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

*committed to preventing tragedy that arises from illicit drug use*

PO Box 36, HIGGINS ACT 2615
Telephone (02) 6254 2961
Email mcconnell@ffdlr.org.au
Web www.ffdlr.org.au


# SUBMISSION OF FAMILIES AND FRIENDS FOR DRUG LAW REFORM TO THE INQUIRY OF THE HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES INTO THE IMPACT OF ILLICIT DRUG USE ON FAMILIES

.

# RECOMMENDATIONS

**Recommendation 1:**

The overriding objective of drug policy should be to safeguard life and promote the physical and mental well-being and social functionality of all. It should not be to make people drug free when this would be at the expense of their physical and mental well-being and social functionality.

**Recommendation 2:**

Governments should be open to the truth in formulating measures to achieve this overriding objective. They should become informed on the basis of the best available evidence of the likely consequences of the policy and law that they put in place.

**Recommendation 3:**

Substitution therapies such as methadone that are effective in stabilising the lives of drug users should be expanded and procedures surrounding their dispensation should be modified so as to avoid stigmatising and discriminating against those suffering from an addiction.

**Recommendation 4:**

The dispensation of drug therapies in different states and territories should be co-ordinated so as to facilitate freedom of movement of those suffering from and being treated for an addiction.

**Recommendation 5:**

Drug policy should not involve the sacrifice of the life and well being of drug users in the purported interests of the rest of the community.

**Recommendation 6:**

There should be open minded exploration of measures that may promote the well-being of drug users including the research of promising measures even though they may lack strong evidence of efficacy.

**Recommendation 7:**

Absence of proof of efficacy of a measure to promote well-being should not be used as a pretext to refuse implementing it where there is strong evidence that it does promote well-being.

**Recommendation 8:**

Governments should develop policies that address the social and economic risk factors of substance abuse.

**Recommendation 9:**

Governments should pay special attention to the promotion of well-being of

the large proportion of the young population with personality types in moderate or high risk of using available illicit drugs.

**Recommendation 10:**

Governments should take steps to ensure that only effective school education programs are supported and that the principles for drug education in schools contained in the National School Drug Education Strategy are followed.

**Recommendation 11:**

Anti-drug media campaigns should:

(a) be carefully designed so as to have the desired impact on the target audience and not be shaped by what may seem convincing to those not in that audience; and

(b) not cause parents to panic or otherwise react in ways damaging to the well-being of their children who may use drugs.

**Recommendation 12:**

Drug policy should:

(a) reflect the fact that some illicit drugs are more dangerous than others and that some methods of ingestion are more dangerous than others;

(b) influence drug users to use less harmful substances or ingest them by less harmful means.

**Recommendation 13:**

Drug policies should empower families to make choices that best promote the well-being of their family members.



.


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

*committed to preventing tragedy that arises from illicit drug use*

PO Box 36, HIGGINS ACT 2615
Telephone (02) 6254 2961
Email mcconnell@ffdlr.org.au
Web www.ffdlr.org.au


# SUBMISSION OF FAMILIES AND FRIENDS FOR DRUG LAW REFORM TO THE INQUIRY OF THE HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES INTO THE IMPACT OF ILLICIT DRUG USE ON FAMILIES

## I. INTRODUCTION

1. Families and Friends for Drug Law Reform. believes that the starting point of the Committee's inquiry should be acknowledgment of the moral compass that it intends to use in guiding its deliberations. We urge the committee to take to itself two principles:

- That the overriding objective should be to safeguard life and promote the physical and mental well-being and social functionality of all; and
- That in seeking to forward this objective they should be open to truth.

2. In other words, Families and Friends for Drug Law Reform believes that the Committee should not make being drug free and overcoming addiction the overriding objective. Being drug free and overcoming addiction is what so many families dearly wish for their children or other family members but they do not wish this to be achieved at the expense of the life and well-being of their member. The choices are clear for them:

- if the choice is between being drug free and death, families will chose life;
- if the choice is between regaining stability in life but still using drugs in place of continuing chaos, families will choose stability.

**Recommendation 1:**

The overriding objective of drug policy should be to safeguard life and promote the physical and mental well-being and social functionality of all. It should not be to make people drug free when this would be at the expense of their physical and mental well-being and social functionality.

3. Judging what will save life and promote well-being is where being open to truth comes in. Openness to truth is the moral principle that underlies the statement that drug policy should be based on the best available evidence. It is a principle that all governments in this country, as reflected in their adherence to the current

framework of the National Drug Strategy, have committed themselves. That framework commits governments to "promote evidence-informed practice":[1]

> "Wherever possible, all supply-reduction, demand-reduction and harm-reduction strategies should reflect practices that are informed by evidence derived from rigorous research, critical evaluation, (including assessment of the cost effectiveness of interventions) [and] practitioner expertise . . . ."[2]

4. What, therefore, families are entitled to expect of this Committee can be expressed succinctly. The Committee's work and recommendations should promote policy that safeguards the life and the physical and mental well-being and social functionality of family members by means of measures informed by the best available evidence.

**Recommendation 2:**

> Governments should be open to the truth in formulating measures to achieve this overriding objective. They should become informed on the basis of the best available evidence of the likely consequences of the policy and law that they put in place.

5. The Committee will do a great service if it insists that drug policy throughout Australia reflects these principles because present drug policy does so only in part and families have suffered accordingly. In some respects it is muddled: lacking a clear focus on what it should achieve. In others it has the best of intentions: it seeks to safeguard life and promote well-being but is tragically misinformed on how those objectives can be achieved or government does not accord programs the resources needed to do so. In yet other respects it seeks to do what is wrong: it unashamedly seeks to sacrifice the life and well-being of Australians in pursuit of a supreme objective of making this country drug free.

6. The following story of a young man – the son and brother of members of Families and Friends for Drug Law Reform – shows that the confusion of objectives of this country's drug policies can have fatal consequences.

**A mother's story**

*We first discovered our son was using heroin just a little over two weeks before he died. He had overdosed close to our home and a friend alerted us. Our daughter called the ambulance. My son was unconscious. I was distraught. I was so thankful that the ambulance men were there quietly and efficiently helping my son. But I couldn't understand why the police were also there harassing me, my daughter and my son's friend. There has to be something terribly wrong when a parent is harassed by police when she has just discovered her son's life is in jeopardy. My gut feeling that night was that*

1. Australia, *The National Drug Strategy: Australia's integrated framework 2004–2009*, p. 4 at http://www.nationaldrugstrategy.gov.au/pdf/-framework0409.pdf

2. *Ibid.,* p. 11.



.

*this was not right, there was something very wrong with this system. I guess this was the beginning of my belief that there was an injustice in our drug laws. You see, I knew my son, the police didn't. They would have seen him the way the laws told them to see him – as a criminal. Here was an opportunity to help him. He had not harmed anyone else – but the law got in the way.*

*The ambulance took my son to hospital but he awoke to find the police at the end of his bed. He discharged himself and for the next two weeks we saw little of him – he was afraid the police would call. He then took a hurried, unplanned holiday. He overdosed and died while on that holiday. He was alone at the time. Involvement of the law frightened my son away from available treatment and help.*

*It was August when I discovered that my son was using heroin and in September, just two weeks later, at the age of 24 my son was dead.*

*He accomplished so much in his short life including having a book of computer programs published at the age of 16. He was Captain of his Primary School, he received distinctions in the Australian Mathematics Competition every year from year 7 to year 12, he was an accomplished cross-country runner, played the organ, worked on a paper run, did all the things most kids do. Who would have thought this could happen to him? He was baptised and confirmed in the Christian Church. He attended Sunday School, youth group and church for many years.*

*Just six months before he died he graduated with a degree in computer science, he had a good job and his later hobbies were playing chess and doing the daily cryptic crossword. Did he fit the stereotype that many people have towards young people who use drugs? I think not! I know that many do not deserve the stigma that is placed on them and their families by society.*

7. What had happened here? Without apparent difficulty, this young man was able to secure a substance that the law prohibited. The law and the police had not protected him nor many thousands of other young people from their unwise choice. His parents, like the millions of other parents felt powerless. Objectively, theirs was a household which sociologists would describe as full of protective factors. There was nothing else they could have done to keep that drug from their son. Government had made a pretence of protecting their family. The reality was that government had failed this family just as it has failed millions since. But government did not rest there. The ambulance attended promptly to revive the young man but so did the police. Both were doing their duty. The attendance of the ambulance was motivated by the welfare of the young man. Government had set another agenda for the police. The young man had used an illegal substance. He must have procured and possessed it. Crimes had been committed. The police task was to investigate who had supplied the drug so that that source of supply could be eliminated thus protecting others. In effect, action that policy and law makers expected of the police involved the sacrifice of the welfare and, as it turned out, the life of a young man for the possible benefit of others.

8. Policy and law makers may seek to wash their hands of moral responsibility for this situation on the ground that this is not how they expected the policy and law to play out. In that case they fall short of their moral responsibility to be open to the truth: to become informed on the basis of the best available evidence of the likely consequences of the policy and law that they put in place.

9. Was the policy and law that the police acted on likely to endanger the welfare of heroin users? Clearly yes. Heroin is a potent depressant. Particularly when associated with other drugs including legal ones it can suppress breathing entirely. First aid and medical attention must be readily at hand if death or serious brain injury are to be avoided. Quick action which is vital will be deterred if those in a position to call help fear that doing so will get them into trouble with the police. That is why the young man's friend did not himself call the ambulance. At least he notified the parents. That did not happen in the case of a 16 year old daughter of a member of ours whose scared young mates left her to die within sight of Canberra Hospital.

10. Was the presence of the police not a salutary shock for the young man when he came to? Would it not be the very sort of experience to bring him to his senses so that he would give up this dangerous drug? It is possible that the police action would have had this effect but was it likely to do? The answer is clearly no for most of those like the young man had become dependent on the drug.

11. Addiction is a chronic relapsing condition. The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-IV for short) recognises that a characteristic of addiction is that "the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance".

12. In short, the police action that led to the death of this young man might have been consistent with a moral viewpoint that places top priority on being drug free. It was not consistent with giving priority to welfare and life. The police came to see the situation in that other light too. Thanks to the urging of groups like Families and Friends for Drug Law Reform police services around the country came to adopt protocols under which they do not, in the ordinary course of events, attend overdoses.

13. The law sends a clear message to families with a child who has got into trouble with drugs: you, the parents, have failed in your responsibility in bringing up your child. You have brought up a criminal. Shame is a pervasive experience of families when illicit drug use is involved. Families are known to attribute death from drugs to other causes like car accidents. The shame is isolating and corrosive of the capacity of the family to respond usefully. Blame is cast at the family by others and can be hurled around within it, typically between a father who wants to take a firm line and the mother who wants to support.

14. Parents load themselves with guilt. "Parents and siblings report increased conflict, erosion of trust and a breakdown in communication between them and the



.

drug-affected member and between other family members."[3] All too often the tensions lead to the destruction of the family itself. A mother who is a registered nurse has described in the following terms her experience following the addiction of her son:

> "None of the agencies we had contact with could offer much help or advice for us as parents, and even close friends and family could not understand what we were going through. Their criticisms, advice and suggestions, and the rejection we felt, added to our shame and isolation. We continued to flounder in a black sea of despair, never knowing what crisis we would have to deal with next or whether our children would even manage to stay alive."[4]

## II. DO NO HARM

15. An ethical principle of the medical profession is that the doctor, in treating the patient, should do no harm. It would be as well if law and policy makers were also guided by this principle. Families should have confidence that drug law and policy is there to protect them but it is clearly recognised that much of that law and policy does not do so as the family of the young man came to realise too late. The heroin was harmful. It was addictive and could lead to an overdose causing brain injury or death but so was the law enforcement intervention harmful. It led the young man to flee his family and friends who could have helped him. Away from their support he used alone, exactly what he should not have done to minimise the harm of heroin use. Families are shocked when they come to realise that there is a well established body of knowledge about the dangers that drug law and policy add to the dangers that flow from the drug itself.

### Harms imposed by drug law and policy

16. There is a huge literature on the harms imposed by drug law and policy. We include just two summaries of these harms. The first is from a recent systematic review of harm reduction:

> "There is a set of harms arising from the illegal status of drugs. These harms are largely accrued by the drug user and include imprisonment and loss of liberty, a criminal record (which leads to difficulties with employment etc.), developing criminal experience, and associating with criminal networks. In addition corruption and the presence of black markets are harms borne by the

---

3. Amanda Oreo & Salih Ozgul, "Grief experiences of parents coping with an adult child with problem substance use" in *Addiction Research and Theory*, vol. 15, no. 1, pp. 71–83 (February 2007) at p. 72.

4. Story of "Phoenix" in Brian McConnell & Tony Trimingham (eds), *National Families & Community Conference on Drugs: "Voices to be heard": Conference proceedings, 10-11 November 2000* (Families and Friends for Drug Law Reform, Canberra, July 2001) p. 73. Available on www.ffdlr.org.au.

community. The potential for blood borne virus transmission is also associated with the illegal status of drug use (hurried, inadequate injecting practices for fear of detection; and illegality of injecting equipment in some countries/states)."[5]

17. The second and similar account of the harms inflicted by drug law and policy was written almost ten years ago. It shows that knowledge about the harms of drug laws and policy are far from new. The statement was in fact made by an officers committee inquiring into serious drug offences:

> ". . . 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."[6]

18. In full recognition of these dangers, the officers committee, in error in our view, went on to recommend what has evolved into the *Law and Justice Legislation Amendment (Serious Drug Offences and Other Measures) Act* 2005 which, contrary to what one might expect from its title, makes mere possession by drug users a serious drug offence under Commonwealth law. The officers committee went on to say that the imposition of extra risks on drug users was intended:

> "We may say that [the amplification of risks] is precisely what criminal prohibitions are meant to do. The greater the risks, the greater the deterrent effect, both on those who are habitual users and those who might otherwise

---

5. Alison Ritter & Jacqui Cameron, *A systematic review of harm reduction*, Drug Policy modelling project monograph 06 (Turning Point Alcohol and Drug Centre, Fitzroy, December 2005) p. 47.

6. Standing Committee of Attorneys-General, Model Criminal Code Officers Committee, *Model Criminal Code Chapter 6: serious drug offences: report* (Model Criminal Code Officers Committee of the Standing Committee of Attorneys-General, Canberra, October 1998) pp. 6-7.



.

> be tempted by the lifestyle. Mark Moore, a leading American authority on drug law policy, refers to the 'effective cost' of heroin use – the effective cost of use is an amalgam of all those factors which make the life of the habitual user dangerous, arduous, frightening and expensive. To the extent to which criminal law prohibitions have as their object an increase in the effective cost of heroin use, they counter the requirements of humanity with the logic of pure deterrence."[7]

19. It should not be beyond this Committee's ability to propose a system that dissuades use of illicit drugs without resorting to the blunt and severe instrument of the criminal law.

20. There is no wonder that families feel themselves in a hopeless situation. The core of drug law and policy is to threaten and often to inflict harm on their drug using member with a view to that member ceasing to use. The moral compass applied to reach this point is not the protection of the life and well-being of the drug users but rather the overriding importance of being drug free. Only by a refusal to be open to the truth is it possible to hide the awfulness of this moral choice.

21. As we know from the example of the young man and the many addicted users who continue using in prison, law enforcement pressure has a very limited impact on drug use. Parents are advised to stand back and wait till their children hit "rock bottom" – the accumulation of enough misery to bring them to their senses and give up drugs. In the case of heroin addiction, families are told to expect the death of their member: that a third of those addicted will die. Parents experience grief before their child's death.[8] That death is so likely does not necessarily follow from the heroin addiction. Death is avoidable and a good quality of life possible even though people remain addicted. In this sense Australian families are called on to reconcile themselves to the likely death of a family member brought about by law and policy responses.

## The possibility of well-being with addiction

22. The moral obligation to remain open to the truth would require the Committee to be open to the large amount of evidence that shows that people addicted to heroin are able to live socially responsible lives while being prescribed maintenance doses of that or other addictive drugs like methadone. Around 450 patients are prescribed heroin in Britain.[9] In Switzerland 1,200 receive heroin under strict medical supervision[10] following extensively researched trials that showed big improvements in the health and social functionality of severely dependent heroin

---

7. *Ibid.,* p. 7.

8. Oreo & Ozgul, *op. cit.,* fn 3.

9. Nicola Metrebian, a research fellow at Imperial College London, quoted in "Handouts fix drug crime" in http://www2.swissinfo.org/sen/swissinfo.html?-siteSect=2251&sid=6001767&cKey=1123755067000 visited 22/3/2007.

10. Swissinfo report in *ibid*.

users.[11] Similar results are emerging from a trial in Germany with more than 1,000 patients. Heroin prescription programmes also exist in Vancouver in British Columbia,[12] Spain and The Netherlands.[13] Research in The Netherlands considered combined treatment with heroin and methadone of people with chronic, therapy-resistant opiate dependency. It found that the treatment was safe:

> "The treatment is more effective than in the case of methadone alone. The physical and mental health, as well as social functioning improve, including a reduction of crime."[14]

23. Use of the artificial opiate, methadone, as a maintenance therapy provides the clearest illustration of the impact on drug policy of divergent moral positions. If, as Families and Friends for Drug Law Reform urges, becoming drug free should be subservient to the protection of life and well-being, then methadone maintenance should be endorsed. The evidence in support of its efficacy is strong. It is the best researched treatment for heroin dependency. A Cochrane Review found that:

> "Methadone is an effective maintenance therapy intervention for the treatment of heroin dependence as it retains patients in treatment and decreases heroin use better than treatments that do not utilise opioid replacement therapy."[15]

24. Cochrane reviews are intended to provide high quality and independent findings to inform healthcare decision-making. They combine the results of the

---

11. A. Uchtenhagen, A. Dobler-Mikola, T. Steffen, F. Gutzwiller, R. Blättler & S. Pfeifer, *Prescription of narcotics for heroin addicts: main results of the Swiss national Cohort Study* (Karger, Basel, Freiburg, Paris &c, 1999) being vol. 1 of A. Uchtenhagen, F. Gutzwiller, A. Dobler-Mikola, T. Steffen, M. Rihs-Middel, *Medical prescription of Narcotics.*

12. North American Opiate Medication Initiative (NAOMI), Backgrounder at http://www.naomistudy.ca/pdfs/naomi_background.pdf & Questions and Answers at http://www.naomistudy.ca/pdfs/naomi_faq.pdf.

13. European Monitoring Centre for Drugs and Drug Addiction, *Annual Report 2006: the State of the Drugs Problem in Europe* (EMCDDA, Lisbon, 2006) p. 72 at http://ar2006.emcdda.europa.eu/download/ar2006-en.pdf visited 22/3/07.

14. J.E.E. Verdurmen, A.P.M. Ketelaars, M.W. van Laar, *The Netherlands National Drug Monitor: Fact Sheet Drug Policy* (Trimbos Institute, Utrecht, [2005]) p. 20 http://www.trimbos.nl/Downloads/Programmaas/NDM/-Factsheetdrugsbeleid2005DEF%20Engels.pdf visited 22/3/07

15. R.P. Mattick, C. Breen, J. Kimber, M. Davoli, "Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence", *Cochrane Database of Systematic Reviews* 2003, Issue 2. Art. No.: CD002209. DOI: 10.1002/14651858.CD002209 at at http://www.mrw.-interscience.wiley.com/cochrane/clsysrev/articles/CD002209/pdf_fs.html.



.

world's best medical research studies and are recognised as the gold standard in evidence-based health care. This committee would be in breach of its moral obligation to be open to the truth if it dismissed such strong evidence. Doing so could be justified only on the basis that becoming drug free was more important than the protection of life and well-being. It would seem that the predecessor of this committee was sadly guided by that wrong moral compass when, in effect, it questioned the continuation of methadone maintenance.[16]

25. We restate here for the elimination of any possible doubt that Families and Friends for Drug Law Reform rejoices when anyone who has been addicted shakes off his or her addiction. We thoroughly support measures that help people achieve that goal but we draw the line when it comes to any measure that, in the name of achieving a drug free status, endangers the life and well-being of anyone who is addicted.

**Policy has made liquid manacles of methadone**

26. It should also be made clear that, like many therapeutic drugs, methadone may have unpleasant side effects. It is addictive. Like other opiates it is a 'drying' drug and can cause constipation and reduced saliva production. Long term effects can include tooth decay from reduced saliva and loss of libido. Methadone can be harmful for people with kidney and liver diseases.[17] Further drawbacks associated with methadone arise from the restrictive, demeaning and alienating regime often prescribed for its dispensation. Moreover, it is not effective for some heroin dependents.

27. Having said that, methadone is a safer drug than street heroin because its quality and purity is controlled, it is taken orally rather than injected and it has a longer half life than heroin. Moreover, its side effects can be mitigated. It plays a central role under the National Drug Strategy in reducing the demand for illicit drugs. The medical profession recognise methadone as the 'gold standard' for heroin treatment: it saves life and enables a high proportion of people dependent on illicit heroin to get their life back in order. In short it is a proven means of minimising awful harms. When dispensed in the community by local pharmacists, as is quite widely done, those being treated can feel that they have returned to the community again and are able to live a normal life.

28. An example has recently come to the attention of Families and Friends for Drug Law Reform of the restrictive, demeaning and alienating dispensation regime that tends to tarnish its reputation. A notice recently circulated to methadone patients

16. Australia, Parliament, House of Representatives, Standing Committee on Family and Community Affairs, *Road to recovery: report on the inquiry into substance abuse in Australian communities* (Canberra, August 2003) recommendations 52-54.

17. Australia, Department of Human Services and Health, *Handbook for medical practitioners and other health care workers on alcohol and other drug problems* (Australian Government Publishing Service, Canberra, 1994) p. 46

in the ACT gives a view of a scandalous lack of placements across the country. The notice is headed "There are long waiting lists for most programs interstate". It then continues:

> "Queensland – no places for permanent transfer at public clinics in the Brisbane, Sunshine and Gold Coast areas. Limited private GP places available. Other areas still have waiting lists
>
> "NSW – Sydney area has very few public places available for transfers. Pharmacies are available. South Coast IS NOT taking any transfers at all.
>
> "Tasmania's books are CLOSED indefinitely
>
> "SA, WA and NT have some places, but require several weeks notice of transfer.
>
> "Victoria – No public clinics, all GP prescribers. Places dependent on GP waiting lists."

29. Article 12 of the International Covenant on Civil and Political Rights requires that:

> "Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence."

30. Methadone patients are effectively denied this right in Australia. We ask members of the committee to reflect for a moment on the times that urgent personal reasons or work has required them to travel at short notice. Think too, of what is involved for a methadone patient to come home for Christmas. A member of Families and Friends for Drug Law Reform had to go to lengths that others could never have managed to enable his son in Sydney to join the family in Canberra last Christmas. No wonder that methadone is sometimes referred to as "liquid manacles".

**Recommendation 3:**

> Substitution therapies such as methadone that are effective in stabilising the lives of drug users should be expanded and procedures surrounding their dispensation should be modified so as to avoid stigmatising and discriminating against those suffering from an addiction.

**Recommendation 4:**

> The dispensation of drug therapies in different states and territories should be co-ordinated so as to facilitate freedom of movement of those suffering from and being treated for an addiction.

## Civil war[18] and sacrifice of drug users

31. Parents should not be called on to sacrifice the well-being and life of their drug dependent children, yet this is precisely what happens. Drug policy is bedevilled with concern about sending a wrong message that will encourage children to try illicit drugs. Indeed reported remarks by members of this Committee suggest

---

18 Civil war is defined in the *Macquarie Dictionary* as "a war between parties, regions, etc., within their own country".



.

that the element of harm reduction in the National Strategy does just that. Concern about sending the wrong message and the linked issue of causing community alarm are behind unjustified restrictions on opening sufficient syringe dispensing outlets, opposition to medically supervised injecting centres and the provision of enough drug substitution services in areas where they are needed.

32. Much of Australian drug policy has fomented a civil war in our community in which hate, fear and alienation are the shells fired at drug users and sometimes their family. The rhetoric of conflict is commonly used to describe responses to the drug problem. Parents are called on to sacrifice the well-being and life of their children in time of war. The same thing happens when measures that are known to save lives and promote well-being of drug users are not implemented because their introduction would "send the wrong message". By denying the implementation of these measures, the interests of the "innocent" are pitted against the interests of the "guilty".

33. The sacrifice of others is a fearful exercise to contemplate. It can, if ever, assume a colour of moral justification only when the harm to be avoided is overwhelmingly greater than the harm of the sacrifice AND there is no other way of avoiding that greater harm AND there is a high degree of confidence that the sacrifice will be effective in avoiding the greater harm.

34. The moral choice of sacrifice is at the heart of the work of this Committee. Inconsistencies within Australia's existing drug policy already incorporate big trade offs between perceived concern for existing illicit drug users and concern to protect the others from illicit drugs. A vote for the ditching of harm minimisation and particularly its grossly under-funded harm reduction component would be a vote for more sacrifice; for an intensification of the civil war around drugs that already rages in our society. Some idea of what is at stake is given in the annex to this submission.

**Recommendation 5:**

Drug policy should not involve the sacrifice of the life and well being of drug users in the purported interests of the rest of the community.

### Well-being of drug users and minimising availability to others is reconcilable

35. The tragedy is that existing evidence points to there being no inconsistency between measures that protect the life and well-being of drug users and minimising the likelihood that others will get into trouble with drugs. Here openness to truth is vital. This is not the place for a comprehensive examination of the evidence on this issue. Nevertheless, the following cast doubt on the assumption that firm law enforcement is essential in order to keep drug use low. The examples concern:

- the reduction of heroin users in Zurich following the introduction of widespread substitution therapies including heroin prescription;
- evidence of lack of stimulation of cannabis usage in South Australia following the introduction of the expiation notice system there; and
- a comparison of illicit drug usage among school children in the United States and 30 European countries, showing that levels of drug use bore little if any relationship to the severity of drug law enforcement.

36. A recent study of the canton of Zurich has shown a large decline in the number of new heroin users:

> "The incidence of regular heroin use in the canton of Zurich started with about 80 new users in 1975, increased to 850 in 1990, and declined to 150 in 2002, and was thus reduced by 82%."[19]

37. Since 1990 substitution treatments have been widely available there. Any physician who has received instruction may prescribe methadone or buprenorphine and clinics exist where heroin may be prescribed. Not only did the introduction of these measures to protect the life and well-being of heroin users not lead to an increase in drug use (the point being argued here) but those measures seem to have brought about a large decline in recruitment of new dependent heroin users.

38. In Australia, studies of the impact of the introduction in South Australia in 1987 of the expiation notice system for minor cannabis offences found that this system led to far fewer damaging consequences for young people caught with cannabis than in Western Australia which then followed a stringent law enforcement approach. The study found that those prosecuted in Western Australia were more likely to report harmful consequences in their employment and interpersonal relationships. For example, those processed under the Western Australian system were eight times more likely to be sacked.[20] The study found that there was no evidence of resulting increase in use to offset these benefits:

> "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."[21]

39. The level of illicit drug use in different countries bears no direct relationship to the repressiveness of measures against that use as one would expect if a strong law enforcement had a significant impact on the uptake of drugs. The degree of repressiveness of anti-drug measures varies greatly between countries. In 1999 a survey was made of tenth graders in the United States and 30 European countries

---

19. Carlos Nordt & Rudolf Stohler, "Incidence of heroin use in Zurich, Switzerland: a treatment case register analysis" in *The Lancet*, vol. 367, pp. 1,830-34 (3 June 2006) at p. 1,833.

20. Simon Lenton, Paul Christie, Rachel Humeniuk, Alisen Brooks, Mike Bennett, Penny Heale, *Infringement versus conviction: the social impact of a minor cannabis offence under a civil penalties system and strict prohibition in two Australian states*, National Drug Strategy monograph series no. 36 (Department of Health and Aged Care, Canberra, May 1998) p. x.

21. Neil Donnelly, Wayne Hall & Paul Christie, *Effects of the cannabis expiation notice scheme on levels and patterns of cannabis use in South Australia: evidence from the national drug strategy household surveys 1985-1995*, National drug strategy monograph series no. 37 (Dept of Health & Aged Care, Canberra, May 1998) p. 13.



.

using methods designed to produce comparable results.[22] 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."[22]

40. 16% of 10th grade students in the United States had used amphetamines compared to an average of 2% for amphetamines across the European countries surveyed. The highest European rates of amphetamine use was 8% in the United Kingdom and 7% in both Estonia and Poland. The only countries with a rate of drug injection over 1% were Russia (2%) and the United States (3%).[22]

41. None of these examples prove what the relationship is between the level of drug use and, on the one hand, a drug policy guided by harm minimisation objectives and, on the other, one with a strong prevention and law enforcement approach. What the examples do, is provide forceful evidence that a drug policy focusing on the protection of the life and well-being of drug users is compatible with the objective of reducing the level of drug use. If the evidence points in that direction, the Committee should recommend action consistent with it including research to further clarify the point. The absence of proof of a link should not become a pretext for inaction if the evidence points towards an inconvenient truth. To insist on proof in that situation is not being open to truth.

**Recommendation 6:**

There should be open minded exploration of measures that may promote the well-being of drug users including the research of promising measures even though they may lack strong evidence of efficacy.

**Recommendation 7:**

Absence of proof of efficacy of a measure to promote well-being should not be used as a pretext to refuse implementing it where there is strong evidence that it does promote well-being.

## III. A DRUG POLICY MUST BE MORE THAN PREVENTION

42. A drug policy that uses prevention as its banner is incompatible with protecting life and well-being. Measures that realistically seek to prevent the uptake

22. State University of New York, *Press release issued by the State University of New York at Albany concerning a multi-national study of tobacco, alcohol and marijuana between high school students in 30 European countries and in the United States* (20 February 2001) at http://monitoringthefuture.org/pubs/-espad_pr.pdf.

of drugs are important but any suggestion that measures of prevention alone are sufficient is at best misleading and at worst harmful. This is because:

- a preoccupation with prevention does not take into account the welfare of those who are using;
- it is impossible to "inoculate" or "drug proof" children against using illicit drugs;
- existing law enforcement measures are ineffective in cutting off the supply of illicit drugs to children; and
- a message that prevention alone is what should be achieved promotes harmful responses from the community, families and users.

43. Measures promoting prevention have an important role in a suite of measures responding to illicit drugs just as they do in the current National Illicit Drug Strategy but a drug policy which regards measures of prevention as sufficient is totally inadequate.

44. This section amplifies why "inoculating" or "drug proofing" children against using illicit drugs is impossible and how a prevention message can promote harmful responses. A drug policy that ignored the well-being of those who are using drugs should be unthinkable.

**Young people and risk of drug use**

45. From what is known about risk factors associated with drug use, it is futile to expect that strategies to persuade young people not to take up illicit drugs that are readily available will be anything more than marginally effective. What is more, there is a real danger that misguided anti-drug campaigns will actually increase harmful drug use.

46. A lot is known about risk factors, an accumulation of which predispose children to get into trouble with illicit drugs. These same factors are associated with other problems such as suicide, mental illness and delinquency. They include individual factors like low birth weight and poor social skills, family and other social factors such as family violence and disharmony and neglect, school factors such as bullying and association with a deviant peer group, life events like unemployment and homelessness and community and cultural factors like socioeconomic disadvantage and lack of support services.[23] The accumulation of many factors

23. Commonwealth Department of Health and Aged Care, *Promotion, prevention and early intervention for mental health-a monograph* (Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, 2000) p. 16; National Crime Prevention, *Pathways to prevention: developmental and early intervention approaches to crime in Australia* (National Crime Prevention, Attorney-General's Department, Canberra, 1999) p. 136; Penny Mitchell, Catherine Spooner, Jan Copeland, Graham Vimpani, John Toumbourou, John Howard and Ann Sanson, *The role of families in the development, identification, prevention and treatment of illicit drug problems: commissioned by the NHMRC for the Strategic*



.

unmitigated by few protective factors is more often found in families which are under stress and where there are gaps in parenting. This explains why problem drug use is more often found among the off-spring of such families than others. An obvious response to reduce the uptake of drugs is for governments to develop policies that address those social and economic risk factors over which government policy has influence.

**Recommendation 8:**

Governments should develop policies that address the social and economic risk factors of substance abuse.

47. At the same time young people who get into trouble with drugs also come from families that display a low set of family risk factors. For example, a combination of individual and school factors may lead to trouble with drugs. The child may be of low intelligence, lacking in empathy and have low esteem (listed child risk factors), have failed at school and been rejected by their peers (schooling risk factors) and have suffered intense loss from the death of a family member (a life event risk factor).

48. Research carried out for the Government revealed that illicit drugs were potentially attractive to a wide range of young people of normal personality types.[24] There were those who tended to be outward looking and those who tended to be inward looking. A proportion of both these normal personality types were at risk of getting into trouble with drugs.

49. Outward looking young people tended to be more extrovert, positive and confident in their approach to life and were typically more independent and emotionally stable. Those who tended to look inwards were "generally more introvert and pessimistic in attitude. While many are serious and deep thinking they often appear to be less stable emotionally and more likely to follow the lead of others." In both broad personality types there was a sub-group that would be most unlikely ever to touch drugs just as there was a sub-group that would most probably not.

50. The sub-group of outward lookers who would most probably not use drugs were the "considered rejecters" who "believe that drugs are bad, and are a major problem in all circumstances. They are self-motivated people, with little or no need

---

*Research Development Committee's National Illlicit Drug Strategy Research Progr*am (National Health and Medical research Council, 2001) pp. 3-9 & 13-15.

24. Blue Moon Research & Planning Pty Ltd, *Illicit drugs: research to aid in the development of strategies to target youth and young people* prepared for the Commonwealth Department of Health & Aged Care, Population Health Social Marketing Unit (June 2000) at http://www.health.gov.au/pubhlth-/publicat/document/reports/nidc_bluemoon1.htm. The following account is drawn from pp. 1-30 of this report and in particular pp. 27-29.

to add excitement to their lives. They are happy with their lives and feel in control of things." They accounted for 16% of 15 to 24 year olds.

51. A sub-group of inward lookers consisting of 13% of 15 to 24 year olds is also most unlikely ever to try drugs. People in this sub-group "have little or no need to add excitement to their lives. They differ from the Considered Rejecters in that they are not particularly happy or secure in their lives, and they do not feel in control of things."

52. Those most likely to use drugs are at the other end of the spectrum of the two main personality types. This sub-group among the outward lookers were "thrill seekers" who were prepared to take risks. Comprising 20% of 15-24 year olds, they ". . . enjoyed the excitement of drugs, the 'buzz', the sense of risk, the excitement and the belief that drugs were 'cool'. Their curiosity and pursuit of excitement could tempt them to trial 'hard' drugs, despite their awareness of the potential dangers." Among the less confident inward lookers were "reality swappers" comprising 16% of 15-24 year olds. They "believed that the reality they experience while on drugs was better than the 'straight' world. They believed they lacked the self-respect, love and interests that their peers enjoyed. Moreover while they often acknowledged that their problems were increased because of the drugs they took, the only relief they knew was through drug-taking." The heaviest drug users were likely to come from these two groups.

53. The 37% between the extremes of both the inward looking and outward looking personality types "showed a moderate level of use or potential use of illegal drugs".

54. In short, among the young population there is a large proportion with personality types with a moderate or high potential risk of using illicit drugs. Some of the personality qualities such as preparedness to experiment and take risks that predispose young people to use are qualities that are generally admired.

55. The point that drug use can be a problem in any family is also expressed in the Commonwealth Tough on Drugs booklet for parents: *Our strongest defence against the drug problem . . .* [25] under the heading "Why do young people take drugs?"

> "Some parents think that young people use drugs only if they are having problems at home or at school. But there are many other reasons:
>
> - Availability and acceptability of the drug.
> - Curiosity and experimentation.
> - Wanting to be accepted by peer groups.
> - Rebellion.
> - Depression.
> - As a way to relax to cope with stress, boredom or pain.

25. Australia, *Our strongest defence against the drug problem* written by E. Abetz, Special Minister of States ([2001], Commonwealth of Australia, Canberra)



.

- To experience a high or a rush."[25]

56. These conclusions are supported by answers to household survey questions on why people first used illicit drugs. It is clear that a large proportion of normal young people are at substantial risk of being attracted to illicit drugs. The usage of illicit drugs in the community extends well beyond those from a narrow group of people with a high accumulation of risk factors.

**Factors influencing first use of any illicit drug, lifetime users aged 14 years and older, by sex, Australia, 2004**

| *Factor* | *Males* | *Females* | *Persons* |
|---|---|---|---|
| | *(per cent)* | | |
| Curiosity | 77.5 | 76.4 | 77.0 |
| Peer pressure | 52.7 | 56.7 | 54.5 |
| To do something exciting | 19.5 | 22.0 | 20.7 |
| To enhance an experience | 12.2 | 11.7 | 12.0 |
| To take a risk | 8.4 | 10.3 | 9.3 |
| To feel better | 5.0 | 7.1 | 5.9 |
| Family, relationship, work or school problems | 4.3 | 6.7 | 5.4 |
| Traumatic experience | 1.6 | 3.5 | 2.5 |
| To lose weight | 0.5 | 2.1 | 1.2 |
| Other | 3.3 | 3.4 | 3.3 |

*Notes*
1. Base is those who had ever used an illicit drug.
2. Respondents could select more than one response.

*SOURCE:* Australian Institute of Health and Welfare, *2004 National drug strategy household survey: detailed findings* (Drug statistics series no. 16) (Canberra, October 2005) table 6.2, p. 37 at http://www.aihw.gov.au/publications/-phe/ndshsdf04/ndshsdf04.pdf.

**Recommendation 9:**

Governments should pay special attention to the promotion of well-being of the large proportion of the young population with personality types in moderate or high risk of using available illicit drugs.

## Drug education and media campaigns

57. Good intentions are no guarantee that drug education and media campaigns will be successful. As always, the rule of thumb should be to do no harm. Unfortunately, ill-informed anti-drug strategies can cause harm. They can actually increase drug use. For example, a United States program, Project SMART (Self-

Management And Resistance Training), implemented in the 7th grade "resulted in negative impacts on rates of marijuana incidence and prevalence, with [students who underwent the training] reporting significantly higher rates of use and greater rates of initiation at follow-up than their control counterparts."[26]

58. Even the Drug Abuse Resistance Education program, DARE for short, that is widely used in the United States and has been the model for many similar programs around the world has been shown to be useless if not worse in reducing drug uptake.

> "There were four evaluations of the DARE curriculum [which were delivered by police officers], one being an evaluation of the DARE Plus curriculum, which took the original curriculum and added multifaceted family and community components. Overall, the three evaluations of the standard DARE curriculum failed to find evidence of the effectiveness of the program. The program failed to significantly impact either marijuana or other illicit drug use, either in the short- or long-term. Follow-up rates of hard drug use were almost identical amongst treatment and comparison youths. There was also very little evidence to suggest favourable impacts of the program on marijuana use trajectories, with one study suggesting a significant negative impact of the program on marijuana use rates. The added family and community components of the DARE Plus program failed to improve the effectiveness of the program, finding no significant impact on marijuana use rates. These findings align with findings of previous reviews and meta-analyses of the DARE program."[27]

59. According to evaluations, competence enhancement education programs tend to be the most effective in reducing uptake of drugs.[28]

> "Competence enhancement programs emphasise the teaching of generic life skills such as communication skills, decision making, problem solving, coping skills and stress management, assertiveness, and other socially relevant skills such as those pertaining to dating and relationships. Programs adopting this approach may also include components highly similar to social influences programs such as refusal skills training, normative behaviour and identification of the social influence on drug use. However, many do not directly address drug use, instead addressing a variety of intermediate, interpersonal factors believed to be associated with drug use susceptibility."[29]

---

26. D.W. Soole, L. Mazerolle, & S. Rombouts, *Monograph No. 07: School based drug prevention: a systematic review of the effectiveness on illicit drug use*, DPMP Monograph Series (Turning Point Alcohol and Drug Centre, Fitzroy, 2005) p. 18 at http://www.dpmp.unsw.edu.au/DPMPWeb.nsf/resources/-DPMP+Monographs2/$file/DPMP+MONO+7.pdf.

27. *Ibid.,* pp. 21-22.

28. *Ibid.,* pp. 23-24 & 27.

29. *Ibid.,* p. 17.



.

60. In addition, some social influence programs including an Australian one, the Illawarra Program, "showed significant positive effects on rates of marijuana use that persisted for three years after the completion of the program."[30] In social influence programs "youths are educated about the influence of the media, peers, and adults on subsequent drug use."[31]

61. The principles for drug education in schools contained in the Government's own National School Drug Education Strategy[32] seem consistent with these findings. For example, they state that:

- "Effective drug education should reflect an understanding of the characteristics of the individual, the social context, the drug and the interrelationship of these factors";
- "Approaches to drug education should address the values, attitudes and behaviours of the community and the individual"; and
- "Drug education needs to be based on research, effective curriculum practice and identified student needs."

Families and Friends for Drug Law Reform believes that this Committee would do well to reaffirm the principles of this education strategy.

**Recommendation 10:**

Governments should take steps to ensure that only effective school education programs are supported and that the principles for drug education in schools contained in the National School Drug Education Strategy are followed.

62. There is little evaluation on the extent that media campaigns impact on the uptake of illegal drugs. As the Australian National Council on Drugs put it in its recent position paper on methamphetamine, media campaigns have to be well thought out and targetted if they are not to backfire:

> "Media campaigns have been used successfully to reduce unhealthy behaviours (e.g. tobacco smoking), but their application in relation to illicit drug use is limited and unfortunately not well evaluated. Successful media campaigns are also expensive and require substantial planning and research. In particular, they require a segmented marketing strategy that identifies and successfully targets the 'at-risk' audience (e.g., use media channels that are accessed by drug users and a delivery that is appealing to this audience), research on the target audience to understand their attitudes, beliefs and values (including pre-testing or media campaigns), and most importantly, the

30. *Ibid.,* p. 22.

31. *Ibid.,* p. 17.

32. Department of Education, Training and Youth Affairs, *National School Drug Education Strategy* (Department of Education, Training and Youth Affairs, Canberra, May 1999) p. 8 at http://www.dest.gov.au/archive/schools/-publications/1999/strategy.pdf.

campaign must receive adequate and sustained coverage. Media campaigns run the risk of unintended increases in drug use if they are not adequately research and focus tested."[33]

63. Again it must be stressed that even the most successful school education drug programs and media campaigns cannot prevent people using illicit drugs. All they can realistically hope to do is to influence a moderate percentage of their audience who might otherwise have taken up drugs not to do so. This is illustrated by the successful Illawarra program where students who received the program reported significantly less cannabis use than comparison students at each of the follow-up periods. At 7th grade 6% of the students who received the program reported having tried cannabis compared to 13% in the group that did not receive the benefit of it. In 8th grade the proportions were 12% and 31%, at 9th grade 23% and 40% and in 10th grade 27% and 41%.[34] Put in other words, even the best preventative programs will fall far short of ensuring that all young people do not use readily available illicit drugs. If young people and their families are not to be written off as non-persons, drug policy must reflect this reality. It is for this reason that the Commonwealth Government's National School Education Strategy includes among its principles the statements that:

- "The emphasis of drug education should be on drug use likely to occur in the target group, and drug use which causes the most harm to the individual and society"; and
- "Objectives for drug education in schools should be linked with the overall goal of harm minimisation."[35]

64. Families and Friends for Drug Law Reform has gained the impression from hearings to date of the Committee that members are attracted to media campaigns emphasising the dangers of illicit drug use so as to frighten people into not using them. We also sense concern about the use by public broadcasters such as the ABC of terms like "party drugs" in referring to synthetic drugs like ecstasy. We venture some observations on the effectiveness of scare campaigns and the influence of popular culture on drug use.

**Scare campaigns**

65. Given the waste of life that so often is associated with illicit drug use, Families and Friends for Drug Law Reform would support hard hitting media campaigns which are objective, carefully formulated and targetted. Like the Australian National Council on Drugs,[36] we emphasise the danger that poorly formulated and targetted media campaigns will make the drug problem worse. The

---

33. Australian National Council on Drugs, *Methamphetamines: position paper* (ANCD, Canberra, [2007]).

34. Soole *et al.*, *op. cit.*, fn 26, pp. 95-96.

35. DETYA, *National School Drug Education Strategy,* fn 32, p. 8

36. See above at p. 19.



.

United States has a recurrent history of failed scare campaigns.[37] Reefer madness publicity of the Anslinger era has acquired a cult status. Consideration of the personality profile of those of greatest risk of drug use will show why strategies emphasising the dangers of drug use are ineffective for many. For the "thrill seekers" mentioned on page 16, danger is a challenge. Painting drug use as boring would be a far more effective turn off for these people. The following explains the pitfalls of scare campaigns in a school context:

> "Intuitive approaches have led in the past to the use of 'scare tactics' in drug education. 'Scare tactics' are based on the assumption that 'if we could just show how risky it is - they wouldn't do it'. Students, parents, and teachers are often convinced that confronting young people with the most severe harms will deter them from using drugs. However, programs that rely on 'scare tactics' have not shown a reduction in the incidence of harmful drug use. There may be a number of reasons why this is so. These include a tendency to believe in one's own invulnerability - 'this is not going to happen to me' - and a poor fit between the young person's observation or experience of drug use and the consequences shown in the 'scare tactics' program - 'this is not what I have seen happening to others'. Many students have observed parents, peers, or community members using drugs such as cigarettes, alcohol, and cannabis without appearing to come to harm.
>
> "A health-education program can work against its overt message by inadvertently reinforcing the behaviours it aims to work against. 'Scare tactics', for example, can inadvertently 'glamorise' risky behaviours. 'Survivors' or ex-addicts can gain a heroic status in the telling of their story. Thus 'scare tactics' may make certain behaviours more attractive or compelling, especially to those with something to prove, those with an adventurous streak, or to those who are driven to cause themselves harm."[38]

66. Exaggerated scare campaigns pose another danger. This is that parents are more likely than children to believe the worst about illicit drugs. This is evident from taking telephone calls from parents who have just come across evidence of drug use by their child. Wishful thinking that all has been well with a child whose behaviour has changed is often switched to a panic infused by the most lurid media accounts about drugs. This can lead to parents plunging into a response that has the opposite effect of what they dearly want by, for example, pushing their child closer to a peer group which regards drug use as cool. Where there is drug use, the best outcomes occur when the channels of communication are kept open. This requires reliable

---

37. Rodney Skager, "Drug education in a climate of zero tolerance: finding solutions versus minimising problems" in Richard Midford & Geoffrey Munro (eds.), *Drug education in schools: searching for the silver bullet* (IP Communications, Melbourne, 2006) pp. 166-90 at pp. 169-70 & 185.

38. Helen Cahill, "Devising classroom drug education programs" in Richard Midford & Geoffrey Munro (eds.), *Drug education in schools: searching for the silver bullet* (IP Communications, Melbourne, 2006) pp. 147-65 at p. 148.

information and understanding which do not thrive in a climate of exaggeration and panic.

**Recommendation 11:**

Anti-drug media campaigns should:

(a) be carefully designed so as to have the desired impact on the target audience and not be shaped by what may seem convincing to those not in that audience; and

(b) not cause parents to panic or otherwise react in ways damaging to the well-being of their children who may use drugs.

**Media influence**

67. The influence of the mass media is pervasive. The extent to which it is a harmful influence is itself a matter of concern but whether an influence for good or ill, parents feel themselves singularly powerless in its presence. In the final resort it must lie with government to limit the media's harmful influence. Families and Friends for Drug Law Reform is aware of debate about the extent that the mass media influences young people to use illicit drugs.[39] It would welcome research in this area but believes that the role of media in the promotion of alcohol is probably of greater concern to parents.

68. The use of the term "party drug" which has arisen in hearings of the Committee is criticised as according an alluring image to synthetic drugs like ecstasy. This may be so and against that possibility Families and Friends for Drug Law Reform would favour a neutral term. At the same time, it should be pointed out that the term has long been used by researchers as an informative description of a group of drugs on account of the ambience in which their use was associated. For some seven years surveys have been conducted of "party drugs". These are "considered to include any drugs that are routinely used in the context of entertainment venues, such as nightclubs or dance parties but not already monitored by the main [Illicit Drugs Reporting System]." The first pilot surveys were funded in June 2000 by the National Drug Law Enforcement Research Fund.[40] In the light of this history, the use by the media of the term "party drug" as a convenient description cannot be regarded as a cardinal sin even if now better avoided. Of far greater

---

39. Phyll Dance, Alexander I. Strachan, Peter Deane & Gabriele Bammer, *Monograph No. 12: Popular culture and the prevention of illicit drug use: A pilot study of popular music and the acceptability of drugs* DPMP Monograph Series (Turning Point Alcohol and Drug Centre, Fitzroy, December 2005) pp. 2-5 at http://www.dpmp.unsw.edu.au/DPMPWeb.nsf/-resources/DPMP+Monographs3/$file/DPMP+MONO+12.pdf .

40. Marie Longo, Rachel Humeniuk, Libby Topp, Catherine McGregor, Richard Cooke, Robert Ali, & Suhee Shimamoto, *SA Party Drug Trends 2000: Findings from the Illicit Drug Reporting System (IDRS) Party Drugs Module* (Technical report no. 115, National Drug and Alcohol Research Centre, Sydney, 2001) p. 1.



.

potential concern is the extent of reference to illicit drugs (and other substances) in popular films and music. Of the most popular home video rentals and music recordings in the United States of 1996 and 1997, 22 percent of movies and 18 percent of songs depicted or included references to illicit drugs.[41] This entertainment is distributed principally through commercial media.

### Prevention alone does not promote well-being

69. In summary, a drug policy focusing on prevention at the expense of other elements does not promote well-being. Prevention alone leaves nothing for those for whom prevention has not worked – for the young people involved and their families. In fact fostering a myth that prevention in all circumstances should be possible would intensify the guilt and shame that so many families caught up in drug use already feel and which weakens the capacity of the drug user to get his or her life back in order and the capacity of the family to provide crucial assistance in that process.

70. The facts are clear that a significant proportion of young people within the normal range of personality types are at high risk of using drugs. These young Australians should not be sacrificed at the alter of a false belief that being tough on them will somehow reduce the ready supply of illicit drugs that governments have been unable to control by other means. As we discussed above at page 11, there is considerable evidence that measures that reduce the harm to drug users and their families do not promote drug use. A prevention only drug policy can be justified only by a moral position that relegates life and well-being to second position behind being drug free and disregards the obligation to be open to the truth.

## IV. ALL ILLICIT DRUGS ARE NOT EQUALLY DANGEROUS

71. One hears from ministers statements that might be taken to assert that all illicit drugs and methods and patterns of drug use are equally dangerous. For example, according to the Prime Minister:

> "There is no safe level of marijuana use, there is no safe level of the use of any kind of illicit drugs and the clearer that message can be communicated the better . . . ."[42]

72. This statement is probably correct in that there is no doubt always some risk in using a drug even once. It is clear, though, that the risks posed by different drugs and by different methods and patterns of use vary greatly. In that sense, all illicit drugs are not equally dangerous. This needs to be made clear if the harms of drug use are to be minimised. A belief that all illicit drugs are equally dangerous paralyses responses that would save lives, prevent serious diseases and restore stability to chaotic lives. The obstacles that stands in the way of admitting degrees of danger are

---

41. United States, Office of National Drug Control Policy, *Substance Use in Popular Movies and Music,* National Youth Anti-Drug Media Campaign at http://www.mediacampaign.org/publications/movies/movie_partV.html.

42. Transcript of speech by Prime Minister at http://www.pm.gov.au/media/-Speech/2004/speech672.cfm.

lack of knowledge or the moral position that puts being drug free in front of the protection of life and promotion of well-being.

73. A lot of work is being put into classifying the relative harm of drugs both legal and illicit. A report by British experts published in *The Lancet* this month ranks 20 legal and illicit drugs according to their harm measured. It does so under three parameters: physical harm, dependence and social harm.[43] The study ranked them in the following order of harmfulness with the most harmful first:

1. Heroin
2. Cocaine
3. Barbiturates
4. Street methadone
5. Alcohol
6. Ketamine
7. Benzodiazapines
8. Amphetamine
9. Tobacco
10. Buprenorphine
11. Cannabis
12. Solvents
13. 4-MTA
14. LSD
15. Methylphenidate
16. Anabolic Steroids
17. GHB
18. Ecstasy
19. Alkyl nitrates
20. Khat

74. Unfortunately the study, being based on common drugs in Britain, did not seem to rank methamphetamine. Methamphetamine is more dangerous than amphetamine which is included in the survey.

75. From a ranking such as this it is clear that different strategies need to be devised for different drugs, that great improvements could be expected if people could be moved from the consumption of a more dangerous drug to a less dangerous one. Doing this is not to give up dissuading drug uses from consuming any harmful substance: it is giving first priority to their life and their well-being and the well-being of those dependent on them.

76. Someone who binges on 86% pure crystal methamphetamine and is in grave danger of developing a schizophrenia-like psychosis would be far better off using 10% pure methamphetamine powder. The dangers to mental health from the stimulant methamphetamine with its moreish attraction are probably higher than from cannabis. *The Lancet* study ranked cannabis low for physical harm but

43. David Nutt, Leslie A King, William Saulsbury, Colin Blakemore, "Development of a rational scale to assess the harm of drugs of potential misuse" in *The Lancet,* vol 369 pp. 1,047-53 (24 March 2007) at www.thelancet.com.



.

somewhat higher for dependence and harm to family and community.[44] According to the study on cannabis of the Australian National Council on Drugs, if there is a link to schizophrenia it is not large for those not otherwise predisposed to that illness ("rates of schizophrenia in the Australian population have remained stationary or have decreased despite rising levels of cannabis use"). Use of it does entail a moderate risk of later depression. It is unlikely that cannabis causes anxiety or leads to aggression, violence or other mental disorders.[45] Ecstasy, to take another drug, would seem to be less dangerous than either methamphetamine or cannabis. *The Lancet* study found that:

> "Many of the drugs were consistent in their ranking across the three categories [of physical harm, dependence and social harm]. Heroin, cocaine, barbiturates, and street methadone were in the top five places for all categories of harm, whereas khat, alkyl-nitrites, and ecstasy were in the bottom five places for all."[46]

77. A step to promote well-being would therefore probably involve seeing that users of ecstasy had access to pills that had only ecstasy as an active ingredient rather than more dangerous drugs like methamphetamine as they commonly do.

**Recommendation 12:**

Drug policy should:

(a) reflect the fact that some illicit drugs are more dangerous than others and that some methods of ingestion are more dangerous than others;

(b) influence drug users to use less harmful substances or ingest them by less harmful means.

## V. EMPOWERMENT AND SUPPORT OF FAMILIES

78. Disempowerment also runs through the drug using experience. The first instinct of the family who got to know of their son's heroin use only when they learnt he had overdosed was to enfold him to them. Whatever he had done, he was their son and dear to them. He needed help but what? They did not know. The situation was taken out of their hands. They were not permitted to be in the ward with him. The family felt helpless and bereft.

79. Other families will have more time. Desperately they will try to arrange a scarce treatment place for their child and, having found one, they will use every trick they can think of to coax and cajole their child to take up that place. If they have the money and even if they do not they may be prepared to outlay $10,000 or more for

---

44. *Ibid.*, p. 1,051

45. Jan Copeland, Saul Gerber and Wendy Swift, *Evidence-based answer to cannabis questions: a review of the literature: a report prepared for the Australian national Council on Drugs, December 2004* (Australian National Council on Drugs, Canberra, 2006) pp. 26 & 28-30.

46. Nutt et al., *op. cit*., fn 43 at p. 1,051.

treatment in a private clinic. The child may make some progress but the typical experience is for him or her to relapse. The parents will soon see themselves in an endless dark night. Their dreams are in pieces. Nothing seems to work. This is supported by advice they receive that they should put their child out of mind and get on with their own life for it is up to the user and user alone to make a difference. Parents must be prepared for their child to hit rock bottom for that alone is likely to bring him to his senses.

> "Shock, dismay, confusion and panic seem to reign as the family attempts to come to terms with the discovery [of a member's drug use]. The family tries to contain the problem within the family while at the same time seeking solutions to a problem they are relatively naïve about. This only serves to create a great deal of stress, conflict and disturbance between family members. 'For most, if not all, families it was an event of such deep significance that it completely and forever changes the family and its sense of itself'."[47]

80. The addicted drug users will see things a bit differently to the parents but not that much. Whatever the reasons are that led them to take up the drug, it will be very difficult for them to give it up. The continual struggles that many make to break their habit is heroic. For all too many, the string of failures and the breakings of faith with themselves, their families and others leads them to despair and suicide.

81. Drug policy should be about empowering people: empowering dependent drug users and their families to take back control of their lives as invariably they want to do. This may be through securing a scarce place in an abstinence-based therapeutic community or a twelve step program with Al-Anon. It may be through having the opportunity to enrol in a buprenorphine program not just once but after each relapse that followed a wrestle with a psychiatric condition or social problems. It may involve the families even supporting their family member for a time in continued illicit drug use in order to address another serious problem of his or hers which they judge to have priority. Families must be given the options that enables their drug using member to regain stability and promote the well-being of all.

**Recommendation 13:**

> Drug policies should empower families to make choices that best promote the well-being of their family members.

### Irreconcilability of illicit drug and alcohol policies

82. If illicit drug policy disempowers families so does the liberal, *laissez faire* policy that government pursues regarding alcohol. Under this policy the Government gives primacy to commercial interests and washes its hands of responsibility for the enormous harm that alcohol is causing to children. *The Lancet* study found that "alcohol and tobacco are both in the top ten, higher-harm group". The authors observed:

---

47. Oreo & Ozgul, *op. cit.,* fn 3 at p. 72.



.

> "Our results also emphasise that the exclusion of alcohol and tobacco from [drugs legislation] is, from a scientific perspective, arbitrary. We saw no clear distinction between socially acceptable and illicit substances. The fact that the two most widely used legal drugs lie in the upper half of the ranking of harm is surely important information that should be taken into account in public debate on illegal drug use. Discussions based on a formal assessment of harm rather than on prejudice and assumptions might help society to engage in a more rational debate about the relative risks and harms of drugs."[48]

83. In December 2004, the then Parliamentary Secretary for Health and Ageing, Mr Christopher Pyne, put forward libertarian arguments 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."[49]

84. It is impossible to reconcile the Government's illicit drugs and alcohol policies. Both disempower parents. In one case, policy eliminates choices that would promote the well-being of young people who have become entangled with the illicit substances that the Government has purported to protect them from. In the case of alcohol, the Government policy tells parents that it is all up to them to resist the enormous and pervasive influence of alcohol promotion on their children. It is hard to imagine a clearer example of policies based on irreconcilable philosophical principles. Promotion of the well-being of young people should be the overriding objective in both cases.

28 March 2007

---

48. Nutt et al., *op. cit*., fn 43 at p. 1,052.

49. Christopher Pyne, "Teenage drinking - Who is responsible?" in *ADCA news*, issue no. 24, March 2005, p. 8.

**APPENDIX**

## CONSEQUENCES IF HARM REDUCTION IS DISCONTINUED

The following are likely consequences that would flow from the elimination of the harm reduction component of the *National Drug Strategy*:

- *Discontinue needle and syringe program* – increase in blood born viruses in the general population, possibly to epidemic proportions and a significant increase in health care costs,
- *Cease safe using messages* – users using in unsafe ways leading to increased calls on health care services, possibly death,
- *Cease drug use related counselling* – continuing use of drugs, possibly death,
- *Cease detoxification* – continued use of drugs, increased call on health care services, possibly death,
- *Cease emergency health services for drug use* – overdose sequelae and probably death,
- *Discontinue medically supervised injecting facilities* – no supervision of drug using episodes, no advice on safer practices, no referral to other support services, increased blood born viruses, overdoses, possible deaths
- *Discontinue pill testing* – no knowledge of content or quality of drug, consumption of drug of unknown composition, adverse reactions to drug, possible health consequences, possible death,
- *Cease addiction pharmacotherapy programs* – continued use of illicit drugs, increased profit for drug dealers, consequences flowing from long term use of illicit drugs, increased health care costs, possible death,
- *No early warning systems for strong or adulterated batches of drugs* – increased overdoses, increased call on emergency health services, possible increase in overdose deaths,
- *Police commence to again attend overdoses when ambulances are called* – friends of users who overdose would be afraid to call for help because they may become implicated, possible deaths or other long term health consequences,
- *Repercussions for families* who have to continue to deal with a drug using family member without support and help, including financial costs and poverty, social costs (including more family disintegration, stigmatisation, loss of friends and support networks, intergenerational drug use) personal health costs (including poorer nutrition, the greater possibility of acquiring a blood born virus, intensification of mental health problems),
- *Repercussions for society* including increased crime and corruption, violence associated with "drug turf wars" and with drug debt collection, and spread of blood borne viruses.



.