissioned study makes no mention of involvement of Asian crime syndicates in the rise in importation of cocaine into NSW.

Bush Study	*Officially commissioned study*	**Comments**
	crystal methamphetamine 152kg). The MDBD and crystal methamphetamine seizures were the largest of these types of amphetamines seized in Australia to date" (p. 58). "There has been a growing tendency recently for drugs to be trafficked south through the Andaman Sea, in the Indian Ocean south of Rangoon. Australia's largest heroin seizure to date of 390 kg in 1998 came through this route, and there have also been cases of mixed shipments of methamphetamine and heroin through this route (Gordon 2001)" (p. 16) "the same methods of concealment were used for both heroin and methamphetamine" (p. 59). *Contradiction:* "there is no evidence of Thai or Burmese produced methamphetamine tablets being sold in Australia, and a market would be difficult to establish, given the availability of higher quality domestically produced methamphetamine" (p. 56). Huge increase in import of methamphetamines & cocaine evidenced by increasing seizures at border (table 6.5 & 6.6, p. 76)	
COMPETING MARKETS		
China "At the same time there has been substantial growth in the opium and heroin markets in countries which, like Australia, are supplied from the Golden Triangle. Indeed the Australian Federal Police has noted that 'in the region predominantly now supplied by the Golden Triangle – East and South East Asia [including China], Australia and Canada – opium and heroin addiction grew. According to official Chinese data, opium and heroin addiction in China rose by 870 per cent in the	"Since the mid 1990s, traffickers have increasingly moved heroin through Southern China, Laos, Vietnam and Cambodia rather than Thailand (see Chapter 2). The number of opiate dependent people registered in China - 80% of whom are heroin dependent – increased almost ten-fold (United Nations Office for Drug Control and Crime Prevention 2001). Much of the increase in trafficking of opiates out of Myanmar in the late 1990s was directed towards China. This is consistent with the notion of an expansion of that	Agreement on facts

Bush Study	*Officially commissioned study*	**Comments**
period from 1990-99' (Gordon 2001, 20 & 19; Wardlaw 1999, 4; Morrison 2003, 6; ODCCP 2002, 238-39)" (p. 9).	market. Furthermore, Customs noted that seizures of heroin in China have doubled over the past year, which is again consistent with an increase in the size of the heroin market in the country (Rossi 2002)" (p. 57).	
Canada See discussion at end of table.		
HIGH PRICE OF HEROIN ON AUSTRALIAN MARKET "An objection to shortage of product having such an influence is that the wholesale price of heroin landed in Australia was much more than the wholesale price in Asian markets (Gordon 2002; Hawley 2002, 45). However, this fact does not necessarily provide a commercial incentive to favour the Australian market over others where the costs of supply are lower. A study of the Australian Institute of Criminology puts it this way: ". . . the high retail value of the Australian heroin market is unlikely to benefit traffickers further up the supply chain. Those individuals will be more concerned with immediate needs to reduce the risks of trafficking and receive optimal returns on their investment. In 'lean' years, other markets closer to source, and with fewer trafficking costs (for example, the Asian markets) may simply offer a better proposition" (Morrison 2003, 6)" (pp. 12-13).	"In 2000, the limited price data available indicated that a 700gm block of heroin could be bought in Hong Kong for around US$12,000 (AU$20,000 (Gibson, Degenhardt et al. 2003)). The same amount of heroin was estimated to cost AU$100,000 in NSW. A profit of 500% would seem attractive to most investors" (p. 57)	Disagreement about relevance
INTENTION OF ASIAN SYNDICATES		
Decision not to push heroin to Australia "Criminal intelligence learnt that drug syndicates 'have their market research which tells them that these days	"KI consistently reported that a small number of key groups had traditionally financed major heroin imports to Australia in the 1990s, and these groups had withdrawn from the financing and facilitating these	Substantial agreement on facts. There is agreement that Asian syndicates had decided to export less heroin to Australia.

Bush Study	*Officially commissioned study*	**Comments**
people are more prepared to pop a pill than inject themselves' (Moor 2001a). The police later confirmed this report in evidence before a parliamentary inquiry (McDevitt 2002, 1,221) (p. 11).	imports in the late 1990s. There was some suggestion that these traditionally dominant groups had shifted their activities to areas considered to be of lower risk, such as money laundering and heroin trafficking in other countries" (p. 77) "it seems that major importers significantly reduced or ceased large importations of heroin, so the previous *status quo* of the market was disrupted" (p. 64). "it appears that there may have been a change in the sorts of drugs that facilitators are importing into Australia but there is less evidence that the financiers in South East Asia have changed. This suggests that it is plausible that some major financiers may no longer be importing heroin to Australia, while at the same time others could be importing methamphetamine into Australia instead of, or in addition to, heroin" (p. 58) From 2002 there was a *shift in method of importation* from large consignments to small deliveries: "There was also an increase in the use of airline passenger and postal streams as methods of trafficking" (p. 77). *Speculation about why*: "This was attributed to the disruption of large scale importations and the emergence of new trafficking routes". "A range of briefings received for this study suggested that by the end of 2000, high level heroin distributors were organising alternative sources of heroin in South East Asia through other contacts (see also Chapter 6), possibly because the major importers who had been supplying them were no longer doing so. In short, it would seem that changes in traffickers' importation patterns to Australia could account for some of the	*Speculation different:* In sections quoted, the officially commissioned study attributes this decision overwhelmingly to pressure of law enforcement. Officially commissioned study generally discounts impact of shortage of heroin at source but then admits: "The combination of low profits and increased success of law enforcement, probably led to the reduced dependability of key suppliers of heroin to Australia. This occurred against a backdrop of gradually declining production in South East Asia" (p. 48)..

Bush Study	*Officially commissioned study*	**Comments**
	reduction noted in heroin supply" (p. 60). "A large proportion of the heroin supply is thought to have relied on a centralised network based around a small number of key wholesale suppliers (Australian Crime Commission 2003). These wholesalers relied on large sea cargo shipments. Despite the centralised collaborative networks that provided organisational support and security, there was an increased risk of detection as a result of the coordinated action of Australian law enforcement (Australian Crime Commission 2003). It is considered likely that the 'major players' responsible for financing heroin imports to Australia may have withdrawn their involvement to some extent because of these changes" (p. 61)	
Decision to push stimulants "Criminal intelligence also learnt of 'a business decision by Asian organised crime gangs to switch from heroin production as their major source of income to the making of methamphetamine, or speed, tablets. . . . [T]he Asian drug barons would continue to supply some heroin to the Australian market, but intelligence suggested they were gearing up to aim for a new and much bigger market of people prepared to use methamphetamine pills.' This was also revealed by the Police Commissioner in June 2001 and later confirmed (Moor 2001a & McDevitt 2002, 1,221)" (p. 11).	"The heroin shortage was implicated in a number of changes to high level drug distribution. In NSW, KI reported traffickers switched to other drug types such as methamphetamine and other commodities such as credit card fraud" (p. 78). "Some heroin suppliers moved from heroin to importation of 'ice'" (p. 79). "the diversification of drug suppliers into drug types other than heroin" (p. 81)	Substantial agreement
Capacity of Asian drug syndicates to effect change in market	"Interviews with a variety of law enforcement personnel suggested that in the late 1990s, the heroin trafficking business to Australia was highly centralised, with six major suppliers of heroin to Australia. Three of these were considered 'large scale', two were 'medium' and one was 'small' scale. A decision of one or more of	Centralisation of control supports possibility of market manipulation.

Bush Study	*Officially commissioned study*	**Comments**
	these high level facilitators to stop or markedly reduce their scale of trafficking (perhaps as a consequence of aging, ill-health or incarceration) could explain a marked reduction in the supply of heroin found in Australia (Figure 5.1, trafficking level)" (p. 60)	
Actual increase in import of stimulants "At the time of the reduction in the supply of heroin, data pointed to a substantial increase in the availability of imported methamphetamine-type stimulants supplementing existing substantial local production." (p. 4) "*Seizures of imported methamphetamine-type stimulants:* There were huge increases in the amount of imported methamphetamine-type stimulants seized by Customs. In particular, the weight of crystalline methamphetamine they seized grew by an enormous 832% in 2000-01 to 82.1 kg. In the following year seizures were 88% higher than that (IDRS 2002, 69-70 & IDRS, 2003, 74). These seizures complemented a continuing steady rise in detection of clandestine methamphetamine laboratories in Australia (IDRS, 2002 68)." (p. 5).	Table 6.5 & 6.6 on p. 76 show a huge increase in import of methamphetamines & cocaine from about 1999 evidenced by increasing seizures at the Australian border.	Agreement on facts
Level of seizures as an indicator of availability "Without contrary information bearing on the size of the illicit drug market, 'seizures of drugs by law enforcement agencies . . . can provide an important insight into the actual trends in illicit drug production and trafficking' (WA 1997, v.1, §3.2.4, 61). Thus, police intelligence acknowledges that: 'While seizure rates do not necessarily correspond with production, they can be a good indicator of production trends.' (Gordon 2001, 18 & similarly ODCCP 2002, 18, 29). Research agencies regularly cite rising trends in the rate of seizure as evidence of greater availability (e.g. IDRS	"As an indication of the amount of heroin imported, Figure 4.6 depicts the weight of heroin in kilograms seized by the Customs at the Australian border between 1995/96 and 2001/02. The amount seized in 1998/99 (509 kg) was the largest recorded. By weight, virtually all seizures (98% or more) at the border are detected in NSW. In 2000/01 (encompassing the peak period of the shortage), the amount of heroin seized at the border was at a lower level than proceeding [sic] years, with 218 kg seized compared to 269 kg seized in 1999/00. However, to date, 1998/99 was the financial year in which Customs detected the largest amount of heroin at the Australian border" (p. 45)	Agreement on facts and significance

Bush Study	*Officially commissioned study*	**Comments**
2001, 67)" (p. 8)		
Flexibility of organised crime "Economic globalisation has facilitated the international illicit drug trade. 'Globalisation has significantly expanded the opportunities for sophisticated illegal activity and facilitated closer interaction between organised criminal groups from different locations and cultures' (AFP 2001, 17; Wardlaw 1999, 2-3). In particular, '[g]lobal drug markets are now closely interconnected, both in terms of markets for the same drug type and markets between drug types' (Gordon 2001, 22)" (p. 10).	"the global trend toward the co-shipment of different drugs (Commission on Narcotic Drugs 2001; Australian Bureau of Criminal Intelligence 2002; Australian Federal Police 2002). Australian authorities have noted the co-shipment of heroin and amphetamine type stimulants (ATS) from Asia (Australian Bureau of Criminal Intelligence 2002; Australian Federal Police 2002)" (p. 59). *Qualification:* Evidence of somewhat different organisational structure for those supplying heroin and stimulants: "A consistent factor noted in interviews with law enforcement officers in both Australia and overseas was that the major figures involved in financing heroin importation in Asia were largely independent of those who were responsible for the importation of large shipments of 'ice', or crystal methamphetamine. By 'major' it is meant those responsible for the financing of shipments from Asia. For example, Chinese importers of crystal methamphetamine from China are reported to be different from (although linked to) those involved in high level importation of heroin prior to the shortage. "This may not be the case at other levels of trafficking. One significant group based in Australia has been involved in both heroin and methamphetamine importation. Relatively high level distributors in Australia have reportedly shifted to methamphetamine distribution (Collins, Degenhardt et al. 2003)" (p. 58)	Substantial agreement. *Comment*: The qualification about difference in structure at financier level would seem to be insignificant. It is admitted that there is much co-operation.
History of inefficacy of law enforcement in Australia to reduce availability "Law enforcement agencies manage to seize only a	"the types of law enforcement successes outlined above have been made before without such a significant impact on the heroin market" (p. 59).	Agreement

Bush Study	*Officially commissioned study*	**Comments**
small proportion of the estimated volume of the Australian illicit drug market. In a commentary prepared at the height at the heroin shortage and which would have been cleared with other law enforcement agencies, the National Crime Authority stated as much. It estimated that in 1999-00 only about 12% of heroin was being seized (NCA 2001, 21-22). A researcher with law enforcement connections estimated earlier that: 'In its 'best' year, law enforcement seized approximately 21 percent (1994-95) of the heroin coming into the country, and during its 'worst' year (1992-93), only 3 percent was seized. The average for the period [from 1988-89 to 1995-96] was about 10 percent' (Pruncken 1998)" (p. 8). "In the years leading up to the 2000-01 heroin shortage, large seizures had not led to increases in prices or purity at street level. According to a Sydney study '. . . there was no detectable relationship between the price, purity or perceived availability of heroin at street-level in Cabramatta and average amount of heroin seized, either (a) across Australia, or (b) within New South Wales' (Weatherburn & Lind 1996, 194). The then Commissioner of the Australian Federal Police said of Australia's biggest single seizure of heroin - 400 kg in October 1998 - that 'the indications are we haven't made much dent on the market' (Herald Sun (Melbourne), 25 Nov. 1998, p. 22). The amount seized represented 6% of the size of the Australian heroin market of 6.7 tonnes as estimated by the Australian Crime Commission (NCA 2001, 21-22). It was part of 508 kg seized that year (AIDR 2000, 37). The seizures amounting to 606 kilograms in the lead up to the 2000-01 shortage represented 9%" (p. 8).		
Law enforcement	"Information obtained during this study revealed that multiple heroin seizures in 1998-99, totalling around	Largely agree.

Bush Study	***Officially commissioned study***	**Comments**
"Along with geographic circumstances, Australian law enforcement capacity may have played a subsidiary role in the decision of entrepreneurs to reduce heroin supply to Australia. In an environment of tightening supply of heroin, plentiful supply of methamphetamine-type stimulants and emerging capacity to supply cocaine, entrepreneurs could have assessed that it was more profitable to meet the demand for heroin in markets where law enforcement was not as efficient as it is in Australia and where they could be expected to lose an even smaller proportion to seizures" (p. 12)	one tonne, resulted in the three small to medium operators ceasing heroin supply to Australia. Further seizures in 1999-2000 of a similar volume reportedly affected the three remaining (large scale) suppliers of heroin to Australia. These syndicates reportedly continued to supply heroin to many other countries, but they were reportedly intimidated by these interdictions, and most were 'in hiding now and have been sitting back for some time', having 'pulled back' rather than 'pulled out' (Australian Crime Commission 2003). In 2003, Australian law enforcement agents in Thailand reported that they were still monitoring the activities of these former major importers who were now predominantly involved in moneylaundering" (p. 60). *Speculation:* "This [seizures] change may therefore be attributable at least in part to successful international and/or border level law enforcement" (p. 60). "A large proportion of the heroin supply is thought to have relied on a centralised network based around a small number of key wholesale suppliers (Australian Crime Commission 2003). These wholesalers relied on large sea cargo shipments. Despite the centralised collaborative networks that provided organisational support and security, there was an increased risk of detection as a result of the coordinated action of Australian law enforcement (Australian Crime Commission 2003). It is considered likely that the 'major players' responsible for financing heroin imports to Australia may have withdrawn their involvement to some extent because of these changes" (p. 61). "It is doubtful whether seizures of illicit drugs alone are sufficient to affect supply in the destination market	We admit that efficacy of Australian law enforcement may have been a factor in reducing importation of heroin into Australia rather than other destinations but we maintain on the basis of history of inefficacy of law enforcement to reduce availability that law enforcement had the effect it may have in 2000-01 only because of the reduced supply of heroin. The officially commissioned study admits as much when it states that law enforcement successes before the heroin shortage occurred: "at a time when seized heroin was becoming more difficult to replace because of reduced supplies in the Golden Triangle" (p. 64). *Comment:* Bringing about a change in importation methodologies as a result of law enforcement is not the same thing as law enforcement bringing about a reduction of availability. Organised crime is always innovating to keep ahead of law enforcement. The changes in law enforcement effort cannot explain how law enforcement could have been so successful in reducing heroin coming in at the same time that it was not in stemming the growth in importation of stimulants that were entering through the same channels. There must have been other factors at work. Officially commissioned study acknowledges that "It is doubtful whether seizures of illicit drugs alone are sufficient to affect supply in the destination market" (p. 62).

Bush Study	*Officially commissioned study*	**Comments**
	(Weatherburn and Lind 1997; Wood, Tyndall et al. 2003). However, it appears that these large seizures of heroin were also accompanied by the arrests of key people involved in heroin importation to Australia. These persons were thought to be key facilitators between South East Asian financiers and Australian importers. This factor may have had an effect in either of two ways: a) disrupting the ability of criminal networks to continue to import large amounts of heroin into Australia; or b) deterring groups in South East Asia from bringing large shipments of heroin into Australia. These possibilities are not mutually exclusive so both could have occurred" (p. 62). "it seems that major importers significantly reduced or ceased large importations of heroin, so the previous status quo of the market was disrupted. The heroin market is clearly still being supplied, but it seems to be more like previous decades than late 1990s: smaller, less consistent levels of supply (Chapter 6)" (p. 64).	
A range of factors caused the heroin shortage "It is known that heroin supplies to Australia were subject to a tightening from two sides: big drops in production and a big jump in demand from countries closer to the source of supply. It is also known that the same groups that supplied heroin to Australia were also involved in the manufacture of methamphetamine-type stimulants and the supply of cocaine" (p. 1).	"although the hypotheses advanced as to the causes of the heroin shortage were evaluated separately in the preceding discussion, it is likely that the shortage was due to some combination of these factors that operated synergistically to reduce the availability of heroin in Australia in 2001" (p. 64).	Agreement. *Comment*: The important issue, though, is the weight to be given to the various factors. The officially commissioned study dismisses the relevance of the reduction in supply, downplays the relevance of increase in demand in other markets and emphasises role of law enforcement. To rest content with the generalised conclusion that there were a range of factors responsible avoids facing the very serious policy implications implicit in attributing the decision by criminals to reduce heroin exports to Australia (admitted in the officially commissioned study) to market manipulation on their part.

METHODOLOGY OF OFFICIAL REPORT.

Use of the key informant (KI) method (interviews with police, customs etc involved in law enforcement and criminal intelligence – Official report, pp. 4-5, 6 & 49-50) is inadequate to probe and evaluate rigorously alternative possible explanations for the heroin shortage and increase in supply of other drugs. This is an intelligence and forensic task which in the circumstances can probably only be achieved by an independent quasi-judicial inquiry with competence in the evaluation of intelligence and power to call and cross examine witnesses.

The report acknowledges that:

> "Reliance on law enforcement KI to analyse a reduction in heroin supply has the potential to be biased because the reduction in supply is itself an aim of drug law enforcement and is actively pursued" (p. 6).

The report goes on to say that:

> "However, reports from Australian KI - who have a vested interest in reduced heroin supply to Australia - and international KI - who have no such interest - were supportive of one another and consistent with other data sources" (p. 6).

But this is very weak corroboration since drug law enforcement agencies around the world have a common interest in making a case for the effectiveness of what they are about. It is also particularly hard to expect them not to be influenced by the political sensitivity of drug policy here and elsewhere.

The method of interviews with Key Informants has been used with success in the preparation of annual reports of the Illicit Drugs Reporting System (IDRS) and is useful in the present report in documenting the domestic impacts of the changes in drug supply. It is inadequate in the evaluation of the reasons for the change.

CANADA

The officially commissioned study suggests that the fact that Canada did not experience a heroin shortage is evidence against market manipulation being an explanation for the Australian shortage.

Canada, like Australia, is at least partly supplied from South East Asia. Police seizures give an idea of the Canadian drug market. Even though Canada's population of 29.6 million is bigger than that of Australia, in recent years heroin has been far less used there compared to Australia. In contrast, cocaine is much more plentiful.

Drugs Seized in Canada: 1993— 2001

(Weights in kilograms — Ecstasy in dosage units)

	1993	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*
heroin	153	85	128	83	95	105	88	168	74
cocaine	2,731	7,915	1,544	3,110	2,090	2,604	1,116	1,851	1,783
Ecstasy				1,221	10,222	68,496	400,000	2,069,709	1,871,627
marihuana (kg)	7,314	6,472	5,500	17,234	50,624	29,598	23,829	21,703	28,746
marihuana (plants)	238,601	288,578	295,999	675,863	689,239	1,025,808	954,781	1,102,198	1,367,321
Hashish	56,721	36,614	21,504	25,155	6,118	15,924	6,477	21,973	6,677
Liquid hashish	669	659	663	805	824	852	434	1,240	397

Source: http://www.rcmp.ca/crimint/drugs_2001_e.htm#drugs visited 17/11/04.

Again in contrast to Australia, Canadian police actually estimate the annual amount of heroin consumed. This confirms that the Canadian market is much smaller than Australia's. The Royal Canadian Mounted Police estimated that in 1999 "One to two tonnes of heroin are required annually to meet the demand by the Canadian heroin user population"[1] – a quarter or less than the conservative estimate of 6.7 tonnes for the same period by the National Crime Authority for Australia mentioned in our study (p. 8).

In the absence of direct evidence of the intention of Asian syndicates, the following can be put forward to explain why, in a situation of product shortage, South East Asian traffickers may have chosen to cut back in Australia rather than Canada:

(a) the Canadian heroin market, being much smaller than the Australian one, could be comfortably supplied from product that might otherwise have gone to Australia.
The officially commissioned study erroneously suggests so far as Canada (but not China) is concerned "the relatively small scale of the Australian market means that even if all heroin was diverted from this country, it would be difficult to observe the effects in another country given the larger scale of those markets" (p. 48).

(b) Asian Syndicates compete in North America against other suppliers whereas in Australia for heroin they have enjoyed an apparent monopoly or certainly market dominance. Not supplying Canada could risk them losing market share which would not so easily be lost in Australia.

(c) Asian syndicates could well have had in mind events some six years before when they did lose market share in North America:

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1. Royal Canadian Mounted Police, *Criminal Intelligence Directorate, Drug Situation, Canada, - 1999* - http://www.cfdp.ca/rcmp99.pdf.

> "In 1994, South East Asian trafficking was disrupted by a joint Royal Thai Government/ Drug Enforcement Agency operation (US Department of Justice Drug Enforcement Administration 2002), allowing Columbian syndicates to take advantage of the gap in the market. This shift is seen clearly in Figure 2.9. South East Asian syndicates may have sought other markets, particularly Canada and Australia, to replace the United States market (law enforcement source)" (Officially commissioned study, p. 16 & similarly p. 30).

CAPACITY OF ASIAN CRIME SYNDICATES TO TARGET AUSTRALIA

If they implemented a decision to push heroin in Australia in the early 1990s they could equally have the capacity to decide to market supplies elsewhere or change the drugs they marketed.

> "South East Asian trafficking groups are thought to have successfully targeted the Australian heroin market to attain significant market share, supplying cheaper, purer, heroin than had previously been supplied to Australia. This was achieved through links with the increasingly influential and numerous members of Asian crime gangs in Australia, particularly in key areas in Sydney, namely Haymarket and Cabramatta (Lintner 2002)." (Officially commissioned study, p. 30).