Submission of
Families and Friends for Drug Law Reform
to the INQUIRY INTO
of the Road and Community Safety Committee of the
Parliament of Victoria
into
DRUG LAW REFORM

ANNEX B

Social impacts of drug criminalizing drug use and possession

Better drug policy productive of a better world

by

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1. This paper argues that reform of drug policy holds out the prospect of widespread improvement of many entrenched and intractable social problems and that it has the capacity to do so at a fraction of the cost and effort of other interventions. Existing drug policy is costly and ineffective. Reform should be politically attractive because it is likely to ameliorate a wide range of social problems at no net cost to budgets. Indeed it may even save money and reap these benefits within an electoral term.

2. The influence of drug use and drug policy on social problems and the influence of those social problems on drug use is bidirectional. That is to say, dependency on illicit drugs is generally (though no always) influenced by risk factors such as poor health, poverty and crime commonly associated with disadvantage. Acquisition of a drug dependency is itself a risk factor for the acquisition of additional risk factors of disadvantage and drug dependency will aggravate or compound such factors. The paper postulates that this is bidirectional influence occurs not just between drug use and other social problems but that drug policy itself has a substantial influence in terms of both illicit drug use and associated social problems. In other words those problems, including drug use itself, are aggravated by policy responses designed to prevent and combat illicit drug use.

3. While it is generally recognised that there is a close association between drug abuse and disadvantage, the link between drug policy and disadvantage has not received the attention that it deserves. The paper begins by describing how drug policy has been largely ignored as a driver of disadvantage. It then sketches the close correlation between drug use and other social problems. It makes the point that abuse of illicit substances is widely recognised as a potent risk factor of virtually all of Australia's most intense pockets of disadvantage and intractable social problem. This paper argues that much or most of the harm associated with abuse of illicit substances can be attributed more to drug policy than to the substances themselves in that the subjection of drug users to the processes of the criminal law disconnects them from their family, their friends, their work and society. The potent influence of this disconnection is indicated by the extent that the reconnection is greatly facilitated in jurisdictions where drug users are not marginalised as criminals.

4. The paper argues that drug policy is a potent influence on social problems and impedes the development of social capital. Of particular relevance are the pathways by which young people of typical personality types from unproblematic backgrounds are at high risk of trying drugs. Indeed, the paper describes how our current drug policy not only completely fails to keep drugs away from young people but actually facilitates and stimulates the supply of drugs and thus fosters drug abuse. People with few environmental or other risk factors are at risk of trying illicit drugs. Of these a small proportion will develop a drug dependency

and intensify their risk of becoming severely disadvantaged. Those who develop a drug dependency are themselves likely to transmit risk factors for disadvantage and drug abuse to their own children and others dependent upon them. In this way drug abuse as fostered by drug policy becomes an initiator and perpetuator of intergenerational disadvantage. These processes are then illustrated by reference to the experience of homelessness. After that the paper argues that discarding the criminal law as the principal element of drug policy can serve as a circuit breaker to remediate social disadvantage and enhance social capital. The last section of the paper sketches some of the striking benefits reaped by countries that have taken this course.

Failure to take account of drug policy as a driver of disadvantage

5. Civil society organisations with a broad interest in ameliorating disadvantage and fostering social capital have typically paid little or no attention to the scope for drug law reform to promote their objectives. The field of drug policy has been left to those who focus upon crime, prisons and health and within each of these domains interest in drug policy is restricted to a few criminologists, a still small number of specialists in addiction medicine and blood borne viruses and a larger community of drug treatment workers. It is particularly surprising that the mental health professions pay so little attention to drug policy. Addiction is a recognised mental health condition and those with common mental health conditions like depression and anxiety are at a particularly high risk of developing a substance dependency. This is only the start.

6. Drug users, having been caught by the police, then stressed by the coercive processes of the criminal law, notably arrest, incurring fines and possibly even imprisonment. This stress typically aggravates existing mental health problems and precipitates others where they did not exist. Indeed the crossover between substance dependency and other mental health conditions is so common that the Senate Select Committee on Mental Health reported in 2006 that the combination of substance dependency and other mental health conditions is the expectation rather than the exception (SENATE 2006, Chapt .14).

7. This paper argues that this narrow focus marginalises the issue of drug policy and that councils of social service and other civil society organisations with a focus on disadvantage should pay close attention to the capacity of better drug policy to ameliorate much entrenched disadvantage.

Correlation between drug use and other social problems

8. Abuse of illicit substances is widely recognised as a potent risk factor of virtually all of Australia's most intense pockets of disadvantage and intractable social problems. The examples include homelessness discussed in a later section.

Child abuse and neglect:

9. “Families in which alcohol or other drug use is present are more likely to come to the attention of child protection services, more likely to be reported, more likely to have children removed from their care, and more likely to have them remain in out-of-home care for long periods of time, than are families with the same characteristics but not substance use” (Taplin & Mattick (2011) p. 6).

10. Results from a Child Welfare League of America survey of ten American States conducted in 1991 found that 36.8 per cent of children (11 834) serviced by State welfare agencies and 57.4 per cent of children (64 200) served by voluntary child and protective services were affected by problems associated with alcohol and other drug use (Dawe *et al.* 2007, p. 10).

11. Children and young people in families affected by drug dependence also face many challenges to their health and well-being. Child abuse and neglect, and the experiences of young people in the care and protection system, clearly have serious implications for present and future health. (ACTCOSS 2003, p.48).

School dropout

12. In the words of Prof. David Penington: "I was simply appalled at the Prime Minister's statement praising PLC (Pymble Ladies College) in Sydney for expelling nine girls for allegedly handling marijuana. We know a large number of those girls in that school will have used it, and to say that expulsion is part of the solution is fundamentally wrong. One of the risk factors of going to heroin is leaving school early, or having been dismissed from school early. We've got political leadership not willing to listen to the facts" (Prof. David Penington quoted in *The Age* (Melb) 1st Edition Friday 28 May, 1999 pp. A16-A17). Even so, current Education Department guidelines for NSW public schools mandate immediate suspension and referral to the police. “Suspension is to occur immediately if the substance is being represented by the student as an illegal substance, or on confirmation that the substance is, in fact, illegal" (NSW DOEC 2015).

13. Use and other involvement with illicit drugs are significant reasons for suspension and dropout from schools. In 2012 749 students were suspended for up to 20 days for “Possession or use of a suspected illegal substance.” These suspensions do not include drug dealing. Anecdotal evidence suggests that a significant proportion of the 8,692 students who were suspended for “Serious criminal behaviour related to the school” were participating in the distribution of drugs to their peers. Adolescents are attracted to this by the ready money. Most suspensions occur to students in years 7 to 10 (NSW DOEC 2013).

A study of school dropout across the United States found that “prior use of cigarettes, marijuana, and other illicit drugs increases the propensity to drop out and the earlier the initiation into drugs, the greater the probability of premature school leaving." (Mensch & Kandel).

Delinquency and imprisonment

14. It is widely recognised that the criminalisation of possession of drugs for personal use causes crime. Desperate dependent drug users often engage in crime when under the influence of drugs or to secure the wherewithal to purchase their drugs. If, as they often are, suffering from another mental health condition, that condition will be compounded if they end up in prison. On reception, some 64% have a substance use disorder (Butler & Allnutt 2003, table 3, p. 14). The conviction and prison regime will intensify the isolation from work, housing, family and society and generally render them less capable of making their way in society when they are released (similarly Homel 1999, p. 134).

Blood-borne viruses

15. "Routine HCV notification data, and the survey of antenatal patients, indicate that around 80% of prevalent HCV infections have occurred through injecting drug use. Recent studies of incident HCV notifications since 1995 indicate that of those cases where the transmission route was determined, the proportion of incident HCV infections due to injecting drug use was even higher, at around 90% (MACASHH 2006 p. 7).

Poor physical and mental health

16. "Substance use disorders (which include harmful use and dependence on alcohol or other drugs) typically involve impaired control over the use of alcohol or other drugs. Obtaining, using and recovering from alcohol or drugs consumes a disproportionate amount of the user's time, and the user continues to drink alcohol or take drugs in the face of problems that they know to be caused by them. They typically become tolerant to the effects of alcohol or drugs, requiring larger doses to achieve the desired psychological effect, and abrupt cessation of use often produces a withdrawal syndrome. Many experience other psychological and physical health problems, and their alcohol or drug use often adversely affects the lives of their spouses, children, and other family members, friends and work-mates" (Teesson & Burns 2001, p. 101 & similarly DHAC 2000, 16).

Suicide

17. The Bureau of Statistics has pointed out in a recent release on causes of death in Australia that accidental poisonings including drug overdoses are among the leading causes of death for the youngest cohort (ABS 2016):

"'The link between drug and alcohol abuse has been identified as a significant risk factor in suicide, this is particularly unsettling for a country battling with alcohol binge drinking and recreational and prescription drug abuse problems.' . . . Ryan McGlaughlin, CEO of Suicide Prevention Australia added 'The research suggests that the risk of suicide among drug users is between four and fourteen times that of the general population; due to the effects of drug abuse on psychological, social and health factors'" (SPA 2011).

The potent association between drug use and suicide is confirmed in a meta analysis of 64 studies. The analysis published in the reputable peer reviewed journal, *Drug and Alcohol Dependence* utilised the statistical concept of standardized mortality ratios that reveal the extent to which death in a study population exceeds the rate of the population at large:

> " . . . standardized mortality ratio (SMR) is a relative index of mortality, expressing the mortality experience of a given study population relative to that of a comparison ("standard") population. In this study, the SMRs were used to estimate whether risk for suicide among those with specific alcohol or drug use disorders were at greater risk than expected in the general population. SMRs were calculated by dividing the observed number of suicides by the expected number of suicides and multiplying by 100, in order to yield results without decimals as . . . " (Wilcox *et al.* 2004, p. S13).

1. The meta-analysis showed that while Alcohol use disorder was a high risk factor for suicide, it was far exceeded by risk factors associated with the consumption of illicit drugs. Someone with an alcohol use disorder was almost 10 times more likely to attempt suicide than a member of the community at large (being just a heavy drinker raises one's risk of suicide by 3.5 times), the risk factor for those with an opioid use disorder were 13 more times more likely, intravenous drug users were between 13 and 14 times more likely and mixed drug users (those we would refer to as polydrug users) an astounding 16 to 17 times more likely (Wilcox *et al.* 2004).

Drug use and dependency by children brought up in drug using families

18. In a study exploring homeless young peoples' reasons for leaving home "just over one-quarter of these young people (26%, n = 28, 16 young women; 12 young men) attributed their homelessness to the drug and alcohol use of a family member. Almost all of these young people were using drugs and/or alcohol to varying degrees prior to leaving home and among these 16 indicated that their personal drug and alcohol use contributed to their homelessness. However all of these young people believed that it was their family member(s)' drug and alcohol use and not their own that was the primary reason they left home. Several young people specifically indicated that they began their use of drug and alcohol in response to their parent(s) use" (Mallett, Rosenthal & Keys 2005, p 194). "The Australian Drug Foundation and the Australasian Society of HIV Medicine [have] both noted, [that] many drug users have experienced family breakdown problems" (HofR 2007, §10.10, p. 296 and similarly Mitchell *et al* (2001) pp. 14-15),

Family breakdown:

19. Eight organisations providing family services gave evidence to a House of Representatives *Inquiry into aspects of family services* "that marriages often break down largely as a result of problems associated with alcohol, drugs and

gambling. Apart from the economic drain they cause, such addictive behaviours often bring associated problems of domestic violence" (HofR 2008 p. 55).

Indigenous disadvantage:

20. "Around 23% of Indigenous students aged between 12 and 15 years indicated that they had used any of cannabis, hallucinogens, amphetamines, cocaine, opiates or ecstasy in their lifetime. Lifetime use of any illicit substance was more common among the Indigenous students than for the students in the main [Australian Secondary Students Alcohol and Drug Survey] (ASSAD) sample" (Smith & White 2010, p.3)

Poverty, welfare dependency and unemployment:

21. Illicit drugs like alcohol are introductions from an alien world to indigenous society – a society that is already under enormous stress from alienation dispossession and suppression of culture. It is therefore unsurprising that drug abuse wreaks intends having in indigenous communities and compounds their intense disadvantage. "The variables most studied and reported as characterizing substance-abusing families are the confluence of conditions such as low income/poverty, unemployment, low maternal education and unstable accommodation. For many families, poverty is said to predate drug use. Families typically reside in communities that have been impacted by long-term unemployment and intergenerational educational disadvantage where drug availability and opportunities for exposure to alcohol and illicit drugs are high" (Dawe *et al*., 2007, p. 49).

22. Illicit drugs like alcohol are introductions from an alien world to indigenous society – a society that is already under enormous stress from alienation, dispossession and suppression of culture. A most vivid and moving account of the level of harm associated with indigenous drug abuse was delivered in an address by Douglas Walker, a Senior Aboriginal man from Oodnadatta, to a national families and community conference on drugs in 2000:

> " . . . my story that I would like to share with you is the story of my family tree. My family tree was like the old desert oak. In the desert the old desert oak is very strong, very tall, it has a lot of branches and the wind and storm come along and try and blow it away but it still stands and the leaves are still green and very strong.
>
> Today, when I look at that family tree, that old desert oak, it is old, the branches have fallen, there are not many leaves on the family tree and so when I talk about my family system I talk about the family tree. There is nothing much left - there are no leaves. Where the leaves were there are crosses. Something similar to what Isabel has shown you.
>
> Our family has too many funerals - too many funerals. You go back home and you have a death in the family. The following day, while you are still grieving, you hear of another death and the sad thing is that they are mostly young people, very very young people, similar to your family, your

> sons and your daughters and your nieces and nephews or your grandchildren.
>
> Some of you spoke yesterday. I heard you talk about losing a loved one, but your family tree is still strong like the old desert oak, still got plenty of leaves. Maybe only one leaf is missing, of your loved one. But my family tree is dying. The branches are all gone, the leaves are all gone, so what I am doing today is just like you. I am on a journey of recovery and my journey is looking at your world and my world because what has happened is that we went away from our world and we lived in your world but we found that your world, if we didn't know how to live in it, would kill us.
>
> The thing that is killing us in your world is alcoholism and drugs because it is not part of my family structure. My grandfathers and his grandfathers and their grandfathers never drank, never smoked. They had a value system. I am not saying that we should not live in your world. What I am saying is that we all can live together but our journey of recovery has already crossed over and we need to sit down and hear my people's voice, as the theme of your two day conference is "voices to be heard". We need to talk out loud" (McConnell & Trimingham 2001, pp. 37-38).

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23. This is not the place to do an encyclopaedic survey of the links between drug policy and all these issues. I will use homelessness to illustrate the interconnection of risk factors and, particularly, the cumulative influence of mental illness and substance abuse.

Young people and risk of drug use

24. 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, 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 (Mitchell *et al* (2001) pp. 3-9 & 13-15). The accumulation of many factors 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 drug use associated with problems 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.

25. 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 or 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).

26. Research carried out for the Government, from which the following account is drawn, revealed that illicit drugs were potentially attractive to a wide range of young people of normal personality types (Blue Moon Research & Planning pp. 1-30 esp. pp. 27-29). There are those with an outward looking personality and those who tend to be inward looking. A proportion of both these normal personality types are at risk of getting into trouble with drugs.

27. Outward looking young people tended to be more extrovert, positive and confident in their approach to life. They are typically more independent and emotionally stable. Those who tend to look inwards are “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 do so.

28 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 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.

29. 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 termed “Cocooned Rejectors” “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.”

30. 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.” While in this group “the incidence of trial of most drugs is lower than for the Thrill Seekers, . . . they tend to use them more heavily. This group has the highest level of trial of heroin. They tend to be male and living alone or with peer group. The heaviest drug users were likely to come from these two groups.”

31. 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”.

32. 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 drugs are qualities that are generally admired.

33. The point that drug use can be a problem in any family is also expressed in a Commonwealth Tough on Drugs booklet for parents issued by the Howard Government: *Our strongest defence against the drug problem . . .*(Abetz (2001) 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.
> - To experience a high or a rush.”

34. These conclusions are supported by answers to household survey questions on why people first used illicit drugs. It is clear from the following table 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.

Table 5.27: Factors influencing first illicit use of a drug, lifetime users aged 14 years or older, by age, 2013 (per cent)

Factor	14–19	20–29	30–39	40+	14+	18+	Recent user[(a)]	Ex-user
Friends or family member were using it/offered by friend or family member	44.4	51.3	52.5	51.6	51.4	51.7	51.2	51.5
Thought it would improve mood/to stop feeling unhappy	19.2	8.7	6.7	5.1	7.1	6.7	11.9	4.1
To do something exciting	32.4	23.2	21.4	14.3	19.2	18.9	26.8	14.6
To see what it was like/curiosity	72.2	69.1	69.2	62.2	66.2	66.1	67.0	65.8
To enhance an experience	16.3	16.8	14.9	10.0	13.3	13.3	22.1	7.8
Other	*4.4	4.2	2.8	3.0	3.3	3.3	5.3	2.0

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

(a) Used in the previous 12 months.

Notes

1. Base is those who have illicitly used at least 1 of 17 drugs in their lifetime.

2. Respondents could select more than one response.

SOURCE: National Drug Strategy Household Survey detailed report: 2013, Additional material, Supplementary tables, Illicit drug tables (423KB XLS) 2 at http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549638 visited 11/10/2015.

Drug policy as a facilitator and stimulant of drug abuse

35. The focus of this paper is the social harm and disadvantage brought about by drug policy rather than the details of the coercive processes of the criminal law on which it purportedly relies for its efficacy. This criminal law foundation is the traditional focus of attention of drug law reformers and is the reason why those focusing on social welfare are inclined to leave to others consideration of drug policy. There are few if any drug users, much less parents and other family members, who regard drug dependency as anything other than a blight on their life. From that perspective any questioning of the banning of a harmful drug is counter intuitive. A central thesis of this paper is that that assumption must be questioned. This paper argues for consideration of unintended harmful impacts of our current drug policy. In doing so, it is not possible to avoid consideration of why criminal prohibition fails to restrict the supply of illicit substances and indeed, as this paper contends, promote their availability.

36. A daunting aspect of the drug problem is the size of the drug trade. The United Nations Office on Drugs and Crime (UNODC) has estimated that each year the world trade is worth many hundreds of billions of dollars (UNODC 2005) and the Australian Crime Commission has recently estimated the annual cost to the Australian economy of serious and organised drug crime to be $4.4 billion (ACC 2015c p.8), to which must be added response and prevention costs. The trade in Australia explains why illegal addictive substances are so readily available to young people. The challenging truth is that drug law enforcement serves to stimulate rather than suppress the trade. The reasons it does so are:

- Firstly: Law enforcement encourages the direct peer-to-peer pyramid marketing system at the heart of the retail trade generally involving networks of friends and acquaintances. Peer to peer marketing is extraordinarily persuasive, resilient, efficient and resistant to police penetration. Dr John Marks, who ran a clinic prescribing heroin in Liverpool, remarked in the following terms upon the motivation of drug users to sell: "insurance companies would love to have salesmen like drug addicts." (Hari p. 213);
- Secondly: much of the drug trade exists under the radar because there is no typical self-perceived victim in a crime of drug dealing: both the purchaser and the seller have a strong interest in keeping the transaction confidential. Like corruption and in contrast to the victims of most crimes, those engaged in drug dealing are unlikely to report the offence;
- Thirdly: The profit reaped by high level drug dealers is in the realm of many hundreds percent. An ecstacy pill manufactured for 2 cents might sell on the streets for between $25 and $50 (IDDR 2013-14, table 56). Cutting off a legal supply of drugs to a population of existing dependent users leaves a vacuum that criminals immediately fill. This occurred in the United States a hundred years ago when those who had developed a heroin dependency as a result of medical treatment ceased to be able to secure a supply from doctors and, after the closure of opium dens in Pakistan and elsewhere in South East Asia (Seccombe 1995 &

McCoy 2003). Indeed there exists a record of a Californian drug dealer bribing officials to close down a clinic in California. "The man who launched the drug crackdown in California did it because he was paid to – by the drug dealers themselves" (Hari 2015, p. 40). One needs to be aware of the possibility that not all voices calling for the perseverance and intensification of drug law enforcement will be motivated by a sincere wish to reduce drug use.

- Fourthly: the drug trade is resistant to any significant level of penetration by law enforcement. The very high profit margins allow criminal enterprises to outspend law enforcement agencies in hiding their tracks and facilitating their trade by money laundering, corruption and violence to intimidate businesses (ACC 2015c, pp. 8 & 9);
- Fifthly: There is an endless supply of middle level dealers prepared to run the risk of apprehension in return for the high profits. In the words of a former Tasmanian police commissioner and member of the Board of the Australian Bureau of Criminal Intelligence:

> “I don't think [police action is] having any effect on the supply in Australia. I think that what we do quite regularly when we catch some of the Mr Bigs is that we make life much easier for some of the other Mr Bigs who haven't been prosecuted and caught. We've put their competition in prison and left the world open for them and they're extremely difficult to catch and they go on with their business . . . .” (APGDLR 1997).

The addicted user who deals to feed a habit is the disposable bottom layer of the distribution pyramid, the cannon fodder of the drug war. At most, local policing merely displaces the market.

- Sixthly: For a deterrence to be effective, it should be swift and certain. Drug law enforcement is neither (Kleiman, 2009). Based on the most recent Australian usage and arrest rates, less than a 2% chance of ever being caught;
- Seventhly: The impact that police seek to have on the drug market works to the benefit of drug dealers: Drug law enforcement works to raise the price of drugs and thus, it is hoped, place drugs beyond the reach of users; but higher prices also raise the profit margin for drug suppliers who are better able to invest in measures to hide their tracks. Money laundering, violence and corruption thus support and conceal “serious and organised activity” (ACC 2015c p. 5).
- Eighthly: raising the price of drugs, far from moderating demand and thus supply, serves as an incentive to supply. The Australian Crime Commission is well aware that profit attracts further supply: “ . . . the price paid for methylamphetamine in Australia is among the highest in the world, making the importation of the drug and its precursor chemicals an attractive target for transnational crime groups” (ACC 2015a, p.3);
- Ninthly: The demand for addictive substances by those dependent upon them is relatively insensitive to price so that the effort of drug law enforcement to raise the price of drugs does little to dampen demand;

- Tenthly: The forbidden fruit aspect of illicit drugs is a marketing attraction as well as a deterrence. As we have seen, surveys show that many people initiate drug use because it involves doing “something exciting” or “cool”;
- Eleventhly: Others try drugs to avoid pain or, in the words of the household survey, to “improve [their] mood/to stop feeling unhappy” – This is a form of self medication combating unhappiness or social awkwardness;

37. These are the reasons why one would expect that drug law enforcement would be ineffective but has it actually been so? Market indicators of level of use, availability, price and purity confirm the ineffectiveness of drug law enforcement (FFDLR 2005 & FFDLR 2006). In the case of crystal methamphetamine, this is shown by the following recent data (FFDLR 2016):

> *Level of use:* stable at around 2.1%. If law enforcement had been effective the level of use would have declined. Methamphetamine and amphetamine use has remained stable at about 2.1% since 1993 and there has been a recent doubling of the use of ice, its most potent form.
>
> *Availability:* consistently since 2003 some 60% or more of respondents were of the view that ice has been "very easy" or "easy" to obtain;
>
> *Price:* One would expect a rise in price to be a mark of success of drug law enforcement but in the most populous jurisdiction, New South Wales, the median retail price of ice has remained remarkably stable for the past 15 years at $50 a point (0.1 g) (IDRS NSW 2014, p. 47). In contrast, since about 2011, after 15 years of stability, elsewhere the median price per point of ice doubled (IDRS 2014 table F3 p. 161). This could well have resulted from market manipulation by suppliers to exercising their market power; and
>
> *Purity:* the surge in recent years in use of the purest form of methamphetamine, crystalline methamphetamine or ice, is strong evidence of the failure of supply reduction strategies.

Drug abuse as an initiator of intergenerational disadvantage

38. We have established that trying illicit drugs is attractive to a large proportion of normal young people without any of the risk factors associated with drug use. We have also explained that drug law enforcement, far from eliminating or even reducing supply of those drugs, stimulates their availability. The combination of these two phenomena has disastrous social consequences. Teenagers who have experienced through their families or social environment few risk factors may nevertheless be moved to seek the excitement or comfort that illicit drugs can be thought to bring. Most of those who try those drugs will cease using them as they grow older but a small proportion will become dependent on them. Those who do or who are unlucky enough to be among the few caught by the police, are likely to accumulate a set of risk factors that they would not otherwise acquire. They may, for example be expelled from school, thus truncating their education. In securing

their supply of drugs or while arrested or imprisoned they will find themselves mixing with a deviant criminal peer group. They may even be enticed to deal in drugs in order to finance their own supply. Their relationship with their families and "straight" friends" will be stretched to a breaking point. The net result of this is that their own children will probably grow up in an environment populated by many, many more risk factors than they did. Dependence on illicit drugs thus adds to the risk factors that make it more likely that adolescents will acquire a mental illness and engage in crime. Like a snowball, young people endowed with a surfeit of risk factors and paucity of protective factors are likely to acquire more and more risk factors as they roll through life. They are particularly at danger at points of transition such as leaving school and family breakup.

39. Risk factors involving use of illicit drugs and linked to child neglect and abuse are increasingly being amplified down generations. A downward spiral through generations can occur in the following way. Illicit drugs are potentially attractive to a wide range of young people of normal personality types without any particular additional risk factors (Blue Moon 2000). A small proportion of these will become addicted. Their own addiction will be a risk factor in itself and will also contribute to a larger set of risk factors for their own children not least of mental disorders because:

> (a) substance abuse by parents is a risk factor for adverse mental health outcomes during the infancy and childhood of children of these parents (DHAC 2000, pp. 49, 74).
>
> (b) substance abuse by children is a risk factor for other negative outcomes like school failure which amplify the risk of the children developing a mental disorder (DHAC 2000 p. 16).
>
> (c) Substantial substance abuse in a neighbourhood is a risk factor for violence and other crime in that neighbourhood which in turn amplifies the risk of those in the neighbourhood developing a mental disorder (DHAC 2000 p. 16).

40. In the first generation of drug using parents, it is likely that grandparents will be around to help out. A further generation on and there are likely to be more risk factors impinging on the children. In that second generation of drug using parents there are likely to be few protective factors such as the protective influence of grandparents able to provide support. This has long been a serious problem in the ACT. The then director of Marymead, an ACT family support service, said in 2001:

> "[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" (Mickleburgh 2001).

41. A 2004 Report to the ACT Government recognised and paid particular attention to this group.

> "Of particular relevance to this Review is the identification of a number of client groups requiring special attention, many of which also find themselves as clients of child protection services:

- families, the fastest growing group of clients, some of whom are experiencing second- and third-generation poverty, joblessness, homelessness and/or domestic violence as a result of inadequate interventions;
- accompanying children, many of whom have experienced trauma (such as witnessing domestic violence), live in insecure accommodation, and are enduring the effects of situational factors such as drug and alcohol use, problem gambling and mental health problems"(Vardon 2004 p.46)

42. It is patently clear, as this brief survey illustrates, that illicit drug use is intimately associated with child neglect and abuse either directly or through its known links to other potent risk factors for those harms.

A Case study: Homelessness and drug policy

43. So far this paper has sought to make the claim that in general terms drug policy is a driver of disadvantage and even of Australia's most intractable and costly chronic social problems. To illustrate the point, this study will now look in a little more detail at the relationship between drug policy and homelessness.

Features of the Homeless population

44. The Australian Institute of Health and Welfare, a Commonwealth White Paper on homelessness and Professor Vinson's studies of locational disadvantage in Australia all list poor physical or mental health and substance abuse as risk factors for homelessness.

45. As the Australian Institute of Health and Welfare points out, those who are homeless can be expected to experience a set of multiple disadvantages. "Homelessness," it declares, "is a complex issue, involving more than just a lack of housing. Factors in the life course of people that increase their risk of becoming or remaining homeless can include:

- Structural factors:
  - Poverty
  - Unemployment
  - Lack of affordable housing
- Personal circumstances:
  - Discrimination
  - Poor physical or mental health
  - Intellectual disability
  - Drug and alcohol abuse
  - Gambling
  - Family and relationship breakdown
  - Domestic violence
  - Physical and sexual abuse." (AIHW 2011).

46. The Commonwealth Government's white paper on homelessness makes the point that "Homelessness is not just a housing problem" (FAHCSIA, *Road Homes,* (2008) p. viii):

> "Many people who become homeless have struggled with considerable personal disadvantage throughout their lives. This may include poverty or long-term unemployment, poor education, violence, mental health problems, disability and substance abuse. For these people the path into homelessness, can start many years earlier.
>
> . . .
>
> "There is no single cause of homelessness. People at risk of homelessness typically face multiple difficulties. Underlying issues might include domestic and family violence, mental health problems, poverty or drug and alcohol addiction. Often, a single further pressure or event – job loss, eviction, poor health or relationship breakdown – can tip a person who is already vulnerable into homelessness.
>
> "People without support networks, skills or personal resilience, or who have limited capacity due to their age or disability, can quickly become homeless. Those with the least resources are likely to remain homeless longer. When a person becomes homeless, even briefly, the impact can be long-lasting.
>
> "There are four main pathways into homelessness:
>
> - Housing stress, often driven by poverty and accumulating debt
> - Family breakdown, particularly driven by domestic violence
> - Poor life transitions, particularly transitions out of the child protection system, prison or statutory care
> - Untreated mental health and substance use disorders that lead to the loss of housing, education, employment, family and other relationships" (Homelessness Taskforce (2008), pp. 6 & 24).

47. Professor Tony Vinson has grouped disadvantage or risk factors leading to homelessness and other problems under social distress, poor health, economic disadvantage, educational disadvantage and weak community engagement (Vinson (2007a)). Vinson points out that "the impacts on well-being when households are suffering housing stress [include] poor health, lower school performance, higher crime rates and unemployment" (Vinson (2007b) p.10).

48. There is a concordance between the foregoing risk factors for homelessness and the factors associated with drug abuse and delinquency (Mitchell *et al* (2001) pp. 14-15). Furthermore, these risk factors have feedback effects. Thus, poverty, including homelessness, and anomie are known social environmental risk factors for adolescent risky behaviours like illicit drug use.

Homelessness as a multiplier of other problems

49 Just as homelessness is a consequence of a range of earlier "problems", of "risk factors" or of "determinants" uncompensated for by "protective factors," so the experience of homelessness can intensify existing problems or precipitate new ones. In this way human beings can be caught up in a vortex of disadvantage that increasingly plays out in their own life and in the life of their children and others dependent on them. In this way, disadvantage is guaranteed to echo down generations. Two disadvantages commonly intensified or precipitated by homelessness are mental ill health and crime. It is to these that this paper will now briefly turn.

Homelessness and mental illness

50. Mental illness is much more common among homeless people than in the general community. A study of a large number of people in inner-City hostels in Sydney found that at least 75% had at least one significant mental health disorder. "A 1998 study reported that about 75% of homeless people contacted through inner-city hostels in Sydney had at least one significant mental disorder (as defined by formal diagnostic tests). The prevalence was higher for women (81%) than men (73%)." In contrast the expected prevalence rate in the Australian population of at least one mental disorder is just 18%. (Forell, McCarron & Schetzer 2005, p. 51). The Homelessness Task force noted that: "About one third of SAAP clients required intensive and/or ongoing assistance with mental health issues (Homelessness Taskforce 2008, p. 8). A British survey found ". . . a staggering 76% of interviewees who lived on the streets or in hostels, had some form of mental health problem –either diagnosed by a doctor (65%) or self identified (11%)" (St Mungo's 2009 p. 4).

> "Homelessness and inappropriate housing expose people with mental illness to a wide range of risk factors for their mental and physical health and wellbeing. These include violence and abuse, harmful alcohol and other drug use, poor nutrition and sleep, severe social isolation, lack of amenities for self-care, disease, and even exposure to the elements. All of these are major stressors that are highly likely to compromise mental and physical wellbeing and pose additional challenges for providing continuing care" (Rickwood 2005 p. 36).

51 Rickwood attributes the high coincidence of mental illness and homelessness in part at least to deinstitutionalisation of mental health services. "Of major concern is the level of homelessness experienced by people with mental illness. An unintended consequence of the deinstitutionalisation that has taken place over the period of the National Mental Health Strategy has been an increase in the number of people with mental illness who are homeless or inadequately housed. Data collated by the AIHW on supported accommodation programs show that mental illness, directly and indirectly, is a major contributor to homelessness" (Rickwood 2005, p. 36).

Substance dependence as a compounder of disadvantage of the homeless

52. The high level of mental health and other health problems among the primary homeless lead commentators to suggest that street homelessness should be viewed as a health rather than a bricks and mortar problem (St Mungo's 2009 p. 4). Society is indeed conflicted in how it should respond to primary homelessness: the law has it that a large proportion of rough sleepers are criminals. This is not so much because of the law on street offences (see Forell, McCarron & Schetzer 2005, pp. 108-09) but because of the high proportion of homeless people afflicted with a substance abuse disorder. It is noteworthy that the substances of greatest impact are not so much stereotypical alcohol as illicit drugs.

> " . . . Homeless people as a group are more likely to encounter the law than other groups because of their greater involvement in illicit drug taking. Further, their lack of financial resources may also mean that homeless people use illegal means to get sufficient money to support their addiction" (Forell, McCarron & Schetzer 2005, p. 111)

53. Substance use disorders are also recognised as mental health conditions under both the International Classification of Diseases (ICD-10) of the World Health Organization and Diagnostic and Statistical Manual (DSM-IV) of Mental Disorders of the American Psychiatric Association.

54. The Commonwealth's Homelessness Taskforce, which noted that 12 per cent of Supported Accommodation Assistance Program (SAAP) clients reported a mental health problem other than a substance use one, added that:

> "19 per cent reported a substance use problem and another 5 per cent reported both a mental health and a substance use problem. The majority of these clients were men aged between 25 and 44 years".

55. Much higher prevalence has been detected in a particularly large Victorian survey. This survey was conducted in 2005-06 of 4,291 homeless people in Melbourne. It found that 43 per cent had substance use problems (Johnson & Chamberlain 2007 p. 5). The drugs concerned were predominantly illicit rather than alcohol or prescription medications:

> "The most common drug was heroin, but a minority identified alcohol or other prescription drugs. This is consistent with recent findings indicating that drugs have displaced alcohol as the most abused substance among the homeless, particularly among the young" (Johnson & Chamberlain 2007 p. 5)

56. Substance dependence is regarded as a risk factor for homelessness as well as many other disadvantages but the large Melbourne study suggests that homelessness is itself an even more potent risk factor for substance abuse:

> "We identified that 1,940 people, or 43 per cent of the sample, had substance use issues. Table 2 shows that two-thirds (66 per cent) of them developed substance use problems after they became homeless. Our data confirm that substance use is common among the homeless population, but for most people drug use follows homelessness. Drug

> use is an adaptive response to an unpleasant and stressful environment and drug use creates new problems for many people" (Johnson & Chamberlain 2007 p. 8).

57. Here we have another of those self perpetuating vortices of disadvantage. Disadvantage and other risk factors lead to homelessness. Homelessness is likely to lead to the mental disorder of substance dependence. The substance concerned is likely to be an illicit drug like heroin. Criminal prosecution and imprisonment is a likely consequence of use of illicit drugs. Imprisonment is likely to compound or create other mental health problems and remove chances of employment and stable housing. Is there any way of breaking this downward cycle of disadvantage?

58. Rickwood emphatically believes that establishing people in stable accommodation does:

> Appropriate accommodation not only removes the risks associated with unsuitable accommodation or homelessness, but also provides a base from which a person can focus on their recovery. It enables people to develop links with organisations and services within their community, and allows them to channel their energy into other factors supportive of their ongoing wellbeing (such as education or employment). (Rickwood 2006 p. 36).

43. Substance dependence is often the most urgent issue in the lives of many rough sleepers whose resulting chaotic lifestyle sabotages their dreams and best of intentions. Effectively addressing this can bring stability that facilitates them securing and maintaining housing.

43. We have seen that submitting drug users to the processes of the criminal law is implicated in many of the social disadvantages that they experience. Treating someone as a criminal serves to marginalise them, to push them on to the edges of society. Johann Hari in the conclusion of his book, *Chasing the Scream,* writes of his former partner:

> "You confront the addict, shame him into seeing how he has gone wrong, and threaten to cut him out of your life if he won't get help and stop using. It is the logic of the drug war, applied to your private life. I had tried that way before. It always failed. Now I could see why. He coped with his childhood by cutting himself off. He obsessively connected with his chemicals because he couldn't connect with another human being for long. So when I threatened to cut him off – when I threatened to end one of the few connections that worked, for him and me – I was threatening to deepen his addiction." (Hari 2015 p. 293).

59. At the end of his long journey towards enlightenment Hari concludes: "The opposite of addiction isn't sobriety. It's connection. It's all I can offer. It's all that will help him in the end. If you are alone, you cannot escape addiction. If you love, you have a chance. For a hundred years we have been singing war songs about addicts. All along, we should have been singing love songs to them." (Hari 2015 p. 293).

60. Unless one is inclined to dismiss this as sentimental twaddle one should reflect that, as described above, our existing drug strategy is counter-productive. It stimulates the supply of illicit substances. Prohibition is one of

the conditions required for the drug trade to flourish. One needs also to reflect on the spectacular results achieved in other countries which have removed the application of criminal processes to drug users.

61. Much evidence 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 (Mirza 2004). In Switzerland 1,200 receive heroin under strict medical supervision (Mirza 2004) following extensively researched trials that showed big improvements in the health and social functionality of severely dependent heroin users (Uchtenhagen *et al.* (1999)). Similar results are emerged from a trial in Germany with more than 1,000 patients. Heroin prescription programmes have also existed in Vancouver in British Columbia (NAOMI), Spain and The Netherlands (EMCDDA 2006, p.72). 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." (Verdurmen, Ketelaars, & van Laar 2005, p. 20).

Experiences of countries that have abandoned processing drug users as criminals

62 In Australia, advances in drug policies from the 1980s, when Australia led the world in developing and applying principles of harm minimisation, consistently involved ameliorating the rigours of the criminal law. This took the form of making sterile syringes available to minimise the risk of transmission of HIV and other blood borne viruses; providing for dispensing of the artificial opiate, methadone; substituting expiation notice systems for standard prosecution in the case of minor cannabis offences and diversion schemes that have seen drug users referred to education and treatment rather than being subjected to the usual processes of the criminal law. All these successful steps involved ameliorating the rigours of the criminal law. Most were taken with the express intention of minimising the disruption to the life of drug users, it being realised that a conviction for a criminal offence and imprisonment disrupted the family, social and work life of people. With a conviction it is extremely difficult for anyone to secure employment and impossible to travel to some countries. Studies have documented the beneficial outcome of many of these measures (Lenton *et al.* 1998, x) but in virtually all cases the criminal law has remained the gatekeeper for processing drug users and criminal sanctions serve as the underpinning threat for failure to comply with the ameliorating measure. In other words, the life of the drug user and particularly the dependent drug user is perpetually threatened by the circling, snapping crocodile of criminal sanctions.

63 Australia has long since lost its pre-eminence and world leadership in drug policy innovation. Other countries, particularly in Europe, have stolen a march on Australia and it is to the experience of these countries that we now briefly turn.

The United Kingdom:

64 The United Kingdom is unique in always having permitted heroin to be prescribed to addicted patients as recommended by the Rolleston enquiry in 1926. Moreover, the drug continues to be widely used as an analgesic for intractable pain. The right of doctors to continue prescribing it as a pharmacotherapy to treat opiate addiction was substantially curtailed in 1956. Since then only a small number of specialist doctors have been permitted to continue to prescribe heroin for this purpose. Only some 300 receive that treatment (Metrebian, 2006). From 1982 until 1995, Dr John Marks in Liverpool expanded a heroin prescription program from a dozen people to more than 400 for opiate dependent drug users. The situation of patients treated at this clinic improved markedly (Hari 2015, pp.207-14).

Switzerland:

65 In the years leading up to the announcement in 1992 by the Swiss Federal Council to undertake an intervention research program on the diversified prescription of the narcotic substances, Switzerland was experiencing a severe heroin problem. Realising that years of repressive drug law enforcement was not reducing the problem, the authorities in Zurich decided to set aside a park outside the railway station as an area in which drug users could, without intervention by the police, use their drugs. This became the notorious needle park and a scandal of the city. This led to the 1992 announcement of a heroin trial undertaken in accordance with a general study plan of November 1993. The plan required that those admitted be at least 20 years of age, have a heroin dependency of at least two years and have repeatedly failed previous treatments. The Swiss had to guide them only the small-scale trial undertaken by Doctor Marks in Liverpool. The trailblazing Swiss initiative attracted worldwide attention including much criticism. The data collected over three years between January between 1994 and 1996 was carefully evaluated (Uchtenhagen *et al.* (1999) p. 1 & Rihs-Middel and Hämig 2005). It showed remarkable improvement in the well-being of dependent heroin users on the program. So positive were the findings that Switzerland thereupon incorporated heroin prescription in its national drug policy. This was challenged by those championing a drug free approach and made the subject of two national referenda both of which endorsed the program. Meanwhile the World Health Organization reviewed the results of the trial. It is confirmed the achievement of the spectacular results but criticised the study's design on the ground that it was not possible to determine whether the improvements derived from the prescription of heroin or the significant psychosocial support provided to the drug users (WHO 1999). This qualification was used by the Australian Government of the time as a further ground for rejecting a heroin trial in Australia. It also influenced the design of a trial by The Netherlands which ensured that its trial compared opiate dependent drug users receiving heroin (diamorphine) with standard methadone.

The Netherlands:

66 Decriminalisation of the use of drugs and introduction of a policy not to prosecute them for possession in 1976 from which time, in application of an

expediency principle under Dutch law, those who use the drug are not prosecuted for possession of small quantities for personal use. This is openly tolerated in coffee shops at which cannabis may be consumed. From 1998 it has followed Switzerland in conducting a heroin trial. The Swiss study had not precisely compared the efficacy of diacetylmorphine with the gold standard opiate substitution treatment of methadone. This was done in The Netherlands where a group treatment-resistant heroin addicts who had already been treated with methadone was prescribed heroin in combination with methadone. These were compared with another group on methadone alone.

Germany:

67 Substitution therapy is possible in seven locations, namely Bonn, Frankfurt am Main, Hamburg, Hannover, Karlsruhe, Cologne and Münich where a trial had taken place. Further localities have yet to be established. According to the government, at the end of the year in 2010, 360 patients were receiving artificial heroin at public expense.(Deutsches Ärzteblatt 2011);

Portugal:

68 Portugal decriminalised the personal possession of all drugs in 2001. This means that, while it is no longer a criminal offence to possess drugs for personal use, it is still an administrative violation, punishable by penalties such as fines or community service. The specific penalty to be applied is decided by ‘Commissions for the Dissuasion of Drug Addiction’, which are regional panels made up of legal, health and social work professionals.

> “In reality, the vast majority of those referred to the commissions by the police have their cases ‘suspended’, effectively meaning they receive no penalty. People who are dependent on drugs are encouraged to seek treatment, but are rarely sanctioned if they choose not to – the commissions’ aim is for people to enter treatment voluntarily; they do not attempt to force them to do so” (Murkin 2014)

Improvements in health and social integration

Fall in involvement in crime

69 *Liverpool* police reported "that in the 18 months before getting a prescription from Dr. Marks, [the 142 heroin and cocaine addicts studied in the area] received, on average, 6.88 criminal convictions, mostly for theft and robbery. In the 18 months afterwards, that figure fell to an average of 0.44 criminal convictions. In other words: there was a 93 percent drop in theft and burglary. “‘You could see them transform in front of your own eyes,’” An amazed [Inspector] Lofts told a newspaper: “‘They came in in outrageous condition, stealing daily to pay for illegal drugs; and became, most of them, very amiable, reasonable law-abiding people.’" (Hari p. 211).

The drop in shoplifting was so massive that Marks & Spencer publicly praised the policy and sponsored the first world conference on harm reduction and drug taking in Liverpool in 1990" (Hari p. 214).

70 *Switzerland* On the basis of self reporting there was a reduction of 94 per cent or more in the “prevalence and incidence rates of self-reported

criminality after one year of treatment in the programme, compared to thee time before admission." These reductions were confirmed from police records and self reported victimisation which which drug users themselves often experience. Overall " . . . street robberies (a crime typically committed by drug addicts have dropped in Zurich (City and Canton) by about 70 per cent between 1993 and 1996" (Killias, Aebi & Ribeaud 2005, p. 197).

So spectacular has been the reduction in crime of those receiving prescribed heroin that a noted Swiss criminologist has concluded: "In all, heroin treatment constitutes without doubt one of the most efficacious crime prevention measures of ever trialed." (Killias *et al* 2002 p. 80).

71 *Portugal* "The proportion of drug-related offenders (defined as those who committed offences under the influence of drugs and/or to fund drug consumption) in the Portuguese prison population also declined, from 44% in 1999, to just under 21% in 2012 . . . During the same period, there was a reduction in recorded cases of other, more complex crimes typically committed by people who are dependent on drugs, such as thefts from homes and businesses" (Murkin 2014).

Decline in drug use

72 *Liverpool*: "[Drug use] actually fell – including among the people who weren't being given a prescription. Research published in the proceedings of the *Royal College of Physicians of Edinburgh* compared Widnes, which had a heroin clinic, to the very similar Liverpool borough of Bootle, which didn't. In Bootle, there were 207.54 drug users per hundred thousand people; in Widnes it was just 15.83 – a twelvefold decrease." (Hari p. 213).

73 *Netherlands:* No country exceeds the Netherland's permissive reputation for cannabis with its so-called "coffee shops". In spite of those using the drug not being prosecuted for possession of small quantities, the usage of cannabis (and indeed) of other drugs is substantially lower there than in Australia and the United States (Netherlands 2008).

> "Countries with more stringent policies towards illegal drug use did not have lower levels of such drug use than countries with more liberal policies. In the Netherlands, for example, which has more liberal policies than the US, 1.9% of people reported cocaine use and 19.8% reported cannabis use. (Degenhardt et al quoted in Greenwald 2009, p. 25).

74 *Switzerland*: participants on the heroin trial reported a dramatic reduction in use of heroin in the first six months of treatment and in the following six-month period a further, albeit less pronounced, progression was found. Cocaine consumption as reported by the patients and corrected for urine samples also showed a marked progressive tendency to reduction (Uchtenhagen *et al.* (1999) 55). Decrease in consumption of illicit heroin and cocaine "reduces the risk of continued contacts with the drug market" (Uchtenhagen *et al.* (1999) p. 58)

A study of the canton of Zurich, reported in *The Lancet,* has shown a large decline in the number of new heroin users. This study was carried out after

the trial ended and while heroin prescription had become a standard treatment:

> "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%" (Nordt & Stohler 2006, p. 1,833).

75 *Portugal*:

> "• Levels of drug use are below the European average
> • Drug use has declined among those aged 15-24, the population most at risk of initiating drug use
> • Lifetime drug use among the general population has increased slightly, in line with trends
> • lifetime use is widely considered to be the least accurate measure of a country's current drug use situation
> • Rates of past-year and past-month drug use among the general population – which are seen as the best indicators of evolving drug use trends – have decreased
> • Between 2000 and 2005 (the most recent years for which data are available) rates of problematic drug use and injecting drug use decreased
> • Drug use among adolescents decreased for several years following decriminalisation, but has since risen to around 2003 levels
> • Rates of continuation of drug use (i.e. the proportion of the population that have ever used an illicit drug and continue to do so) have decreased.
>
> Overall, this suggests that removing criminal penalties for personal drug possession did not cause an increase in levels of drug use" (Murkin 2014).

Decline in drug trade

76 *Liverpool*: "On the streets of the neighbourhood, the drug gangs started to recede. [Dr Marks] overstated it at the time when he said drug dealing had been totally wiped out – the writer Will Self, reporting on the ground, asked around and learned there was still dealers to be found. But the police said there were far fewer than before – Inspector Lofts explained at the time: "Since the clinics opened, the street heroin dealer has slowly but surely abandoned the streets of Warrington and Widnes."" (Hari p. 211).

Improvement in general well-being

77 *The Netherlands:* The group of treatment-resistant heroin addicts who had already been treated with methadone and who were prescribed heroin in combination with methadone were compared with another group on methadone alone. The study concluded that:

> ". . . the treatment with heroin in combination with methadone is more effective than the continuation of methadone alone. With this additional heroin therapy, the patients can benefit from the treatment with respect to their health and their social functioning. This applies to both intravenous and inhalation administrations of heroin. In a number of patients there is an indication for continuation of treatment."

On its completion, the study had to face a problem of what to do with patients whose condition had markedly improved from the combination of methadone and heroin therapy. It was found that

> " . . . discontinuation of the heroin prescription in most patients who benefited from the treatment resulted in a serious deterioration of the health status within two months of stopping."

In summary for those receiving combination therapy,

> "Undesirable effects with regard to the health of the patients and problems associated with control and management during the treatment were relatively scarce leading to the overall conclusion " . . . that treatment with heroin is practicable, at least under the conditions described in the protocols of the [study]. The costs of the treatment are presented in the report. . . . [Thus] supervised medical co-prescription of heroin may be a useful supplement to the existing treatment options for chronic heroin addicts" (van den Brink *et al.* 2002 p. i)

The Dutch results are all the more spectacular in that the interventions brought improvements to those who had been using for an average of 16 years, had been on methadone for 12 years and had high levels of physical, mental and social dysfunction.

78 *Germany*: In the estimation of the city authorities, the success of the project is unambiguously positive. Up to now every controlled heroin prescription has been based on an exceptional authorization of the Federal Institute for Medicines and Medical Products. The project has been extended three times, each for half a year, up to the end of June this year (2007).

The health department of the city of Frankfurt stressed that for a particular group the controlled prescription of heroin is the only promising entrance to therapy and has long since proved itself. The city began the pilot scheme in 2003 with just under 100 drug addicts. The city wants the group expanded up to 150 clients.

According to information of the health department nearly all the Frankfurt study participants have found an apartment, even though many had previously been homeless. Some had even gained employment. The study has also shown in other cities that a stabilised social situation of drug addicts reduces the corresponding level of criminality. (*Deutsches Ärzteblatt* 2007)

Improvement in physical health

79 Switzerland: "There was a marked regression in particular in the area of injection related skin diseases. Underweight conditions after 18 months of treatment primarily involved patients with HIV infection. The need for medical treatment was considered to be about the same level as after 12 months of treatment" (Uchtenhagen *et al.* (1999) p. 48).

80 *Portugal*: "Although the number of newly diagnosed HIV cases among people who inject drugs in Portugal is well above the European average, it has declined dramatically over the past decade, falling from 1,016 to 56 between 2001 and 2012. Over the same period, the number of new cases of AIDS among people who inject drugs also decreased, from 568 to 38. A similar, downward trend has been observed for cases of Hepatitis C and B

among clients of drug treatment centres, despite an increase in the number of people seeking treatment" (Murkin 2014 and similarly Goulão 2015).

Improvement in mental health

81 *Switzerland:* In the Swiss trial of heroin maintenance, the proportion of patients with good mental status increased from 64% on admission to 82% after 18 months & those with poor status halved from 36% to 18% (Uchtenhagen *et al.* (1999) 51). "The decrease in aggressive behaviour also showed further improvement after the 12th month of treatment" (p. 53)

Pregnancies

82 *Switzerland:* the physical state of health of women on the trial was impaired. All had suffered hepatitis B and 10 women also had hepatitis C. Two were HIV positive. Psychological features included depression, eating disorders and personality disorders. The course of pregnancies and births, with the exception of one spontaneous abortion during withdrawal, went without complications. No malformations occurred in the children and there were no sudden infant deaths (Uchtenhagen *et al.* (1999) 54).

Poverty

83 *Switzerland:* Pharmacotherapies have helped dependent users to reintegrate into the community in other ways. "Financial debts constitute a serious impediment to social integration; they represent a major obstacle and have a demoralising effect. . . . Debts decreased continuously during the [pharmacotherapy] treatment period. After 18 months of treatment, one third of patients were debt free and a further quarter were only moderately indebted" (Uchtenhagen *et al.* (1999) p. 60).

Welfare dependency

84 *Switzerland*: The number of patients receiving welfare increased slightly before dropping below that of the initial value in the third six-month treatment period. The group progression is significant. It is noteworthy that not always the same patients were involved. More than a third of those initially requiring welfare no longer needed this type of support, and more than a third of those who were originally independent of welfare later received it, as this income was reduced (Uchtenhagen *et al.* (1999) p. 61).

Housing

85 *Switzerland:* "homelessness decreased and patients no longer had to live in institutions. Even the non-dependent form of accommodation in lodgings decreased, whereas independent accommodation became more common . . . Unstable living conditions dropped below half the initial value, stable living conditions increased accordingly. These changes were continuous over the entire treatment period and are highly significant" (Uchtenhagen et al. (1999) pp. 58-59).

Employment

86 *Switzerland:* "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

temporary had found a permanent job. The changes occurred predominantly during the first year of treatment" (Uchtenhagen et al. (1999) pp. 59-60).

Social contacts

87 *Switzerland:* the circle of friends and contacts of dependent drug users is typically other drug users. There were " . . . clear changes in contact with drug users. 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 contact. It [was] unclear to what extent new contacts with drug users relate to other patients participating in the programme" (Uchtenhagen et al. (1999) pp. 61-62).

88. One can do no better than end with a quote by Johann Hari summing up the triumph of Swiss drug policy: " "The number of addicts dying every year fell dramatically, the proportion with permanent jobs tripled, and every single one had a home. A third of all addicts who had been on welfare came off it altogether. And just as in Liverpool, the pyramid selling by addicts crumbled to sand" (Hari, p. 222).

Conclusion

89. Existing drug policy was formulated with the best of intentions. Prohibited drugs like heroin are dangerous unless used under medical supervision leave dependent users susceptible to overdose and death. Restrictions on the availability of such drug may offend libertarian principles in the case of a decision by a mature adult fully informed of the risks involved but given the potential attraction of addictive drugs to minors there is a strong argument for the State to be guided by Conservative paternalistic principles to reduce the availability of such substances. That being the case, what measures most effectively reduce the availability of those substances? The answer is certainly not criminal prohibition because prohibition stimulates the availability of those addictive substances. Criminal prohibition does this by inflating the price that addictive substances can command from a captured markets of dependent users. Opiate users are now dying from overdose at the rate of over 300 per year which is back to the level that existed at the end of the 1980s (IDRS 2014 table 76 p. 99 & ABS 2016 cause X4 in ABS 3303.0 Causes of Death, Australia, 2014; Table 1.2 Underlying cause of death, All causes, Australia, 2005–2014).

90. Quite apart from the risk of fatal overdoses producing death, acquired brain injuries in the case of many non-fatal overdoses, or blood borne diseases contracted from non-sterile injecting, subjecting drug users to the stigmatising and stressful processes of the criminal law has many harmful consequences for the drug users themselves and through their children and other dependents to subsequent generations. Those collateral harms contribute to many if not all Australia's most intractable and costly social problems. It is therefore surprising that social welfare organisations of civil society that attempt to address those harms such as homelessness have for the most part left unaddressed the impact of drug policies. The present paper calls for this to change. The harms associated with drug policy are too serious and widespread to be left to the attention of the few civil society voices and

researchers who give attention to that subject. That this is a profitable focus of attention is demonstrated by the experience of countries which have abandoned the processing of drug users (though not of drug dealers) as criminals. It is therefore high time that organisations of civil society pay attention to the scope for the removal of the application of criminal processes to drug users to promote broader welfare in the community. The experience of other countries shows that this approach has the paradoxical and counter intuitive benefit of effectually restricting the availability of the illicit substances themselves.

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