Drug Law Reform Debate

Edited by Justin Healey

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**INTRODUCTION**

*Drug Law Reform Debate* is Volume 379 in the *Issues in Society* series of educational resource books. The aim of this series is to offer current, diverse information about important issues in our world, from an Australian perspective.

**KEY ISSUES IN THIS TOPIC**

Illicit drug use in Australia is a significant justice, health, economic and social welfare issue. Relaxation of drug laws has been proposed by a number of reform groups, criminologists and commentators in response to concerns that existing government policies and criminal sanctions have been a failure. Opponents claim that such a relaxation of laws, including decriminalisation and legalisation, will remove the deterrent effect and increase drug use and unleash even greater drug-related problems into the community.

This book examines the prevalence of illicit drug use, and presents a range of arguments in the drug policy reform debate. Should the law remain tough on drugs, or go softer on hard drugs?

**SOURCES OF INFORMATION**

Titles in the ‘Issues in Society’ series are individual resource books which provide an overview on a specific subject comprised of facts and opinions.

The information in this resource book is not from any single author, publication or organisation. The unique value of the ‘Issues in Society’ series lies in its diversity of content and perspectives.

The content comes from a wide variety of sources and includes:

- Newspaper reports and opinion pieces
- Website fact sheets
- Magazine and journal articles
- Statistics and surveys
- Government reports
- Literature from special interest groups

**CRITICAL EVALUATION**

As the information reproduced in this book is from a number of different sources, readers should always be aware of the origin of the text and whether or not the source is likely to be expressing a particular bias or agenda.

It is hoped that, as you read about the many aspects of the issues explored in this book, you will critically evaluate the information presented. In some cases, it is important that you decide whether you are being presented with facts or opinions. Does the writer give a biased or an unbiased report? If an opinion is being expressed, do you agree with the writer?

**EXPLORING ISSUES**

The ‘Exploring issues’ section at the back of this book features a range of ready-to-use worksheets relating to the articles and issues raised in this book. The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

**FURTHER RESEARCH**

This title offers a useful starting point for those who need convenient access to information about the issues involved. However, it is only a starting point. The ‘Web links’ section at the back of this book contains a list of useful websites which you can access for more reading on the topic.
CHAPTER 1
Illicit drugs and the law

DRUGS – THE REAL FACTS
Illicit drugs advice from the Australian Government’s National Drugs Campaign

ECSTASY
(E, Ex, Ecstasy, MDMA, XTC, eggs, pingers, disco biscuits, pills)

Ecstasy is the common street name for Methylenedioxy-methamphetamine (MDMA). Basically a stimulant with hallucinogenic properties, ecstasy most often comes in pill form (hence the creative nickname ‘pills’) in a multitude of colours differentiated by ‘stamps’. Usually swallowed, E can also be crushed or snorted.

The effects and toxicity of each pill are unpredictable, making overdose a real possibility.

What it does

The stimulants in ecstasy speed up the central nervous system, while any hallucinogens in the drug simultaneously affect perception. MDMA reduces inhibitions and causes users to become more alert, affectionate and energetic. Ecstasy starts to ‘come on’ within 20 minutes of taking it, producing a euphoric rush that peaks after another hour or so. Effects can last up to eight hours, followed by a comedown which may be accompanied by fatigue and irritation. These effects are intensified if use is combined with other drugs, including alcohol.

Short term

Ecstasy increases blood pressure and pulse rate, and raises body temperature. The user loses appetite and sweats a lot, maybe even vomits. Some people can overheat, while side effects such as involuntary jaw clenching, teeth grinding and dilated pupils are common, as is anxiety and insomnia during the comedown. Taking a pill in a hot, humid environment (like a rave party or a mosh pit) can cause dehydration, and although rare, heart failure and death. There’s also well known cases of people over-hydrating and suffering water-intoxication, leading to a swelling of the brain.

Long term

While inconclusive at this stage, mounting evidence suggests repeated use of ecstasy acts as a neurotoxin to the brain. Heavy users report symptoms of depression (such as lethargy and mood swings), decreased concentration skills and memory damage. This is because the serotonin in the brain is reduced by ecstasy use. Animal studies indicate that this serotonin depletion can be long-lasting (up to three years) and may even be permanent.

Water intake needs to be actively managed when ecstasy is consumed – drinking too much can be just as dangerous as too little.

Bottom line

Like any illicit drug that is manufactured in crude backyard labs, there is not much in the way of quality control. While the active ingredient in ecstasy is meant to be MDMA, most pills don’t actually contain it. Why? Well, it’s difficult to gain access to the base chemicals required to manufacture and it is tricky to synthesise chemically. Most pill-makers are using unsophisticated equipment and aren’t averse to cutting costs wherever possible.

Keep in mind, no matter what your dealer or mate who sold you the pills might think or say, it is very doubtful even he or she really knows the origins of the merchandise, let alone be qualified to vouch for their quality. Usually, they’re just repeating what they’ve been told from...
whoever gave them the pills. What that all means is, instead of buying MDMA, you’re more likely to be scoring a cocktail of methamphetamine and other synthetic hallucinogens, including Paramethoxyamphetamine (PMA). Other cheap ingredients used to pad out ecstasy pills can include caffeine, ketamine (a horse tranquiliser), paracetamol and ibuprofen.

ICE
(meth, crystal meth, d-meth, shabu, tina, glass)

Ice is the street handle for crystal methamphetamine hydrochloride, which now accounts for 90 per cent of all methamphetamine seized by police in Australia since the mid-’90s. Generally coming as a crystalline powder or in colourless ‘rocks’, ice can be smoked, snorted or injected.

What it does

The intense ‘high’ or ‘rush’ experienced from taking ice can last up to 12 hours, depending on how many times it is consumed. Users experience feelings of exhilaration and arousal. The drug works by flooding the brain’s receptors with monoamines. With repeated use, these receptors are killed off, so that the user is unable to feel pleasure at all without more ice. Hence its highly addictive nature, both physiologically and psychologically.

Short term

Increased heart rate and breathing, hypertension, circulatory and heart problems. It increases libido, so users are more likely to engage in risky sexual behaviour resulting in an increased risk of contracting a sexually transmitted infection (STI).

Long term

Over time, ice literally ages people. Injecting it causes scarring, abscesses, vein damage and increases the risk of blood-borne pathogens. Heavy users suffer damaged teeth, skin lesions, malnutrition, reduced lung function and general aches, pains and cramping. Aside from the risk of stroke, its also been shown to affect mental health and cognitive function – ice addicts suffer paranoia, hallucinations, memory loss, sleep deprivation and psychosis.

Bottom line

Ice is one of the worst drugs out there. In terms of social impact, access to the drug becomes the prevalent, overriding priority for any ice addict, and they often become aggressive and violent, alienating their families and friends.

MARIJUANA (CANNABIS)
(pot, grass, weed, dope, reefer, joint, spliff, ya(r)ndi, rope, mull, cone, skunk, bhang, ganja, hash, chronic)

The cannabis plant produces three different products. Marijuana is the leaf and flowering head of the female plant and contains the psychoactive substance delta-9 tetrahydrocannabinol (THC). Cannabis plants also produce hash which comes in small coloured blocks (ranging from yellow to black) and hash oil. The most common form of consuming the drug in Australia is smoking the dried leaves and flower buds of the plant in either joints or bongs.

Research indicates men who consume large amounts of cannabis have difficulties in the bedroom, with many not being able to achieve fulfilment.*

What it does

THC is absorbed through the lungs (or stomach) into the bloodstream and taken to the brain, where it floods the receptors with the brain’s reward chemicals. In general, smoking cannabis gives the user a relaxed effect. It also increases appetite, colloquially known as getting the ‘munchies’.

Short term

Difficulty in concentration, impaired co-ordination, bloodshot eyes and dryness of the mouth.

Long term

Respiratory diseases, smoking-related cancers and low sperm count and even lower sex drive. Psychological dependence on the drug leads to increased irritability, memory loss, emotional imbalance, lack of motivation, paranoia and anxiety attacks, and there’s also a link to psychosis and schizophrenia in heavy pot smokers. There can be social implications as well – such as relationship problems with family and friends. Unemployment has also been linked directly to marijuana abuse.
Despite the fact that many believe teenagers are ‘all smoking dope’, four in five young Australians (14-19) have NEVER used it.**

**Bottom line**

Like any form of inhaling what is essentially burnt carbon, smoking weed is basically bad for you. And because much of the ganja sold nowadays is grown hydroponically, there is anecdotal evidence of a high concentration of toxic chemicals still in the plant when smoked.

**COCAINE**

(coke, snow, Charlie)

(crack cocaine: crack, rock, base, sugar block, freebase)

Cocaine is a stimulant that comes in a white powder form. Usually snorted, it is also injected, swallowed or rubbed into the gums.

**What it does**

Depending upon quality and purity, all three forms of cocaine provide an intense, short-lived rush caused by the release of a neurochemical called dopamine. Aside from the unusual feelings of arousal, users feel overly confident and talkative.

**Short term**

Increased heart rate, agitation, paranoia and hallucinations, muscle spasms and vomiting. Bingeing on cocaine over several hours or days leads to a ‘crash’ (i.e. depression and lethargy).

**Long term**

Cocaine psychosis – characterised by violent, aggressive behaviour and paranoid delusions – as well as sleeping disorders, sexual dysfunction, strokes, convulsions and kidney failure. Also, snorting the drug damages the nasal membranes which can eventually lead to the collapse of the nose’s septum. Injecting it will cause tissue damage.

**Bottom line**

Whatever your source claims, purity of coke in Australia is very low compared with some other countries, so local supply is invariably ‘cut’ with other drugs such as speed, meth and ecstasy powder.

**The combination of cocaine and alcohol produces a chemical called cocaethylene, which is more toxic to the system than taking either drug by itself.**

**SPEED**

(whiz, point, zip, go-ee, snow, gas, pure, eve, gogo)

Speed is an amphetamine. It generally comes in an off-white/yellowy powder, but can be pink or even brown – ranging from very fine to quite coarse – or as a viscous liquid in capsules. The drug can be swallowed, smoked, snorted, injected or taken rectally.

**What it does**

As with all amphetamines, speed gives an intense rush after taking it. Increased energy, suppressed appetite and alertness are normal – mainly because the drug acts to accelerate the messages between the brain and the body. Consequently, breathing and heart rate increase, as does blood pressure.

**Short term**

Excessive sweating, overheating, blurred vision, headaches, teeth grinding, jaw clenching, nausea and diarrhoea.

**Long term**

Like ice, long-term use ages the user considerably and will lead to dental degradation, heart problems, weight...
loss, potential stroke and a high risk of addiction. As well as suffering decreased emotional control and delusional or compulsive behaviour, dependent users can be violent and abusive, and the drug is blamed for destroying many families and friendships.

‘Speed psychosis’ is common with any overdose of amphetamines and closely resembles paranoid schizophrenia.

**Bottom line**

Speed is a particularly ‘dirty’ drug, cut or mixed with any number of other drugs and even detergents to increase profits. Use it over the long term and you’ll look haggard, get bad skin, ruin your teeth and may become irrational, aggressive and even violent.

**GHB**

(G, fantasy, liquid E, grievous bodily harm (GBH))

Gamma-hydroxybutyrate or GHB is a drug commonly found in the dance scene and is sometimes referred to as liquid ecstasy due to its stimulating, euphoric and supposed aphrodisiac qualities. Chemically-speaking, however, it is not related to MDMA at all. Mildly salty in flavour, it is colourless and odourless.

**What it does**

GHB, originally developed as a general anaesthetic, is an overall relaxant. Users experience reduced inhibition and a general drowsiness. Overdosing on it can result in unconsciousness, convulsions and vomiting, while mixing it with alcohol is particularly dangerous and can lead to complete respiratory failure, cardiac arrest and death. Worse, the drug is physically and psychologically addictive – withdrawal causes insomnia, anxiety, sensitivity to light and loud noise, and dulling of mental responses.

**What it does**

When mixed with alcohol, GHB can intoxicate quickly – this is the reason why it is often implicated in ‘drink spiking’.

**Bottom line**

The main risk to GHB users is overdose, resulting in death. Despite assurances from the supplier, you will have no idea of any given batch’s varying strength or dilution, so ascertaining exactly what a ‘safe’ dose is, is very difficult. Not worth the risk.

**DEPRESSANTS**

(benzos, tranks, serries, mandies, sleepers)

Otherwise known as ‘downers’, depressants act to slow or reduce the function of the brain and body. Mainly used as prescription medicines, they’ve also become popular as ‘illicits’ or mood-altering substances. They can cause anything from feelings of relaxation and mild contentment, to sedation and total blackout.

**What they do**

Depressants can act as an anaesthetic to the central nervous system, reducing feelings of anxiousness, stress or paranoia. They also relieve insomnia and relax the body’s muscles. Often, users report their mood improves and they experience feelings of being more sociable. In terms of the drug scene, depressants can be used as a crude ‘antidote’ to overcome symptoms of withdrawal or ‘comedown’ from taking other illicit stimulants.

**Short term**

Dizziness, confusion, slurred speech, shallow breathing, impaired coordination and judgement, and low blood pressure. Self-medicating with depressants while under the influence of other drugs is dangerous, it can lead to respiratory arrest or even death.

**Mixed with alcohol, depressants lower your respiratory rate to the point you can actually stop breathing.**

**Long term**

Many depressants or barbiturates are also addictive if taken regularly, and withdrawal symptoms include sleeplessness, panic attacks and anxiety.

**Bottom line**

They’re meant to be prescribed by a doctor for specific reasons and not to come down off other drugs. If you’re using downers just to come off other drugs, it’s better to just sleep it off. Take too many, or with the wrong cocktails of drugs, and you risk coma or death.

**SOURCES**

* Anthony Smith – La Trobe University Study.

The 2010 National Drug Strategy Household Survey was conducted between late-April and early-September 2010. This was the 10th survey in a series which began in 1985, and was the fifth to be managed by the Australian Institute of Health and Welfare (AIHW).

More than 26,000 people aged 12 years or older participated in the survey, in which they were asked about their knowledge of and attitudes towards drugs, their drug consumption histories, and related behaviours. Most of the analysis presented is of people aged 14 years or older, so that results can be compared with previous reports.

**USE AND ATTITUDES**

**Tobacco**

In 2010, the proportion of people aged 14 years or older smoking daily (15.1%) declined, continuing a downward trend that began in 1995. The decline in daily smoking was largest for those aged in their early-20s to mid-40s, while the proportion of those aged over 45 years who smoked daily remained relatively stable or slightly increased between 2007 and 2010. Despite the decline in the proportion of people in Australia smoking tobacco, the number of smokers has remained stable between 2007 and 2010, at about 3.3 million.

In the 12-17 years age group, girls were more likely to smoke daily than boys (3.2% to 1.8%). This was the only age group where females were more likely than males to smoke daily.

Support for policies aimed at reducing harm caused by tobacco remained high in 2010. In particular, there were increasing levels of support for a rise in tax on tobacco products to pay for health education and to contribute to treatment costs.

**Alcohol**

The proportion of the population aged 14 years or older who consumed alcohol daily declined between 2007 (8.1%) and 2010 (7.2%). However, there was little change in the proportion of people drinking alcohol at levels that put them at risk of harm over their lifetime (20.3% in 2007 and 20.1% in 2010), or from a single drinking occasion at least once a month (28.7% in 2007 and 28.4% in 2010). As the Australian population has increased, the number of people drinking at risky levels increased between 2007 and 2010. Around 7% of recent drinkers changed their drink preference, shifting away from pre-mixed spirits; this preference was particularly evident for those aged less than 29 years.

There was higher support in 2010 (compared with 2007) given to alcohol measures related to venues, such as restricted trading and limiting the number of venues. Abstainers and those drinking at low-risk levels were more likely than risky drinkers to support policies aimed at reducing alcohol-related harm.

**Illicit drugs**

Recent illicit drug use increased in 2010, mainly due to an increase in the proportion of people who had used cannabis (from 9.1% in 2007 to 10.3% in 2010), pharmaceuticals for non-medical purposes (3.7% to 4.2%), cocaine (1.6% to 2.1%) and hallucinogens (0.6% to 1.4%). However, recent ecstasy use decreased, and there was no change in the use of meth/amphetamines, heroin, ketamine, GHB, inhalants and injecting drug use.

Between 2007 and 2010, ecstasy and meth/amphetamines were perceived to be less readily available, with less opportunity to use, but cocaine, hallucinogens, painkillers/analgesics (both prescription and over-the-counter) and tranquilisers/sleeping pills for non-medical purposes were perceived to be more readily available.

Of all illicit drugs, community tolerance has increased for cannabis use, while people in Australia still consider heroin to be the drug most associated with a drug problem.

**POPULATION GROUPS**

**Sex and age**

Males were far more likely than females to use all drugs (both illicit and licit), except for pharmaceuticals which were used by a similar proportion of males and females. Females were considerably less likely than males...
to drink alcohol daily and in quantities that placed them at risk of harm. Females were also more likely than males to support measures aimed at reducing problems associated with drug use, and to support penalties for the sale and supply of illicit drugs.

Across Australia, those aged 18-29 years were the most likely to report using illicit drugs and drinking alcohol at risky levels in the previous 12 months. The proportion of 12-17 year olds abstaining from alcohol increased in 2010. Those aged 40-49 years were most likely to smoke daily.

Other groups

Patterns of drug use differ by other population characteristics depending on the drug type of interest. In general, high proportions of Aboriginal and Torres Strait Islander people smoked tobacco, drank alcohol at risky levels and used cannabis in the last 12 months compared with non-Indigenous Australians, as did people living in the Northern Territory compared with other states/territories. People living in Remote and Very remote areas were more likely to smoke and drink at risky levels, but less likely to use illicit drugs such as cocaine compared with those in Major cities and Inner regional areas.

Other differences were apparent for people who were unemployed, identified as homosexual/bisexual, did not have post-school qualifications, and were never married, as well as for students.

Attitudes

People who used drugs generally had a more accepting attitude towards drugs, and were less likely to support measures to reduce harm. Recent drug users (both licit and illicit), males, and younger people were all more likely to support policies that legalised drugs, and to approve of regular drug use, and showed less support for measures aimed at reducing harm associated with drugs.

In 2010, as in previous years, excessive alcohol use was mentioned more often than other drugs as being the most serious concern to the community, followed by tobacco and heroin. The proportion of people nominating marijuana, alcohol and tobacco as a ‘drug problem’ all decreased, whereas the proportion nominating cocaine, hallucinogens and pain killers increased.

HEALTH AND HARM

Health

Compared with non-smokers (never smoked or ex-smokers), smokers were: more likely to rate their health as being fair or poor; more likely to have asthma; twice as likely to have been diagnosed or treated for a mental illness; and more likely to report high or very high levels of psychological distress in the preceding 4-week period.

Recent drinkers who drank at levels that put them at risk of harm from a single occasion of drinking were 1.7 times as likely as low-risk drinkers (1.9%) to experience very high levels of psychological distress. A higher proportion had also been diagnosed with a mental illness (13.6% compared with 11.1%), however, the relationship between drug use and mental illness is complex.

Psychological distress and diagnoses or treatment for a mental illness continue to be highest among recent users of meth/amphetamines, ecstasy, cannabis, and cocaine.

Harm

In 2010, the proportion of pregnant women who smoked decreased after they found out they were pregnant (from 12.6% before realising they were pregnant to 8.1% after finding out). The proportion of pregnant women abstaining from drinking alcohol increased in 2010 (from 40.0% in 2007 to 52.0% in 2010).

Between 2007 and 2010, the proportion of people experiencing incidents related to illicit drug use decreased. This was influenced by a decline in people being verbally abused and being put in fear. However, the proportion of people reporting they were physically abused by a person under the influence of alcohol increased (from 4.5% to 8.1%) during this period.

Driving was the most common risky activity included in the survey to be undertaken while under the influence of drugs, but this decreased in 2010. In 2010, males continued to engage in more risky behaviours and activities than females while under the influence of illicit drugs or alcohol.
ILLICIT DRUGS EXPENDITURE AND DEATH RATES

These data sourced from recent newspaper reports highlight the costs and mortality rates of illicit drugs.

ILLEGAL DRUGS INDUSTRY ADDS $6BN TO ECONOMY

Uren, David (13 September 2013), ‘Illegal drugs industry adds $6bn to economy’, The Australian.

- The illegal drugs industry contributes about $6 billion a year to the size of the economy, while tax avoidance adds a further $20 billion, research by the Australian Bureau of Statistics shows.
- The illegal drugs industry is in withdrawal, with falling spending on marijuana and heroin cutting total spending by 19% over the past 5 years.
- The ABS estimates $3.6 billion was spent on marijuana in 2010, followed by $1.1 billion on amphetamines. Australian consumers spent $585 million on cocaine, $520 million on heroin and $200 million on ecstasy.
- The ABS calculates illegal drugs account for 0.8% of total household consumption and 0.4% of the total economy.
- Of the total illegal drug industry, the ABS classifies $1 billion as agriculture (marijuana cultivation), while $4.4 billion is retail and wholesale. Manufacturing generates only $46 million. The study does not count the ‘cutting’ or dilution of drugs such as heroin and ecstasy as manufacturing.
- The findings estimate that drug seizures (preventing drugs from reaching their end users) total only $80 million.
- The ABS estimates $542 million is spent on smuggled drug imports. Heroin and cocaine are entirely imported while 95% of ecstasy supplies come from overseas.
- Marijuana is entirely domestically produced, while 80% of amphetamines are manufactured locally.

NATION’S $7BN DRUG SPLURGE

Corduroy, Amy (22 June 2013), ‘Nation’s $7b drug splurge’, The Age.

- According to an analysis of Australian Bureau of Statistics data by drug harm-minimisation group Anex, Australians are spending over $7 billion a year on illicit drugs – $2 billion more than spent on fashion.
- Drug experts and anti-drug campaigners said the data showed Australians spent about seven times more buying drugs in 2010 than governments spent on enforcing drug laws.
- The figures have raised questions about the effectiveness of spending on anti-drug laws and prohibition.
- The vast majority of the drug money is going directly to drug manufacturers and sellers, with early ABS analysis showing profit margins of more than 80%.
- Figures updated since the first draft, provided by Anex, showed that in 2010 Australians spent about $3.8 billion on cannabis. This figure could be an underestimate, as a report by Access Economics in the late 1990s had estimated the cannabis market alone was worth $5 billion.

DRUGS A BIGGER KILLER THAN CARS

Stark, Jill (23 June 2013), ‘Drugs a bigger killer than cars’, The Sydney Morning Herald.

- Analysis of Australian Bureau of Statistics data by drug harm-minimisation group Anex has found that in all age groups, except for 15-24 year-olds, overdose deaths outstrip vehicle accident fatalities.
- In 2011, 241 drug overdose deaths among 25-34 year-olds were recorded, compared with 110 on the roads.
- In the 35-44 year-old group, 234 people lost their lives to drugs, while 82 died in car accidents. Among 45-54 year-olds, 75 were killed on the roads in cars, compared with 211 through overdoses.
- Prescription painkillers, such as oxycodone and fentanyl, are increasingly being abused, leading to a spike in accidental overdoses.
- Anex chief executive John Ryan said prescription drug abuse was a growing problem and many people were becoming addicted after using medication to treat pain. Often deaths occurred accidentally when people doubled their daily dose or combined pills with alcohol.
SPENDING DOWN ON HARM REDUCTION FOR ILLICIT DRUGS: REPORT

Australian governments are spending more on law enforcement against illicit drugs than on treatment and prevention, according to a report by the National Drug and Alcohol Research Centre. Antigone Anagnostellis explains in this item from ‘The Conversation’

The report, presented at a symposium in Canberra today, compared state and federal government expenditure between 2002/3 and 2009/10.

While overall spending on illicit drug policy has increased to $1.7 billion in 2009/10 (up from $1.13 billion in 2002/3), it decreased for harm reduction measures such as needle exchange programs, the report found.

“That’s of real concern because Australia has led the way in terms of harm reduction from the mid 1980s and it seems that spending has decreased in that area despite known effectiveness of those programs,” said Alison Ritter, lead study author and specialist in drug policy at the National Drug and Alcohol Research Centre at the University of NSW.

Spending was highest on law enforcement (66%), then treatment (21%), prevention (9%) and harm reduction (2%).

STATE VS FEDERAL FUNDING

“It’s interesting when we talk about illicit drug policy, the federal government is often the target for attention from researchers and advocacy groups,” Professor Ritter said.

“But in actual fact, in terms of policy influence, in order for advocacy groups to get bang for their buck they should be talking to state and territory governments probably a lot more than we do.”

Carolyn Day, Associate Professor in addiction medicine at the University of Sydney, said that while the federal government is responsible for funding primary health care, there are specialist services which tend to fall under state responsibilities.

“It can be very frustrating because it’s difficult to know who is responsible for what,” she said.

UPHILL BATTLE

Alex Wodak, Emeritus consultant at St Vincent’s Hospital in Darlinghurst, Sydney, said there is minimal evidence that law enforcement is cost-effective.

“If governments were serious about repairing the structural deficits in their budgets and responding effectively to illicit drugs, they would shift spending from drug law enforcement to treatment and harm reduction,” he said.

Despite the high spending on law enforcement measures, Dr Wodak said that illicit drugs are still readily available.

“According to the 2010 Illicit Drugs Reporting System, 92% of drug users said that hydroponic cannabis was easy or very easy to obtain and 87% said that heroin was easy or very easy to obtain.”

Dr Wodak said that governments should include a direct line of spending on illicit drugs.

“It is up to governments to use these new figures, if they are serious about their budget problems and are serious about illicit drugs. Unfortunately, bad policy has been good politics for a long time. This is now starting to change.”

Antigone Anagnostellis is editor at The Conversation.
Law enforcement still accounts for the lion’s share of Australian governments’ spending on illicit drugs, according to the first comprehensive review of drug policy spending since 2003.

The review Government Drug Policy Expenditure in Australia – 2009/10, which looked at spending on prevention, treatment, harm reduction and law enforcement, found that spending on harm reduction measures fell over the period while prevention and treatment spending remained steady.

In 2009/10 federal and state governments spent a total of $1.7 billion in direct response to illicit drug use including:

- $1.12 billion on law enforcement – two thirds of the total spend (66%)
- $361 million on treatment – just over a fifth (21%)
- $157 million on prevention – just under a tenth (9%)
- $36 million on harm reduction – 2%
- State and territory government spending accounted for more than two thirds of the spend (69%).

Lead author of the report Professor Alison Ritter, director of the Drug Policy Modelling Program at the University of New South Wales, said that while spending on policing was high and had increased over the period, even allowing for inflation, it was not inconsistent with spending in other developed nations such as the USA, UK, Sweden and the Netherlands.

However she said the drop in spending on harm reduction and the stable treatment spending over the period was concerning.

“Australia has an enviable reputation worldwide in implementing programs which reduce the health harms of illicit drugs,” said Professor Ritter. “If anything we might have expected to see spending in this area increase over the period.

“Over the seven years since we last analysed the Australian Drug Budget there has been increasing evidence for the effectiveness of harm reduction measures such as supervised injecting centres and the provision of naloxone, for example.”

She said that international best practice in responding to drugs required a balanced approach between health responses and law enforcement responses.

“It is impossible to know from looking at the expenditure alone whether Australia has got this balance right,” Professor Ritter said.

“What we do know is that there is very good evidence for the effectiveness of treatment and harm reduction and that there is a large unmet demand for treatment. So we would have expected the balance of spending to shift towards these areas rather than remain static.”

Dr John Herron, chairman of the Australian National Council on Drugs, has described the report as “very significant”.

“It further strengthens the view of the Council that a much greater investment in preventing and treating drug and alcohol problems as well as reducing their harmful impacts is needed in Australia,” Dr Herron said.

“As Deloitte Access have recently highlighted there is well over $100,000 to be saved for the taxpayer every time we treat rather than imprison a drug offender. This does not mean reducing the important role of law enforcement but in allocating new funding to prevention, treatment and harm reduction programs as well.”

* This figure represents a drop in total spend compared with the 2003 report because of a methodological change. Indirect spending (on the social costs of drug use) has been removed to allow for direct international comparisons.
ILlicit Drug Data Findings

Following is a snapshot of findings from the latest Illicit Drug Data Report produced by the Australian Crime Commission.

The Illicit Drug Data Report (IDDR) 2012-13 provides a snapshot of the Australian illicit drug market. The report brings together illicit drug data from a variety of sources, including law enforcement, health organisations and academia. The IDDR is the only report of its type in Australia and provides an important evidence base to assist decision-makers in the development of strategies to combat the threat posed by illicit drugs.

- The 101,749 national illicit drug arrests this reporting period is the highest on record.
- The 19.6 tonnes of illicit drugs seized nationally this reporting period is the second highest on record.
- The 86,918 national illicit drug seizures this reporting period is the highest on record.

**Amphetamine-type stimulants**

- The number and weight of ATS (excluding MDMA) detections at the Australian border increased in 2012-13 and are the highest on record.
- The number and weight of MDMA detections at the Australian border increased this reporting period, with the 4,139 detections in 2012-13 the highest number on record.
- Drug profiling data indicates that the majority of analysed methylamphetamine seizures are primarily manufactured from ephedrine/psuedoephedrine.
- The number and weight of national ATS seizures increased in 2012-13 and are the highest on record.
- The number of national ATS arrests continued to increase, with the 22,189 arrests in 2012-13 the highest on record.

**Cannabis**

- There were a record 3,629 cannabis detections at the Australian border in 2012-13, with cannabis seeds continuing to account for the majority of detections.
- The number and weight of national cannabis seizures increased, with the number of seizures the highest reported in the last decade.
- National cannabis arrests continued to increase, with the 62,120 arrests in 2012-13 the highest number reported in the last decade.

**Heroin**

- The number and weight of heroin detections at the Australian border increased in 2012-13, with the 513.8 kilograms detected the highest on record.
- Profiling data from 2012 indicates the majority of analysed heroin seizures originated in South-East Asia.
- The weight of national heroin seizures increased to 544.4 kilograms in 2012-13, the highest weight reported in the last decade.
- The 2,463 national heroin and other opioid arrests reported in 2012-13 is the lowest number reported since 2007-08.

**Cocaine**

- Although the weight of cocaine detected at the Australian border almost halved in 2012-13, the number of detections more than doubled and is the highest on record.
- Cocaine profiling data indicates the continued prominence of Colombia as a source country for cocaine seized at the Australian border.
- There was a record number of national cocaine seizures this reporting period, with the weight of national cocaine seizures the highest reported in the last decade.
- There was a record 1,282 national cocaine arrests in 2012-13.

**Other drugs**

- Over the last decade, the number of performance and image enhancing drugs detected at the Australian border has increased 751.6 per cent, with the 10,356 detections in 2012-13 the highest number on record.
- The number of national steroid seizures and arrests continued to increase in 2012-13 and are the highest number on record.
- There was a record 509 tryptamine detections at the Australian border in 2012-13.
- There was a record 277 anaesthetic detections at the Australian border in 2012-13.
- The 565 national hallucinogen arrests reported in 2012-13 is the highest number on record.

**Clandestine laboratories and precursors**

- Despite a decrease in the number of clandestine laboratories detected nationally, the 751 laboratories detected in 2012-13 is the second highest number in the last decade.
- The majority of clandestine laboratories continue to be detected in residential areas; however detections in commercial/industrial locations increased in 2012-13.
- The greatest proportion of laboratories continue to be addict-based; however, the proportion attributed to laboratories of other sizes almost doubled in 2012-13.
- While the weight of ATS (excluding MDMA) and MDMA precursor detections at the Australian border decreased in 2012-13, the number of detections increased and is the highest reported in the last decade.

**Initiatives**

- The leading drug policy document in Australia is the National Drug Strategy 2010-2015.
- A number of key amendments were recently made to the Criminal Code Act 1995 to strengthen the serious drug offences framework.
- The Australian Government is considering options to strengthen existing border controls to prohibit the importation of new psychoactive substances and is working with states and territories to address the domestic manufacture, supply and advertising of these substances.

GLOBAL DRUG FIGURES

The latest World Drug Report from the United Nations Office on Drugs and Crime notes stability in the use of traditional drugs, but points to an alarming rise in new psychoactive substances.

At a special high-level event of the Commission on Narcotic Drugs (CND), the United Nations Office on Drugs and Crime (UNODC) launched in Vienna the 2013 World Drug Report. The special high-level event marks the first step on the road to the 2014 high-level review by the Commission on Narcotic Drugs of the Political Declaration and Plan of Action which will be followed, in 2016, by the UN General Assembly Special Session on the issue.

While drug challenges are emerging from new psychoactive substances (NPS), the 2013 World Drug Report (WDR) is pointing to stability in the use of traditional drugs. The WDR will be a key measuring stick in the lead up to the 2016 Review.

UNODC Executive Director, Yury Fedotov, said “We have agreed on a path for our ongoing discussion. I hope it will lead to an affirmation of the importance of the international drug control conventions, as well as an acknowledgement that the conventions are humane, human-rights centred and flexible. There must also be a firm emphasis on health and we must support and promote alternative sustainable livelihoods. It is also essential that we recognise the important role played by criminal justice systems in countering the world drug problem and the need for enhanced work against precursor chemicals.”

EMERGING DRUG PROBLEMS

Marketed as ‘legal highs’ and ‘designer drugs’, NPS are proliferating at an unprecedented rate and posing unforeseen public health challenges. Mr Fedotov urged concerted action to prevent the manufacture, trafficking and abuse of these substances.

The number of NPS reported by Member States to UNODC rose from 166 at the end of 2009 to 251 by mid-2012, an increase of more than 50 per cent. For the first time, the number of NPS exceeded the total number of substances under international control (234). Since new harmful substances have been emerging with unfailing regularity on the drug scene, the international drug control system is now challenged by the speed and creativity of the NPS phenomenon.

This is an alarming drug problem – but the drugs are legal. Sold openly, including via the internet, NPS, which have not been tested for safety, can be far more dangerous than traditional drugs. Street names, such as ‘spice’, ‘meow-meow’ and ‘bath salts’ mislead young people into believing that they are indulging in low-risk fun. Given the almost infinite scope to alter the chemical structure of NPS, new formulations are outpacing efforts to impose international control. While law enforcement lags behind, criminals have been quick to tap into this lucrative market. The adverse effects and addictive potential of most of these uncontrolled substances are at best poorly understood.

In response to the proliferation of NPS, UNODC has launched an early warning system which will allow the global community to monitor the emergence and take appropriate actions.

THE GLOBAL PICTURE

While the use of traditional drugs, such as heroin and cocaine, seems to be declining in some parts of the world, prescription drug abuse and new psychoactive substance abuse is growing.

While the use of traditional drugs, such as heroin and cocaine, seems to be declining in some parts of the world, prescription drug abuse and new psychoactive substance abuse is growing. In Europe, heroin use seems to be declining. Meanwhile, the cocaine market seems to be expanding in South America and the emerging economies in Asia. Use of opiates (heroin and opium), on the other hand, remains stable (around 16 million people, or 0.4 per cent of the population aged 15-64), although a high prevalence of opiate use has been reported from South-West and Central Asia, Eastern
New data reveal that the prevalence of people who inject drugs and are also living with HIV in 2011 was lower than previously estimated.

and South-Eastern Europe and North America.

Africa is emerging as a target for the trafficking as well as production of illicit substances, although data are scarce. Mr Fedotov called for international support to monitor the situation and to prevent the continent from becoming increasingly vulnerable to the drugs trade and organised crime. There is also a need to help the large number of drug users who are the victims of the spillover effect of drug trafficking through the continent.

New data reveal that the prevalence of people who inject drugs and are also living with HIV in 2011 was lower than previously estimated: 14.0 million people between the ages of 15 and 64 are estimated to be injecting drugs, while 1.6 million people who inject drugs are also living with HIV. The revised estimates are 12 per cent lower for the number of people who inject drugs and 46 per cent lower for the number of people who inject drugs and are living with HIV. These changes are the result of revised estimates in countries that acquired new behavioural surveillance data since the previous estimates, which were made in 2008.

In terms of production, Afghanistan retained its position as the lead producer and cultivator of opium globally (75 per cent of global illicit opium production in 2012). The global area under opium poppy cultivation amounted to 236,320 ha and was thus 14 per cent higher than in 2011. Nonetheless, given a poor yield, owing to a plant disease affecting the opium poppy, in Afghanistan, global opium production fell to 4,905 tons in 2012, 30 per cent less than a year earlier and 40 per cent less than in the peak year of 2007.

Estimates of the amounts of cocaine manufactured ranged from 776 to 1,051 tons in 2011, largely unchanged from a year earlier. The world’s largest cocaine seizures – unadjusted for purity – continue to be reported from Colombia (200 tons) and the US (94 tons). Cocaine use continues falling in the US, the world’s largest cocaine market. In contrast, significant increases in seizures have been noted in Asia, Oceania and Central and South America, and the Caribbean in 2011.

The use of amphetamine-type stimulants (ATS), excluding ecstasy, remains widespread globally and appears to be increasing in most regions. In 2011, an estimated 0.7 per cent of the global population aged 15-64, or 33.8 million people, had used ATS in the preceding year.

The prevalence of ecstasy in 2011 (19 million, or 0.4 per cent of the population) was lower than in 2009. However, at the global level, ATS seizures have risen to a new high of 123 tons in 2011, which is 66 per cent more than in 2010 (74 tons) and double the 2005 figure (60 tons).

Methamphetamine continues to dominate the ATS business, accounting for 71 per cent of global ATS seizures in 2011. Methamphetamine pills remain the predominant ATS in East and South-East Asia: 122.8 million pills were seized in 2011, although this was a 9 per cent decline compared with 2010 (134.4 million pills). Seizures of crystal methamphetamine, however, increased to 8.8 tons, the highest level during the past five years, indicating that the substance is an imminent threat. Mexico recorded its largest seizures of methamphetamine, more than doubling within a year from 13 tons to 31 tons, thus representing the largest reported seizures globally.

Cannabis remains the most widely used illicit substance. While cannabis use has clearly declined among young people in Europe over the past decade, there was a minor increase in the prevalence of cannabis users (180 million or 3.9 per cent of the population age 15-64) as compared with previous estimates in 2009.

To read the latest available World Drug Report, go to: www.unodc.org/wdr/
SYNTHETIC DRUGS EXPLAINED

ABC HEALTH & WELLBEING FEATURE REPORT BY CATHY JOHNSON

They go by names like Benzo Fury, Kronic and White Revolver, and come as powders, pills or dried herbs. What exactly are ‘synthetic drugs’ and why are they a cause for concern?

News reports into the death of a Sydney teenager, who jumped off his home balcony after reportedly taking a drug known as NBOMe, may have been the first time many of us heard the term ‘synthetic drugs’.

But what are these substances that have aroused the concern of law enforcers, health experts and the wider community?

What are synthetic drugs?

The term synthetic drugs is often used to describe drugs that are new to the market, or have become more widely used in recent years. The effect of these drugs mimics those of more established drugs like LSD, cocaine and cannabis (but are sometimes much more potent).

The name ‘synthetic drugs’ is confusing, however, because it doesn’t distinguish these newer drugs from illicit drugs such as LSD, ecstasy and speed that are also synthesised from chemicals (rather than extracted from plants like cannabis, cocaine and heroin).

Synthetic drugs are also known as ‘legal highs’, although this label too is problematic as their legal status is highly complex. It differs in different areas and is constantly changing as new laws come into effect; for instance, state and federal governments recently banned products that were at one time legally sold through sex shops, tobacconists and online.

“A drug that was legal to possess yesterday, could be banned tomorrow,” the non-profit education and advocacy group, the Australian Drug Foundation (ADF), warns.

Other generic ‘street’ names include herbal highs, party pills, herbal ecstasy or bath salts. Some of the specific brand names include Kronic, White Revolver, Ash Inferno and Black Widow.

A more accurate description that is increasingly being used is ‘emerging psychoactive substances’ or EPS. (The term psychoactive means these drugs act on the brain to cause changes in thought, mood and/or behaviour).

How new are these drugs?

Some of these drugs have been around for decades but have become more widely used in recent years, says Dr Monica Barratt, research fellow with the National Drug Research Institute at Curtin University.

But others are new to consumers. For instance, the first evidence of people using the NBOMe group of drugs – sometimes known as ‘synthetic LSD’ – came from the United States in 2010, Barratt says. “And it’s only in the last 12 months there’s really been any discussion of the NBOMe series being used in Australia.”

Drug educator Paul Dillon says concerns about the use of synthetic cannabis products in Australia arose around 2010.

How are they dangerous?

It’s hard for people to know exactly how EPS will affect them as these drugs have not been widely studied.

Also manufacturers are constantly changing the chemicals in these drugs in an attempt to stay ahead of the law, which means different batches of a drug can contain quite different ingredients, even if the packaging and name are the same.

“The absolute biggest danger is that these are completely untested products. In many cases, we just don’t know what they are,” says Dillon. While the effects are variable and not always harmful, “it’s highly likely there are risks”, he says.

These drugs have been linked with ‘a significant number’ of deaths – including four in Australia associated with NBOMe drugs and at least four linked to synthetic cannabis products.

There is some scientific evidence synthetic cannabis products can cause serious seizures and increased heart rate (possibly contributing to heart problems in vulnerable individuals) – effects that people do not normally experience when using cannabis-based drugs, Barratt says.
NBOMe

Like LSD, NBOMes are hallucinogens – that is, drugs that distort your perceptions – and both can cause psychosis (a loss of contact with reality) in certain people.

But NBOMes can have other toxic effects on the body not experienced with LSD, says Barratt.

These include:
- Heart and blood vessel problems
- Agitation
- Seizures
- Hypothermia
- Metabolic acidosis (when the kidneys can’t remove enough acid from the body)
- Organ failure
- And death.

Sometimes people aren’t aware they are taking NBOMe as it has been sold to them as LSD. But the dose in a single tab can be up to six times that normally found in a single tab of LSD.

“It looks the same [as LSD], it’s a tab of blotter paper, but when a person takes it, it might be a very high dose for them,” Barratt says.

How widespread is the use of ‘synthetic drugs’?

No one knows exactly how widespread use of EPS is. Dillon believes these drugs still make up only a fraction of the illicit drug market, but both he and Barratt believe EPS use has grown in recent years. While much of the publicity has focused on young people, especially teenagers, evidence suggests they are also popular with adults in their 20s and 30s. A 2011 survey of 316 users of synthetic cannabis products found that 50 per cent of users were aged 28 and over and a quarter were over 35, Barratt says.

Users may be motivated by curiosity, alleged legal status, and a desire to avoid testing positive in drug tests such as those conducted in some workplaces. However tests are increasingly being developed to pick up these new drugs.

How can harm from these drugs be reduced?

Be aware of the following (some of this advice comes from the Australian Drug Foundation):
- It’s very hard to determine the effects of EPS, even if you’ve taken them before, as products are constantly changing. So activities like driving, swimming and operating machinery are especially unsafe for anyone affected by these drugs.
- Many EPS contain a range of fillers and numbing agents that could lead to health problems, particularly if injected.
- Some products can cause seizures and/or fast or irregular heartbeats. These are especially problematic if you have any underlying health conditions.
- It can be difficult for medical practitioners to know how to treat someone who has overdosed on or has health problems caused by EPS, given the large number of these drugs on the market. Treatment could be quicker and more effective if someone can advise exactly what has been taken and the dosage – supplying the packet might be helpful.

If you find yourself in a situation where someone is badly affected by any drug, call an ambulance straight away. Don’t let fear of police involvement affect your decision. Ambulance officers will not call on police to be involved unless there is a death, serious violence they need help controlling, or if the person has illicit drugs on them when they arrive at hospital, Dillon says.

And don’t wait, Barratt says. “Waiting a few hours can make the difference between someone being saveable to being dead.”

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NATIONAL DRUG STRATEGY

The following executive summary and first chapter extract from the National Drug Strategy framework document outline the key features of the overarching harm minimisation approach to federal government drug policy.

EXECUTIVE SUMMARY

The aim of the National Drug Strategy 2010-2015 is to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities.

The harms to individuals, families, communities and Australian society as a whole from alcohol, tobacco and other drugs are well known. For example, the cost to Australian society of alcohol, tobacco and other drug misuse in the financial year 2004-05 was estimated at $56.1 billion, including costs to the health and hospitals system, lost workplace productivity, road accidents and crime.

The overarching approach of harm minimisation, which has guided the National Drug Strategy since its inception in 1985, will continue through 2010-2015.

This encompasses the three pillars of:

- **Demand reduction** to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community.

- **Supply reduction** to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.

- **Harm reduction** to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

The three pillars apply across all drug types but in different ways, for example, depending on whether the drugs being used are legal or illegal. The approaches in the three pillars will be applied with sensitivity to age and stage of life, disadvantaged populations, and settings of use and intervention.

In the National Drug Strategy 2010-2015, the three pillars are underpinned by strong commitments to:

- Building workforce capacity
- Evidence-based and evidence-informed practice, innovation and evaluation
- Performance measurement
- Building partnerships across sectors.

Specific objectives have been identified under each pillar as follows:

**Demand reduction**

- Prevent uptake and delay onset of drug use
- Reduce use of drugs in the community
- Support people to recover from dependence and reconnect with the community
- Support efforts to promote social inclusion and resilient individuals, families and communities.

**Supply reduction**

- Reduce the supply of illegal drugs (both current and emerging)
- Control and manage the supply of alcohol, tobacco and other legal drugs.

**Harm reduction**

- Reduce harms to community safety and amenity
- Reduce harms to families
- Reduce harms to individuals.

1. ABOUT THE NATIONAL DRUG STRATEGY

The National Drug Strategy provides a national framework for action to minimise the harms to individuals, families and communities from alcohol, tobacco and other drugs.

At the heart of the framework are the three pillars of demand reduction, supply reduction and harm reduction, which are applied together to minimise harm. Prevention is an integral theme across the pillars.

The 2010-2015 framework builds on longstanding partnerships between the health and law enforcement sectors and seeks to engage all levels and parts of government, the non-government sector and the community.

Australia has had a coordinated national policy for addressing alcohol, tobacco and other drugs since 1985.
Drug Law Reform Debate

when the National Campaign Against Drug Abuse was developed. In 1993 it was renamed the National Drug Strategy. This 2010-2015 iteration is the sixth time the strategy has been updated to ensure it remains current and relevant to the contemporary Australian environment.

Mission: To build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities.

The harms from drug use
The harms to individuals, families, communities and Australian society as a whole from alcohol, tobacco and other drugs is well known.

- The cost to Australian society of alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities by minimising alcohol, tobacco and other drug misuse in 2004-05 was estimated at $56.1 billion, including costs to the health and hospital system, lost workplace productivity, road accidents and crime. Of this, tobacco accounted for $31.5 billion (56.2 per cent), alcohol accounted for $15.3 billion (27.3 per cent) and illegal drugs $8.2 billion (14.6 per cent).
- The excessive consumption of alcohol is a major cause of health and social harms. Short episodes of heavy alcohol consumption are a major cause of road and other accidents, domestic and public violence, and crime. Long-term heavy drinking is a major risk factor for chronic disease, including liver disease and brain damage, and contributes to family breakdown and broader social dysfunction. Drinking during pregnancy can cause birth defects and disability, and there is increasing evidence that early onset of drinking during childhood and the teenage years can interrupt the normal development of the brain.
- Tobacco smoking is one of the top risk factors for chronic disease including many types of cancer, respiratory disease and heart disease.
- Illegal drugs not only have dangerous health impacts but they are a significant contributor to crime. They are a major activity and income source for organised crime groups. Like alcohol, illegal drugs can contribute to road accidents and violent incidents, and to family breakdown and social dysfunction. Unsafe injecting drug use is also a major driver of blood-borne virus infections like hepatitis C and HIV/AIDS.
- Other drugs and substances that are legally available can cause serious harm. The harmful use of inhalants, like petrol, paint and glue, can cause brain damage and death. The misuse of pharmaceutical drugs can have serious health impacts and their trafficking contributes to illegal drug-related crime.
- Alcohol, tobacco and other drug use can contribute to and reinforce social disadvantage experienced by individuals, families and communities. Children living in households where parents misuse drugs are more likely to develop behavioural and emotional problems, tend to perform more poorly in school and are more likely to be the victims of child maltreatment. Children with parents who drink heavily, smoke or take drugs are more likely to do so themselves – leading to intergenerational patterns of misuse and harms. Family breakdown and job loss is also associated with problematic drug use.
- Disadvantaged populations are at greater risk of harms from alcohol, tobacco and other drug misuse. For example, Aboriginal and Torres Strait Islander peoples experience a disproportionate amount of harms from alcohol, tobacco and other drug use. Drug-related problems play a significant role in disparities in health and life expectancy between Indigenous and non-Indigenous Australians. Indigenous Australians are more likely to die of smoking-related illnesses, such as diseases of the respiratory system and cancers, than other Australians.

Throughout this strategy, these terms are used:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug</td>
<td>The term ‘drug’ includes alcohol, tobacco, illegal (also known as ‘illicit’) drugs, pharmaceuticals and other substances that alter brain function, resulting in changes in perception, mood, consciousness, cognition and behaviour.</td>
</tr>
<tr>
<td>Illegal drug</td>
<td>A drug that is prohibited from manufacture, sale or possession – for example cannabis, cocaine, heroin and amphetamine type stimulants (ecstasy, methamphetamines).</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>A drug that is available from a pharmacy, over-the-counter or by prescription, which may be subject to misuse – for example opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine and steroids.</td>
</tr>
<tr>
<td>Other substances</td>
<td>Other psychoactive substances, legal or illegal, potentially used in a harmful way – for example kava, or inhalants such as petrol, paint or glue.</td>
</tr>
</tbody>
</table>

Harm minimisation
Since the National Drug Strategy began in 1985, harm minimisation has been its overarching approach. This encompasses the three equally important pillars of demand reduction, supply reduction and harm reduction being applied together in a balanced way.

- Demand reduction means strategies and actions which prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community.
- Supply reduction means strategies and actions which prevent, stop, disrupt or otherwise reduce
the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.

- **Harm reduction** means strategies and actions that primarily reduce the adverse health, social and economic consequences of the use of drugs.

The National Drug Strategy 2010-2015 seeks to build on this multi-faceted approach which is recognised internationally as playing a critical role in Australia’s success in addressing drug use.

Figure 1 illustrates the approach that will be taken to implement the harm minimisation framework under the National Drug Strategy 2010-2015:

- The three pillars apply across all drug types but in different ways. For example, supply reduction of legal drugs refers to regulation of supply, but for illegal drugs means disruption of supply. This is covered in more detail against each pillar.
- The approaches within the three pillars need to be sensitive to age and stage of life, disadvantaged populations and settings of use and intervention. People may be more vulnerable to experimenting with drugs at transition points such as moving from school to work. The workplace, schools, licensed premises and communities need to be considered as settings for possible interventions. The potential of new media, such as social networking sites on the internet, to deliver interventions also needs to be considered. Integrated cross-sectoral approaches may be needed for disadvantaged populations such as people with co-occurring mental health and alcohol and other drug-related problems. These are explained in more detail below and against each pillar.
- The three pillars will be underpinned by commitments to:
  - Partnerships across sectors
  - Consumer participation in governance
  - Building the evidence base, evidence-informed practice and innovation
  - Monitoring performance against the strategy and its objectives
  - Developing a skilled workforce that can deliver on the strategy.

**ENDNOTES**


Patterns of drug use and social attitudes to drug use have changed dramatically over time. Britain initiated the Opium Wars (1839 and 1858) with China over the opium trade – not to stop it, but to ensure that British interests profited from it. The Chinese wanted to ban opium consumption and importation. The British demanded that the Chinese buy (and presumably consume) opium from the British East India Company.

The notion of making drug use illegal did not really emerge in western societies until the late nineteenth century. Before that, in Australia, Britain, Europe, and the United States, whether people used drugs was considered a personal decision – subject to social disapproval, but not illegal. Alcohol was of course the most widely used psychoactive substance.

Medicinal origins
Most of today’s illegal drugs originally had medicinal uses. Opiates are very effective pain killers. Heroin, a very pure form of opiate, was developed – by the Bayer company – to treat wounded soldiers and send them back into battle as heroes (hence the name ‘hero-in’). It was used medically in many countries for many years. Ecstasy (MDMA) was first synthesised in 1912, and later used in psychotherapy. Cocaine was advocated by Sigmund Freud as a cure for heroin addiction (and it was also once an ingredient in Coca Cola). Until the early twentieth century, cannabis could be bought over the counter and was used (often in tincture form) to treat a range of ailments.

Before the 1960s, when the notion of ‘recreational’ drug use became a cultural phenomenon, most instances of drug dependency resulted from medical uses of drugs like heroin and morphine.

The idea of prohibition
Internationally, the temperance movement, which had begun in the late eighteenth century, gained prominence in the late nineteenth century, advocating the legal prohibition of alcohol and other drugs. The temperance movement argued against drug and alcohol use on the grounds that it was morally irresponsible and caused violence, indolence, poverty and social decay.

Influenced by temperance activists, US President Theodore Roosevelt convened an international opium conference in Shanghai in 1909, which was followed by another conference in The Hague in 1911, which led to the International Opium Convention. This convention became the foundation for later international treaties and conventions on drug use.

The 1914 Harrison Narcotic Act banned the production and sale of opiates and cocaine in the United States, the first prohibitionist legislation (although in form it was a revenue act, requiring the registration of, and payment of special taxes by, producers, distributors and suppliers of opiates and cocaine). In practice, it led to the arrest of thousands of doctors, pharmacists and addicts. The prescription of heroin for medical purposes was not explicitly prohibited by the Harrison Act, but in 1919 the US Supreme Court ruled that the prescription of narcotics was a violation of the ‘good faith practice of medicine’, and therefore a criminal offence under the Act.

The temperance movement had its most well known success in the United States when alcohol was legally prohibited in 1920 (under the Eighteenth Amendment to the Constitution, implemented by the federal Volstead Act and in many cases, state laws and local ordinances). The prohibition of alcohol was enforced enthusiastically – if unevenly – for many years, with special police squads used to crack down on both domestic distillers and alcohol smugglers. Organised crime gangs stepped in to produce and distribute alcohol, which continued to be very popular. Because it was easier to transport and to conceal, spirits took over from beer as the predominant form of alcohol.

Alcohol consumption probably rose during the prohibition years. In 1933, the United States abandoned its alcohol prohibition experiment.
and the Volstead Act was repealed. Cannabis was made illegal in a number of States in the 1920s, beginning with those States bordering Mexico or with large Mexican immigrant populations, and then spreading to others. Cannabis was prohibited federally in the United States by the 1938 Marijuana Tax Act (although it had already by then been banned in 26 States). Again, the Marijuana Tax Act was also strictly speaking a tax law, which imposed criminal penalties to punish use, possession, supply or cultivation.

Since the 1960s, the United States has waged a ‘War on Drugs’ both domestically and internationally. The Obama administration has abandoned the use of that language as counterproductive and has signalled a shift in resource allocation towards treatment domestically. It remains to be seen whether there is a similar shift in its international policy.

The United States has been the major funder and supporter of the International Narcotics Control Board, a UN body which monitors compliance with international drug treaties. There are several of these treaties – including the 1961 Single Convention on Narcotic Drugs – which require signatory states to pass laws to prohibit the use, possession, sale and production of drugs. Australia is a signatory to all the international conventions on psychoactive drugs.

Ironically, as the historian Alfred McCoy has shown, while the United States has been the most vocal promoter of international drug prohibition, actions of the United States military have given the international drug trade its biggest boosts. First, in the Second World War, American military intelligence made arrangements with Sicilian mafia figures such as Lucky Luciano to support the Allied invasion of Italy. The arrangement allowed the mafia to gain control of – and expand – the international heroin trade, including into the United States. Later, in Vietnam, the CIA sought alliances with the hill tribes of the Golden Triangle against the communist Viet Minh. In exchange for their political support, the CIA provided substantial transport and other logistical support for the hill tribes to sell opium and heroin. And United States soldiers in Vietnam became the major customers for the heroin, in many cases taking their heroin dependence back home with them.

The Vietnam War contributed to the significant increase in drug consumption in Australia in the late 1960s, with American soldiers on ‘rest and recreation’ leave in Australia creating a market for heroin, marijuana and other illicit drugs, and providing a glamorous example for the locals.

In 1976, the Netherlands adopted a policy of selective enforcement of its cannabis laws. The prosecutors and police are instructed not to prosecute minor offenders, and to tolerate a retail supply of cannabis through cafes. The laws prohibiting the possession and use (and supply and cultivation) of cannabis are not actually repealed, but they are not enforced – selectively – by government policy.

Several European countries have since relaxed their laws (or law enforcement) about possession offences, sometimes just for cannabis. But other European countries continue with a predominantly prohibitionist legal system. Sweden claims to have achieved relatively low levels of drug use with a firm prohibitionist approach, which includes compulsory treatment of drug users, and considerable public resourcing of drug rehabilitation and education programs, after an earlier period of liberalisation.

The United Nations World Drug Report 2010 estimated “that between 155 and 250 million people, or 3.5% to 5.7% of the population aged 15-64, had used illicit substances at least once in the previous year. Cannabis users comprise the largest number of illicit drug users (129-190 million people). Amphetamine-type stimulants are the second most commonly used illicit drugs, followed by opiates and cocaine.” (World Drug Report 2010, Chapter 2 Drug Statistics and Trends)

Harm reduction

Harm reduction focuses on minimising the negative impacts associated with drug use, individually and socially. While not advocating drug use, supporters of harm reduction argue that we should accept that some drug use will occur, and focus on addressing the harms caused.

This alternative approach to prohibition gained support in the 1980s, especially in Europe and Australia, and found expression in a number of public health programs.

In response to the arrival of the HIV/AIDS pandemic in the mid 1980s, needle exchange programs were introduced in Australia and in several European countries with the aim of preventing infectious contact between intravenous drug users. Needle exchange programs remain criminalised in many American States.

Safe injecting rooms were introduced in Europe in the 1990s. In 1994 Switzerland began a program of heroin prescription to heroin dependent people who had consistently failed earlier attempts at rehabilitation. The thinking is that providing heroin to participants gives them a chance to achieve greater stability in their lives, not least because they do not have to devote substantial time and energy to obtaining and paying for heroin. Heroin prescription now operates in several European cities and Vancouver.

Drugs in Australia

The first Australian drug law was an 1857 Act imposing an import duty on opium. In the following years, a number of other laws were passed imposing often prohibitive tariffs on opium. The primary purpose of the laws was clearly to discourage the entry of Chinese people to Australia, rather than to restrict the importation of opium itself.

Australians in the nineteenth century were among the world’s biggest consumers of opiates, thanks to the very wide popularity of patent medicines, most of which contained a high proportion of alcohol or
morphine or both. Laudanum, a mixture of opium and alcohol, was taken regularly by upper class matrons and administered to children to calm them.

The first laws restricting opium were carefully worded to apply to opium in smokable form only – not opium as it was taken by the European population.

Cannabis plants were sent to Australia by Sir Joseph Banks on the First Fleet, in the hope that the new colony might grow enough hemp to supply the British Navy with rope. Cannabis was not consumed on a large scale (although it was readily available for sale as cigarettes called ‘Cigares de Joy’ until the 1920s). Cannabis importation and use was prohibited by federal legislation in 1926 (implementing the 1925 Geneva Convention on Opium and Other Drugs), with the States adopting similar prohibition in the following years.

Heroin was legally available on prescription in Australia until 1953. It was so widely used as a painkiller and in cough mixtures that Australia was the world’s largest per capita user of heroin. The 1953 prohibition of heroin was the result of international pressure on Australia to conform to the prohibition of heroin adopted by other countries, with some opposition from the AMA. Ironically, heroin, cannabis, and other drugs were prohibited in Australia well before their use became a major social issue. Before the 1960s, drug use was not completely unknown, but dependent drug use was typically the result of the use of opiates after first using them for medical reasons. There were drug-dependent doctors (and their wives), and a small bohemian subculture that used drugs. Many Australian arrests for drug offences involved visiting jazz musicians.

Among the significant social changes of the 1960s was the emergence of the concept of ‘recreational’ drug use – the consumption of cannabis, heroin, LSD and other psychoactive drugs for pleasure, or in pursuit of spiritual enlightenment. For the first time, drug use became widespread – if not quite mainstream – rather than an activity pursued by a few painters or poets. The official response was increased law enforcement, and legislative change to extend the range of offences and increased penalties for drug offences.

The ‘old’ Australian drug laws were mostly under the various state Poisons Acts, reflecting an underlying approach of regulation and control of medicinal substances, with potentially addictive drugs legally available only on a doctor’s prescription. The ‘new’ drug laws introduced a distinction between use and possession offences, and supply offences. Penalties for possession and use increased, but very substantial penalties were introduced for drug supply, and especially supply of large quantities (‘drug trafficking’). By 1970, all the states had enacted laws that made drug supply a separate offence to drug use or possession offences.

In 1985, the federal and state governments adopted a National Drug Strategy which included a pragmatic mixture of prohibition and a stated objective of harm reduction. Harm reduction has been an official part of Australian drugs policy ever since, although most resources by far are devoted to policing and border patrol attempts at interdiction (‘supply reduction’). Fewer resources are made available for health treatment and drug rehabilitation programs, or for preventative public health programs such as needle exchange.

The needle exchange program has been successful. Australia maintains an extremely low rate of HIV infection among injecting drug users, compared to infection rates of 60% or more among injecting drug users in some US cities, where needle exchange remains illegal. The success of the needle exchange programs encouraged governments to at least consider adopting other harm minimisation initiatives.

The merits of a trial of a heroin prescription program, based on the Swiss model, were debated in the 1990s. The ACT government took steps to begin a trial program, but the Federal Government refused to allow the importation of heroin. Unable to source legitimate and controlled quality heroin, the ACT government abandoned the proposed trial.

Australia has been tentative about allowing legal injecting rooms, with NSW the only state to permit an injecting room, and then only one. The Medically Supervised Injecting Centre (MSIC) operated from 2001 to 2010 on a ‘trial’ basis. In October 2010 legislation to make the Kings Cross MSIC permanent, was passed by NSW Parliament. The Police Commissioner and the Director-General of NSW Health will continue to oversee the centre and it will undergo regular statutory evaluations every five years.

In all states, the impact of prohibitionist laws on drug users is somewhat modified by a number of diversion programs, diverting some eligible users from the criminal justice system to cautions or treatment.

**The drug policy debate**

Public debate over drug policy and calls for ‘drug law reform’ began in the late 1960s and has continued since. The opposition to prohibition was at first largely an argument on libertarian grounds: that people should have the right to consume drugs if they hurt nobody doing so, positing drug offences as victimless crimes. Those arguments are still made.

However, most arguments for reform today come from the harm reduction perspective. It is suggested that the legal prohibition of drugs creates crime, and makes drug-taking more physically dangerous. Prohibition also requires significant public expenditure without preventing significant levels of problematic drug use in the community.

The primary argument against relaxation of the criminal law treatment of drugs is that it would cause drug use to increase, and consequently lead to an increase in drug dependence. The social cost of drug use would increase, as would the costs of dealing with associated crime and drug-related disease. The public health system would be overwhelmed and the cost of treating drug addiction and drug-related disease would increase.

**Conclusion**

The failure of the national drug strategy to reduce drug use and drug-related harm is a fact, and it is argued that the harm reduction strategy has failed.

Australia currently has the most advanced national drug strategy of any country in the world. The drug policy is based on a pragmatic and evidence-driven approach, with a focus on harm reduction, treatment and harm minimisation. The ACT government has been a leader in the provision of harm reduction services, including the introduction of the first medically supervised injecting room in Australia in 2008.

The debate over the success or failure of these policies continues, with some arguing for more radical changes to the current system, while others advocate for a continued emphasis on harm reduction and treatment. The future of drug policy in Australia will continue to be shaped by these debates and the need to balance the competing goals of drug law reform, public safety and public health.
use would likely rise if drugs became more freely available and more freely consumed. Although prohibition cannot completely prevent drug use, the risk of being caught by the police has a directly discouraging effect on drug users and would-be drug users. Prohibition forces drug prices higher, indirectly discouraging drug use.

It is also argued that having laws which make drug use (and supply) illegal has a symbolic effect, 'sending a message' that drug use is socially undesirable.

The counter argument is that making some drugs illegal and yet allowing demonstrably harmful drugs like tobacco and alcohol to be freely available to adults is hypocritical and undermines respect for the law and other social institutions. Forcing up the price of drugs does not prevent people using drugs, but it might encourage people to commit property crimes, or to engage in drug supply offences, to obtain the necessary funds.

The enforcement of laws criminalising drug use can contribute to risk-taking behaviours – for example, injecting drugs alone, or consuming party drugs all at once to avoid sniffer dog detection.

There is a good deal of evidence to suggest that there is a link between illicit drug use and property crime, but the evidence is less strong in proving that drug use actually causes property crime. It may be that people who commit property crime are more likely to be drug users, so that drug use is not a cause. But it is clear that at least some drug-dependent people commit very large numbers of property crimes.

Similarly, there is a good deal of evidence to suggest a connection between cannabis use by teenagers and psychosis, but the evidence is less strong that cannabis actually causes psychosis. Most studies cannot rule out other drug use (especially amphetamines) as a potential cause of mental health problems, and it may be that people with mental health problems are more likely than others to use cannabis (so that the cannabis use is a feature, but not a cause). It is interesting that the national prevalence of psychosis in young people has not increased over the last twenty years, despite significant increase in cannabis use by young people.

The debate about the relative merits of these broad policy positions is not likely to end soon. However, it is likely that we will continue to see a variety of new laws and measures introduced – at times prohibitionist and at times harm reductionist – in an ongoing attempt to address the social consequences of drug use.

Discrimination against drug users

The social stigma attached to illicit drug use means that people who are identified as drug users can experience discriminatory treatment such as denial of services or accommodation.

Is drug addiction a disability?

Under both NSW and federal anti-discrimination laws, it is unlawful to discriminate against a person on the grounds of disability. Over a number of years, it had been frequently suggested that drug dependence was a form of disability, and therefore covered by the discrimination laws, but there was no case deciding the point.

Drug addiction and federal law

In Marsden v HREOC and Coffs Harbour RSL [2000] FCA 1619, a man was refused alcohol service at a club, and later expelled from club membership, because he was on a methadone program. He made a complaint of disability discrimination to the Human Rights and Equal Opportunity Commission (HREOC). The commission conducted an inquiry and concluded there had been no disability discrimination. Marsden appealed to the Federal Court, which decided that drug addiction could be classed as a disability for the purposes of the relevant federal legislation (the Disability Discrimination Act 1992 (Cth)).

Drugs and the law by Steve Bolt, online edition 2011. Hot Topics is intended as an introductory guide only and should not be interpreted as legal advice. Whilst every effort is made to provide the most accurate and up-to-date information, the Legal Information Access Centre does not assume responsibility for any errors or omissions.

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WHAT DO AUSTRALIANS THINK ABOUT THE LEGAL STATUS OF DRUGS?

What does the research evidence tell us about what Australians think about the legal status of drugs? A Drug Policy Modelling Program bulletin by Alison Ritter and Francis Matthew-Simmons

INTRODUCTION

This bulletin summarises data from a nationally representative survey of Australians’ on the legal status of drugs. We draw an important distinction between what Australians think about ‘legalisation’ versus ‘decriminalisation’, and what Australians think about different types of drugs (four drugs are compared: cannabis, ecstasy, heroin and meth/amphetamine).

KEY POINTS

• More than half Australians agree with decriminalisation actions for the personal use of cannabis, ecstasy, heroin and methamphetamine. This does not mean they support decriminalising the sale and supply of these drugs.
• Less than one quarter of Australians support the legalisation of cannabis, heroin, ecstasy, and methamphetamine.
• Australians do make a distinction between legalisation and decriminalisation options.

LEGALISATION OF DRUGS

Australians are asked whether they think that the personal use of drugs should be made legal. This question effectively asks people to think about drug use only (not to think about the sale or supply of drugs).

• 51% of Australians oppose the legalisation of cannabis for personal use.
• More than 75% of Australians oppose the legalisation of ecstasy for personal use.

TABLE 1: SUPPORT FOR LEGALISATION

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support legalisation</td>
<td>25.3%</td>
<td>19.5%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Oppose legalisation</td>
<td>48.4%</td>
<td>54.2%</td>
<td>51.3%</td>
</tr>
<tr>
<td>Ecstasy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support legalisation</td>
<td>7.3%</td>
<td>5.1%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Oppose legalisation</td>
<td>77.3%</td>
<td>81.2%</td>
<td>79.3%</td>
</tr>
<tr>
<td>Heroin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support legalisation</td>
<td>6.1%</td>
<td>4.9%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Oppose legalisation</td>
<td>81.0%</td>
<td>82.7%</td>
<td>81.9%</td>
</tr>
<tr>
<td>Meth/amphetamine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support legalisation</td>
<td>5.0%</td>
<td>4.2%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Oppose legalisation</td>
<td>81.6%</td>
<td>83.3%</td>
<td>82.5%</td>
</tr>
</tbody>
</table>

Footnote: There are some people who are neutral or don’t know whether they support legalisation for personal use or not. Hence the percentages do not sum to 100%: the remaining respondents either ‘don’t know’ or are ‘neutral’.

TABLE 2: SUPPORT FOR DECRIMINALISATION ACTIONS

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for decriminalisation actions</td>
<td>72.3%</td>
<td>73%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Ecstasy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for decriminalisation actions</td>
<td>50%</td>
<td>53.7%</td>
<td>51.9%</td>
</tr>
<tr>
<td>Heroin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for decriminalisation actions</td>
<td>42.7%</td>
<td>49.4%</td>
<td>46%</td>
</tr>
<tr>
<td>Meth/amphetamine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for decriminalisation actions</td>
<td>44.1%</td>
<td>50.1%</td>
<td>47.1%</td>
</tr>
</tbody>
</table>

Footnote: Some people don’t know what they think about decriminalisation. This represented 4% of the sample.

Legalising or decriminalising is the easier route. It allows for real progress in harm minimisation. But it does not allow us to address the underlying causes of drug use or the underlying causes of drug demand. This is where the research is really powerful. We know that, for example, cannabis use is strongly related to mental health issues. We also know that cannabis use is strongly related to alcohol use. And we know that cannabis use is strongly related to tobacco use. So we can start to think about how to address these underlying issues. We can start to think about how to address the underlying causes of drug use, and how to address the underlying causes of drug demand.

More than 80% of Australians oppose the legalisation of heroin and methamphetamine for personal use.

More than 75% of Australians oppose the legalisation of ecstasy for personal use.

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DECRIMINALISATION OF DRUGS

We define decriminalisation as a reduction of legal penalties. This can be done by either changing them from criminal to civil penalties, such as fines (as has occurred in some Australian states such as SA, ACT and NT for cannabis), or by diverting drug use offenders away from a criminal conviction and into education or treatment (known as ‘diversion’, and which is applied across Australia). Decriminalisation applies to drug use and possession offences, not to the sale or supply of drugs.

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When asked “What single action best describes what you think should happen to anyone found in possession of small quantities of cannabis/ecstasy/heroin/methamphetamine?” participants selected from a range of responses:

- Decriminalisation actions include: no action; caution/warning; referral to education; referral to treatment; and small fine ($200).
- Criminalisation actions include: substantial fine ($1,000); community service; weekend detention; prison; or other.

Table two (on the previous page) shows what Australians think about decriminalisation actions for each drug.

- The vast majority of Australians support decriminalisation actions for cannabis use.
- Half of all Australians support decriminalisation actions for ecstasy use.
- Just under half of Australians support decriminalisation actions for heroin and methamphetamine use.

ENDNOTE

1. These data are re-analyses of the Australian Institute of Health and Welfare’s National Drug Strategy Household Survey. In 2010, the total sample size was 26,648. The survey uses a multistage, stratified area random sample design. Data have been weighted to represent the Australian population.

The DPMP Bulletin Series is an accessible short snapshot on key drug policy issues and research. The series includes policy commentaries, summaries of DPMP research and concise reference documents that compile information from multiple sources. They are accessible through the DPMP website: www.dpmp.unsw.edu.au


Two-thirds of Australians are opposed to the easing of drug laws

A May 2012 Herald/Nielsen poll found two-thirds of Australians oppose decriminalisation

- Australians remain firmly opposed to relaxing illicit drug laws despite declarations by a group of eminent Australians (Australia21) and the UN’s Global Commission on Drug Policy recently claiming that the war on drugs has failed.
- The findings show little change in attitudes from a similar poll taken 13 years ago.
- The latest poll finds 27% of voters support decriminalisation, although that figure rises to 50% of Greens and 34% of Labor voters. Support among Liberal and National party voters is much lower, at 18%.
- Attitudes on the issue are entrenched; just 4% say they neither supported nor opposed decriminalisation and 2% say they did not know.
- Greens voters, at 23%, were the most likely to say they or their family had been adversely affected by illegal drugs, compared with 19% of ALP voters and 15% of Coalition voters.
- Men were more likely to support decriminalisation (31%) than women (24%).
- A similar poll taken in March 1999, soon after the Howard government had controversially blocked a heroin trial in the ACT, showed that 71% opposed decriminalisation of heroin use. However, in this latest survey, 45% supported a heroin trial and a similar number supported safe injecting houses for heroin users.

ENDING THE PROHIBITION OF ILLICIT DRUGS

WHERE TO FROM HERE?

Despite gains made in Australia’s harm minimisation program two decades ago, the current situation on illicit drugs is damaging Australian society and resulting in an unacceptable and avoidable death toll.

While recognising the harms that psychoactive drugs are causing, the policy of prohibition, with its emphasis on criminalisation of use and possession, is exacerbating those harms. It is time to reactivate Australian debate on this matter, drawing attention to the accountability of governments for allowing an unacceptable situation to persist, and the fact that the community has allowed this to happen. Such a public debate will not be initiated by politicians, who will only be activated on this contentious issue when there is a strong community groundswell demanding it. Currently, such a groundswell does not exist. The drug culture is flourishing, but so is the culture of fear, which is promoted by the prohibition approach. Many Australians are particularly concerned that liberalisation of our drug laws could increase, rather than diminish, the dangers to children, although a growing international body of evidence indicates that these fears are misplaced. Only when this fear is confronted and the mounting body of evidence of the benefits that could flow from a health-focused approach, regulation and social control, can change be introduced.

There was recognition in the Australia21 Roundtable that reform of drug law with legalisation, regulation and marketing controls is being advocated in the United States at present by a conservative Republican candidate for the Presidency, Ron Paul. The argument in favour of drug law reform was linked to discussion of John Stuart Mill’s principle that activity should be permitted unless it directly poses threats to others. From first principles, this makes it difficult to justify prohibition of personal drug use. There are firm moral, ideological and rights arguments that mean that vigorous drug law reform could have broad political appeal. There is a significant practical and moral difference between problematic and non-problematic substance use but prohibition does not distinguish between the two. International experience with drug law reform to date indicates that decriminalising use and possession has no significant effect on rates of use.

One aspect of the debate which is rarely discussed is that it is now, when the drug problem seems to be relatively quiet, that we can have a sensible debate. Experience shows that a crisis in drug policy occurs every few years. It is much harder to have a sensible debate in the middle of a crisis.

Participants agreed that, for this issue to return to political attention, young people and the broader community will need to be engaged in the policy discussion. In order to move this debate forwards, it was argued that the medical profession, the pharmaceutical profession, churches, civil society groups, university student groups and the media need to be engaged in thoughtfully considering the options. This is also a matter which concerns employers and businesses of many kinds. But if the issue is to be addressed, the national debate must move beyond moralistic slogans and sound bite rhetoric.

It was also recognised that Australia could play a valuable role internationally in challenging the current operation of the treaties and conventions, which have imposed a blanket of drug prohibition on the global community.

The group did not propose a specific set of policy changes. It saw the need to unmask prohibition and its harms and to place the onus on our lawmakers and other community opinion leaders to develop a process that stops the criminalisation and continuing drug deaths of too many young Australians. We should remind ourselves that the 1961 Single Convention, the foundation of the current global system, opens with these words “Concerned with the health and welfare of mankind ...”

RECOMMENDATIONS ARISING FROM THE ROUNDTABLE

1. Australia21 should act to re-open national debate on prohibition, distribute this report to every parliamentarian in Australia and to civil society organisations, business leaders, selected activist groups, student groups in tertiary institutions, law enforcement groups, churches, unions and government agencies, with an invitation to assist in publicising the findings of the Global Commission on Drug Policy.

2. The Board of Australia21 should establish an Expert Advisory Group, charged with the responsibility for raising funds to undertake follow-up of the Roundtable, including the conduct of focus groups in a range of Australian demographic groups and current pattern of allocation. If anything, considerable sums have been spent converting a bad problem into an even worse problem.

Why should Australia start debating this problem now when the situation has been much worse at other times? This is a very reasonable question. The answer is that it is now, when the drug problem seems to be relatively quiet, that we can have a sensible debate. Experience shows that a crisis in drug policy occurs every few years. It is much harder to have a sensible debate in the middle of a crisis.

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2. The Board of Australia21 should establish an Expert Advisory Group, charged with the responsibility for raising funds to undertake follow-up of the Roundtable, including the conduct of focus groups in a range of Australian demographic groups and
professionals dealing with social problems. The group should initiate transparent discussions with organisations in Australia who favour continuation of our current prohibition policy. The expert group should make widely available scientific evidence arising from studies of the economics and statistics of national and international innovations in drug policy.

3. Australia21 should initiate a series of roundtable discussions among key stakeholder groups, including especially young people, peak medical and pharmaceutical bodies, faith groups, civil society groups and senior law enforcement agencies.

4. The Expert Advisory Group should seek meetings with economists and ministerial policy advisors to discuss the findings of this report, and also with:
   • The Intergovernmental Committee on Drugs, the Australian National Council on Drugs and the national drug licensing and regulatory authorities about the need to consider medical use of cannabis and prescribed heroin for the management of people who are heroin dependent.
   • The Federal Attorney-General, Minister for Health and Minister for Foreign Affairs about Australian compliance with the international drugs treaties and conventions and the need to consider the growing international experience with alternatives to prohibition and to initiate international discussions about the findings of the Global Commission on Drug Policy.
   • Senior representatives of the media about the role of the media in promoting an evidence-based discussion on national policy on illicit drugs.

5. Australia21 should undertake a further Roundtable on these matters early in 2013.

By maintaining prohibition and suppressing or avoiding debate about its costs and benefits, it can be argued justifiably that our governments and other community leaders are standing idly by while our children are killed and criminalised.

**IN A NUTSHELL**

- Prohibition puts the production, distribution, and control of illicit drugs into the hands of criminals and exposes young people, police and politicians to their corruptive influence.
- The harms resulting from prohibition substantially outweigh the gains from efforts by police to suppress the criminal drug industry – a fact now accepted by many politicians, police, researchers and leaders of civil society across the world.
- The harms include a large planeload of avoidable Australian deaths annually; home and property crime; our prisons and justice system clogged by victims of the industry; a flourishing drug culture that is fostered and controlled by criminal interests and a complete lack of control of the dosage and toxicity of the drugs that young people are consuming.

- International drug prohibition has, until now, been maintained through international treaties and conventions, spear-headed by a US ‘War on drugs’. The recognition that this war has been comprehensively lost is leading to an international rethink about prohibition and about these treaties and conventions.
- The enormous profits from the black market trade in drugs mean that an ounce of heroin costs many times more than an ounce of gold. The criminals are much better resourced than law enforcement authorities and any success that police have in reducing the supply, results in an increase in the price of drugs and an increase in criminal profits and activities.
- Despite decades of a prohibition approach in Australia, illicit drugs are easily purchasable on our streets and in our prisons. The perverse nature of the system ensures that a steady stream of young people becomes dependent on a continuing supply of drugs.
- Large amounts of public funds are allocated to a failed law and order approach to drug use. These resources would be better directed to managing drug use as a health and social issue as we do with nicotine and alcohol.
- Drug taking undoubtedly produces serious harms to individual drug users and their families. Many of the harms to them, to others and to society at large are a result of the national policy of prohibition and criminalisation which, arguably, increases, rather than decreases, the risks of more people becoming drug dependent.
- This is a very complex issue that demands proper community discussion of a range of alternatives to prohibition, that are now being considered everywhere including in the United States where the failed war on drugs and prohibition began.
- National drug policy should be based on evidence of what works and what does not and the international evidence base on these issues is now both substantial and persuasive.
- It is time to stop sloganeering and insist to all of our political representatives and to our media that Australia must have an informed national debate about the alternatives to a policy that has failed disastrously and is criminalising our young.

AUSTRALIA21 REPORT LACKS SUBSTANCE

The so-called ‘high level’ Australia21 report on illicit drugs, suggesting that decriminalisation across the board, will solve our country’s drug problems, lacks sound scientific basis and credibility and, as such should be discounted, according to this response from Drug Free Australia.

The so-called ‘high level’ Australia21 report on illicit drugs, suggesting that decriminalisation across the board, will solve our country’s drug problems, lacks sound scientific basis and credibility and, as such should be discounted. The following are just some of the reasons:

First, it is not the ‘War on Drugs’ that has failed, but rather, it’s the failure of Australia’s illicit drugs policy to satisfactorily address primary prevention, said Jo Baxter, Executive Officer, Drug Free Australia.

For over 25 years we have endured a policy of harm minimisation, which has left a ‘train wreck’ in families and communities. It has failed to prioritise prevention and spent costly resources on drug maintenance programs, rather than helping people to recover from drug addiction.

For over 25 years we have endured a policy of harm minimisation, which has left a ‘train wreck’ in families and communities.

Many reputable reports, such as a recent one in the Lancet, reveal that Australia has among the highest cannabis and amphetamine use rates in the Asia Pacific. For over a decade, the United Nations World Drug Reports have shown a constant trend, that our illicit drug use rates are the highest in the OECD.

This policy is failing our emerging generation. For instance – the decision to decriminalise cannabis in some states, in the late 1980’s has resulted in our young people being confused about its legal status, with the misconception that marijuana is a legal drug and therefore ‘safe’. The result? Marijuana is the most used of all the illicit drugs. The sad reality is a rise in cases of impaired driving and road trauma, increased incidence of mental illness, including schizophrenia, psychosis and violent episodes. Cannabis is also proven to be a ‘gateway drug’ to amphetamines, crystal meth and heroin. There is now indisputable scientific evidence that it has higher THC content, making it at least as harmful as those in the ‘hard drug’ category.

History shows that, once a drug is made legal, its use accelerates and increases. It becomes a more ‘acceptable’ substance, and usually becomes more accessible. We only have to look at the impact of alcohol and tobacco – both legal, both regulated and both the most damaging in terms of burden of disease in Australia.

Why would the authors not consider these facts? Perhaps their credibility should be questioned? They have failed to recognise that, between 2000 and 2006, when Australia had a ‘Tough on Drugs Strategy’ our illicit drug use rates dropped significantly. The trend now appears to be turning around. Interestingly, this corresponds with the discontinuation of the National School Drug Education Strategy and no visible signs of a clear federal Tough on Drugs Strategy.

The report lacks real substance, and poses numerous generalisations that may sound feasible...
on the surface, but lack practical application. For example, it fails to provide any resolution to the list of tough practical questions posed by the United Nations INCB when addressing the issues around levels of drug legalisation and decriminalisation.

It also fails to give credit to such successes of 100 years of UN Drug Control Conventions as:
- In 2007 drug control had reduced the global opium supply to one third the level in 1907.
- During the last decade, coca cultivation has decreased by one third and the world output of cocaine, and amphetamine type stimulants have stabilised.
- Cannabis output has declined since 2004.

It fails to include relevant information from countries that have tried a more liberal approach and have returned to focus on harm prevention.

For instance:
- **Sweden** – tried legalising and prescribing illicit substances as far back as 1965 and then abandoned it for a ‘restrictive’ drug policy when usage rates escalated. Sweden continues to enjoy the lowest per capita illicit drug use rates in the world. It is no coincidence that they have a correlation of low drug use and significantly lower child abuse rates than their counterparts in Europe.
- **The Netherlands**, who has had a history of liberal drug policy, is now doing an about face. For example in the 1970s, ‘coffee shops’ emerged in the Netherlands offering marijuana products for sale. Even though possession and sale of marijuana are not technically legal, the coffee shops were permitted to sell marijuana under certain restrictions to include a limit of no more than 5 grams sold to a person at any one time. The Dutch saw the use of marijuana among young people more than double. The use of ecstasy and cocaine by 15-16 year olds rose significantly. After marijuana use became normalised, consumption among 18 to 20 year olds nearly tripled – from 15 per cent to 44 per cent. It has since declined due to an anti-marijuana program by the government. In 2004, the government of the Netherlands formally announced its mistake. It stated that “cannabis is not harmless – either for the abusers or for the community”. The Netherlands began to implement an action plan to discourage cannabis use and is currently actively closing many of its coffee shops.

History shows that, once a drug is made legal, its use accelerates and increases.
- **Portugal** – recently, heralded by some who would legalise drugs in Australia, as a model to be emulated, is now winding back its harm reduction strategies, as the results have not been what they had anticipated.
- **In the United States** the Obama Administration has categorically stated that it will not legalise illicit drugs and is actively cracking down on those states where medical marijuana has been sanctioned.
- **The UK** have reversed their National Drug Strategy (2010) from the previous emphasis on harm reduction to one of demand reduction and primary prevention.

Though the authors may once have played a role in policy and practice in the illicit drug arena, they now appear to be somewhat out of touch with current scientific evidence, as well as the reality of what the vast majority of people in Australia really want – a healthy future for our kids.

Decriminalisation or legalisation:
INJECTING EVIDENCE IN THE DRUG LAW REFORM DEBATE

An opinion piece reproduced from *The Conversation* by Alison Ritter, Professor and Specialist in Drug Policy at the University of New South Wales

We should all be concerned about our laws on illegal drugs because they affect all of us – people who use drugs; who have family members using drugs; health professionals seeing people for drug-related problems; ambulance and police officers in the front line of drug harms; and all of us who pay high insurance premiums because drug-related crime is extensive.

Drug-related offences also take up the lion’s share of the work of police, courts and prisons. But what can we do? Some people feel that we should legalise drugs – treat them like alcohol and tobacco, as regulated products. And legalisation doesn’t necessarily need to apply for every illegal drug.

Why legalise?

One of the arguments for legalisation is that it would eliminate (or at least significantly reduce) the illegal black market and criminal networks associated with the drug trade. Other arguments include moving the problem away from police and the criminal justice system and concentrating responses within health.

Governments could accrue taxation revenue from illegal drugs as they currently do from gambling, alcohol and tobacco. A regulated government monopoly could secure direct income; our research suggests this may be as high as $600 million a year for a regulated cannabis market in New South Wales.

The strongest argument against legalisation is that it would result in significant increases in drug use. We know that currently legal drugs, such as alcohol and tobacco, are widely consumed and associated with an extensive economic burden to society – including hospital admissions, alcoholism treatment programs and public nuisance. So why create an environment where this may also come to pass for currently illegal drugs?

The moral argument against legalisation suggests the use of illegal drugs is amoral, anti-social and otherwise not acceptable in today’s society. The concern is that legalisation would ‘send the wrong message’.

The moral argument against legalisation suggests the use of illegal drugs is amoral, anti-social and otherwise not acceptable in today’s society.

Unfortunately, there’s no direct research evidence on legalisation because no country has legalised drugs yet. But suppositions can be made about the extent of cost-savings to society.

Indeed, some of our research on a regulated legal cannabis market suggests that there may not be the significant savings under a legalisation regime that some commentators have argued. But these are hypothetical exercises.
Decriminalisation

An alternative to legalisation is decriminalisation. Experts don’t agree on the terminology and there’s much confusion. But, in essence, decriminalisation refers to a reduction of legal penalties. This can be done either by changing them to civil penalties, such as fines, or by diverting drug use offenders away from a criminal conviction and into education or treatment options (also known as ‘diversion’).

Decriminalisation largely applies to drug use and possession offences, not to the sale or supply of drugs. Arguments in favour of decriminalisation include its focus on drug users rather than drug suppliers. The idea is to provide users with a more humane and sensible response to their drug use.

Decriminalisation has the potential to reduce the burden on police and the criminal justice system. It also removes the negative consequences (including stigma) associated with criminal convictions for drug use.

One argument against decriminalisation is that it doesn’t address the black market and criminal networks of drug selling. There are also concerns that it may lead to increased drug use but this assumes that current criminal penalties operate as a deterrent for some people.

The moral arguments noted above also apply to decriminalisation – lesser penalties may suggest that society approves of drug use.

Many countries, including Australia, have decriminalised cannabis use: measures include providing diversion programs (all Australian states and territories), and moving from criminal penalties to civil penalties (such as fines in South Australia, Australian Capital Territory and the Northern Territory).

Decriminalisation has the potential to reduce the burden on police and the criminal justice system. It also removes the negative consequences associated with criminal convictions for drug use.

Our team’s research on Portugal suggests that drug use rates don’t rise under decriminalisation, and there are measurable savings to the criminal justice system.

In Australia also, there hasn’t been a rise in cannabis use rates despite states and territories introducing civil penalties for users. And research on diverting drug use offenders away from a criminal conviction and into treatment has shown that these individuals are just as likely to succeed in treatment as those who attend voluntarily.

At the same time, research has also noted a negative side effect to the way in which decriminalisation currently operates in Australia – ‘net widening’ – whereby more people are swept up into the criminal justice system than would have occurred otherwise under full prohibition because discretion by police is less likely and/or they do not fulfil their obligations.

Despite the largely supportive evidence base, politicians appear reluctant to proceed along the decriminalisation path. Some commentators have speculated that this is because of public opinion – decriminalisation is regarded as an unpopular policy choice.

But public opinion is largely in support of decriminalisation, where it concerns cannabis (though not decriminalisation for other illegal drugs). In the last national survey, more than 80% of Australians supported decriminalisation options for cannabis. The other reason for equivocal policy support, I believe, is a lack of clarity about the issues.

There’s poor understanding about the different models of decriminalisation and some basic confusion exists. Many people equate decriminalisation with legalisation, but as detailed above, they are very different in policy, intent and action.

Decriminalisation is also sometimes incorrectly confused with harm reduction services, such as injecting centres or prescribed heroin programs.

The Australia21 report released last week to stimulate informed public debate is an important step forward. In order for the debate to progress, we need clarity of terms, and dispassionate presentation of what evidence we have. Every policy has both risks and benefits and we need to talk about these.

Alison Ritter is Professor and Specialist in Drug Policy at the University of New South Wales.

THE CONVERSATION

AUSTRALIA’S DRUG POLICIES
AN INTERVIEW WITH MAJOR BRIAN WATTERS

Katherine Spackman from the Australian Christian Lobby interviews Major Brian Watters, former chairman of the Australian National Council on Drugs, on his views on recent calls for drug law reform.

Welcome to The Political Spot, I’m Katherine Spackman. This week the think group, Australia21, released a report saying the war on drugs had failed and that Australia should consider legalising some substances. Salvation Army Major Brian Watters who has been the chairman of the Australian National Council on Drugs during the Howard Government and recently retired from the United Nations narcotics control board, joins me now. Welcome to the program.

Brian Watters: Thank you Katherine.

Katherine Spackman: What do you make of these suggestions about the War on Drugs has failed?

Brian Watters: Well look the sad thing is I don’t know why people keep going on with these slogans. We have never used that term in Australia and it has never been national policy. If what has been happening in Australia over a number of years was a war, if we fought the Second World War that way, we would all be talking Japanese, I can tell you. Because it’s never been a war, but we’ve fought the Second World War that way, we would all be talking Japanese, I can tell you. Because it’s never been a war, but we’ve had a balanced approach in many ways to the drug issue, and we’ve had periods when we were very, very successful. During the Howard era, we had between 80 and 90 per cent drop in drug deaths in Australia. More than 700 young people a year were being saved from drug deaths by the policies that were put in place. We were the only country in the world that had what we called a heroin drought. We knew from our intelligence services that many of the big drug dealers from around the world had decided it wasn’t worth trying to do business in Australia, it was too risky. And over the last few years we’ve gone backwards again.

Katherine Spackman: How should we use the law in respect to drugs?

Brian Watters: I certainly agree if this is what the people who are putting out this proposal are saying, that we should be very careful not to be criminalising young people, or anybody because they are using drugs. That’s a pretty heavy-handed approach. We should not be sending people to jail if they’ve got an addiction. That’s barbaric. But we should have systems whereby we can compel people to go in and have treatment. We should be using the police to intervene where people are completely out of control, and to support families, and we can certainly use compulsory type treatment and expand the number of facilities. Treatment works if it’s done properly. I have seen hundreds and hundreds of people who would appear to have been absolutely hopeless cases of addiction come good and get on and lead a meaningful life. As I said, so often it’s because of the intervention of the police that they’ve been prepared to look at themselves. And I have had them say to me: “That policeman saved my life.” And that’s what we ought to be doing with the police.

Katherine Spackman: So what is the solution to this?

Brian Watters: Well, there’s no easy solution, except I do get frustrated when people try to give us these deceptively simple solutions: “If we legalise it, and take away the criminal element and take away the profitability of it – (as if we could do all that) there’d be no problem.” It’s a nonsense. And even though it does cost us to maintain our stand against drugs and to provide the law enforcement, etc. we don’t say that with the other things that cost us money, I mean, the number of deaths on the road that are caused by speeding and by wild driving, we don’t say, well look, we will take out the traffic lights and we’ll take the policemen off the road, and if we haven’t got all of these controls the thing will resolve itself. Because we can’t completely stop murder and abuse and rape and burglary, we don’t say, “well, we will give up.” And that’s really, in essence, what’s being said, evidently, but I can tell you from many, many years of experience that families have been beside themselves trying to help their children and it’s only when the law intervened, and took a strong stand and made these people go into treatment that they turned their lives around.

Katherine Spackman: And how so?

Brian Watters: Well, the amount of drug use has escalated. The amount of cocaine coming into the country has escalated – there’s been reduction of the funding and of the facilities for Australian customs to intervene and to stop the flow of drugs into the country. We haven’t got the same sort of support. The Federal Police and others did some brilliant work in the past. The result has been that we’ve become a much more attractive and easily penetrated market for these people. On top of that, I don’t know exactly what is in this paper that has been published and I don’t want to be unfair to them, but this idea that somehow if we liberalise or even, as they talk about, decriminalise the use of drugs, it’s going to solve the problem, is a nonsense. The biggest drug problems that we have in Australia, the most deaths, are caused by a legal drug namely tobacco, and the biggest social problems and the greatest amount of criminality is involved with alcohol. Now they are both available legally, and under controlled situations, and they cause enormous problems. If we were to go down the same track with the currently illicit drugs the same thing would happen. Exponentially it would grow.

Katherine Spackman: That was Salvation Army Major General Brian Watters, talking about the report handed down this week by the think tank group, Australia21, into decriminalising some drugs.

Time to get specific in the drug policy debate

Events in recent months have led to growing national and international recognition that the criminalisation of drugs is producing more social and geopolitical harms than benefits, observes Bob Douglas

In the presence of continuing demand, prohibition leaves the production, distribution, regulation and quality control of drugs such as heroin, cocaine, amphetamines, ecstasy and cannabis in the hands of criminals.

The 2011 Global Commission on Drug Policy report declared that a new approach is needed, with future policy based on community understanding and sound research.

In April this year, Australia21 published a report of a round table of eminent Australian experts on illicit drug policy. This echoed the Global Commission report and urged the re-opening of a national debate on more effective responses to drugs.

Since the launch of Wikicurves and a Sydney symposium organised by Fairfax on May 21, a number of excellent articles from both sides of the debate about prohibition have appeared in Fairfax media. This includes yesterday’s response by the opposition health spokesman, Peter Dutton, who argued against any move to decriminalise drugs.

Australian drug policy has been shaped by a national strategy that since 1985 has been built around three pillars.

The first pillar, known as ‘supply reduction’, aims to reduce the availability of drugs through legislation and law enforcement.

The second pillar, called ‘demand reduction’, involves efforts to reduce the demand for drugs through prevention and treatment services.

The third element of the national strategy aims to directly reduce the harm done by drugs to people who continue using them – ‘harm reduction’, for short.

In the 1990s, Australia was among the countries at the leading edge of international harm reduction.

In 1997, the Howard government drew back from harm reduction and placed renewed emphasis on supply and demand reduction. The government had come under strong pressure from international agencies committed to prohibition and then prime minister John Howard said the latest development in harm reduction strategies – making heroin medically available to some selected heroin dependent people – “sent the wrong message”.

Dr Michael Wooldridge, health minister in the Howard government, had the last word in the Australia21 report. He said: “The key message is we have 40 years of experience of a law and order approach to drugs and it has failed.”

“The key message is we have 40 years of experience of a law and order approach to drugs and it has failed.”

The Australia21 report made no specific recommendations apart from urging, after more than a decade, a reopening of the debate about drug policy. Now that that debate is happening, we need to develop specific proposals for a better way to manage a problem that kills 400 Australians annually and is little affected by our dominant and very expensive law enforcement approach.

Australia is currently in a conservative political mood. It was the Republican US president, Richard Nixon, who declared a war on drugs in 1971.

President Ronald Reagan’s former secretary of state, George Shultz, joined the Global Commission on Drug Policy in 2011 and declared that the war on drugs has been lost. Many of the leading advocates for drug legalisation have been conservative thinkers arguing for market regulation, taxation and social control.

So where should Australia head now?
Several European countries have been trying new approaches. Portugal, Switzerland, Sweden and Holland offer different and relevant approaches, which might well have lessons for Australia.

A vigorous debate about drug policy has also developed in the United States in recent years, with a growing acknowledgement that current approaches have failed.

The tendency in Australia in recent months has been to fear that any softening of prohibition could encourage increased drug use. Rigorous evaluation of some of the European experiments is now available. Some of this evaluation is beginning to appear in the Australian discussions.

**As the world moves away from a preoccupation with prohibition, it is likely to place more emphasis on the social determinants and health impacts of the use of these drugs.**

It is clear that there is no magic bullet for policymakers, with any change producing winners and losers. The biggest losers if prohibition is eased are likely to be the drug barons.

Parents are understandably concerned that liberalising policy could increase the risk that their children might become entrapped by drugs.

The drug barons assiduously promote the drug culture in Australia and internationally. There is no doubt that some currently illicit drugs have enormous potential for harm; that many are addictive (especially heroin) and that drug dependence frequently ruins lives and families.

A shift in policy from prohibition to varying forms of decriminalisation is now being tried in many parts of the world. Finding the least-worst solution to this complex problem now requires careful examination of the European experience, which has recently paid more attention to demand and harm reduction than to relatively ineffective, often counterproductive and always expensive law enforcement efforts to reduce supply.

As the world moves away from a preoccupation with prohibition, it is likely to place more emphasis on the social determinants and health impacts of the use of these drugs.

At its next round table in July, Australia21 will concentrate on what we can learn from the collective European and US experience. We hope this will be a genuine dialogue about a better way forward for Australia and are inviting representation from both the federal health minister and the opposition health spokesman’s offices.

Emeritus Professor Bob Douglas AO was a co-author of the Australia21 report, *The prohibition of illicit drugs is killing and criminalising our children and we are all letting it happen.*

www.australia21.org.au

As a father I understand how dear children are to parents no matter their circumstances.

Law enforcement does achieve significant results and is not yet at its peak of effectiveness.

A recent report by the non-profit group Australia21 advocates decriminalisation with the strongly emotive title *The Prohibition of Illicit Drugs Is Killing and Criminalising Our Children and We Are All Letting It Happen*. I strongly oppose ending illicit drug prohibition because it would be a dreadful experiment with the future of our children, who are the very fabric of our nation. I contend that the decriminalisation of illicit drugs would be more likely to kill and criminalise children and we should not let it happen.

As my contrary words demonstrate, neither side has a monopoly on emotive language. Before addressing the substance of this debate, it is worthwhile considering the tone.

Many arguments in the Australia21 report unfortunately infer that supporters of decriminalisation are experienced, scientific and caring and that opponents supposedly mobilise fear, are callous to the human cost and beholden to the ‘drug law enforcement’ industry.

I caution against automatically characterising participants in this debate as more informed, reasoned, caring or noble simply because of the position they take.

I would also caution on use of case studies from other nations as proof for the decriminalisation case. Given the significant economic, legal and cultural differences between Australia and nations with divergent drug policies, decriminalisation examples are often poor templates for a complex issue. Indigenous Bolivians chewing coca leaf are of little policy relevance to an Australian teenager injecting heroin.

Support for decriminalisation of illicit drugs relies on questionable assertions, including that law enforcement is ineffective, that drug harm is predominantly caused by criminal law and that decriminalisation would solve existing illicit drug problems without creating worse unintended consequences.

Law enforcement has not failed, it’s just not 100 per cent of the answer. We need a pluralistic approach. Specific measures such as quarantining welfare payments and treatment programs can assist families to survive while battling addiction. More broadly economic growth is vital in addressing illicit drugs and many other social problems. Employment provides personal meaning and financial means to reduce the likelihood of social problems.

Law enforcement does achieve significant results and is not yet at its peak of effectiveness. Enforcement can and does reduce supply. Reduction in supply not only reduces the availability but can also increase price, resulting in reduced consumption.

Just as economic challenges require constant reform, law enforcement always has a new horizon. For example, proceeds of crime action. Seizing the assets of drug traffickers can still achieve more in making the drug trade uneconomic for organised crime. In addition to direct impact on supply, enforcement sends a clear message to our youth about the community’s view of illicit drugs as dangerous and illegal.

Drug harm is not caused by criminal law. Criminal sanctions facilitate treatment of users and protects the wider community from harm. Many states have cautioning programs that divert low-level drug offences from courts and compel individuals to attend counselling. The removal of the threat of criminal sanctions would make it near impossible to compel attendance for such purposes. With more serious or recidivist offenders, if the ability of the justice system to impose custodial sentences is removed there is little ability to force individuals to take responsibility. The impact of drug use then continues. The reality is that courts sentence drug users compassionately when they eventually appear.

Illicit drugs are illegal because of their harmful chemical composition, not harmful because they are illegal. Drug-induced or exacerbated mental problems destroy lives and impact our health system. Individuals under the influence of drugs will continue to commit crimes regardless of the source or regulation of the substance.

Illicit drugs are illegal because of their harmful chemical composition, not harmful because they are illegal.

At a time when the government is increasing the regulation against tobacco and alcohol it is difficult to understand support for a soft approach on illicit drugs. Decriminalisation would inevitably create unintended consequences and a minefield of new policy pitfalls. Complex problems frequently need a pluralistic approach. Pessimism and frustration should not be catalyst for dangerous social experiments such as decriminalisation. Incremental improvement on many fronts such as enforcement, economic growth and treatment will be far more likely to lead to progress.

After 33 years, I can no longer ignore the evidence on drugs

In recent decades, Australian governments have relied heavily on drug law enforcement – while providing more limited funding for health and social responses – yet the drug market has continued to expand, observes former Federal Police commissioner, Mick Palmer, in this opinion piece from The Sydney Morning Herald.

As a 33-year police practitioner who was commissioner of the Australian Federal Police during the ‘tough on drugs’ period, I fully understand the concerns of those who argue there is no reason to reconsider drug policy and I shared many of them until recent years. My police experience, in both the state/territory and federal jurisdictions, together with some 15 months practising at the private bar as a defence barrister and several years experience in the drug and alcohol fields, has convinced me that I was wrong.

The reality is that, contrary to frequent assertions, drug law enforcement has had little impact on the Australian drug market. This is true in most countries in the world.

In Australia the police are better resourced than ever, better trained than ever, more effective than ever yet their impact on the drug trade, on any objective assessment, has been minimal.

In the Herald last week (see previous page), the opposition health spokesman, Peter Dutton, asserted that “law enforcement does achieve significant results and is not yet at its peak of effectiveness”. I feel compelled to respond, because frankly the evidence does not stack up. In Australia last year, 86 per cent of drug users said that obtaining heroin was “easy” or “very easy”, while 93 per cent reported that obtaining hydroponic cannabis was “easy” or “very easy”.

The price of street heroin and cocaine decreased by more than 80 per cent in the US and Europe in the past 20 years. Despite a huge investment by the US in drug law enforcement, northern Mexico has descended into a drug cartel battlefield, driven by the demand for illicit drugs within the US. At the local level, our young people can and do purchase illicit drugs with ease and generally with impunity. If this is an effective policy at work, I am not sure what failure would look like.

In any conversation, however, it will be important to acknowledge that there are no good guys or bad guys in the debate, only concerned guys. Too often emotion tends to drive public commentary, with proponents of either side branding their opponents as either “soft on drugs loopy” or “the prohibitionist Gestapo”. Neither label is correct or adds value to the debate.

Mr Dutton argues that supporters of the present policy are just as well informed on the subject as those arguing for consideration of change. The truth is I have found it difficult to find informed commentators willing to support the present drug policy. The Australia21 report was largely based on a roundtable discussion which included two former senior law enforcement officials, two former Commonwealth ministers for health, a former ACT chief minister, two former state Labor premiers, many of Australia’s leading drugs researchers and clinicians, parents who had lost children to drugs and two very impressive young people.

The report came to the same general conclusion as the 2011 report of the Global Commission on Drug Policy, which included former presidents of four countries, a former UN secretary-general, a former chairman of the US Federal Reserve and a former US secretary of state. One of the advocates for drug law reform in South America is Otto Perez Molina, the President of Guatemala, who used to be in charge of drug law enforcement in his country.

We owe it to future generations to be realistic; to be prepared to listen and consider these commentaries and to examine the facts and the options.

Mr Dutton also cautions against the use of experience of other countries that have benefited from liberalising drug policy. I ask a counter question: why, in the face of a poorly-performing policy, should Australia not attempt to benefit from the international drug policy experience, when we try to learn from international policy advances and errors in every other area?

The more liberal approach to drug policy in Switzerland and Portugal in the past 20 years appears to have achieved many benefits with no serious adverse effects.

In contrast, drug overdose deaths are high and rising in Sweden, one of the last developed countries that champions a punitive drug policy.

In recent decades, Australian governments have relied heavily on drug law enforcement (while providing more limited funding for health and social responses), yet the drug market has continued to expand. Around the world, drug production has increased, drug consumption has increased, the number of new kinds of drugs has increased, drugs are readily available, drug prices have decreased and the purity of street drugs has increased.

It’s time the community and its leaders had the courage to look at this issue with fresh eyes.

Mick Palmer, AO APM, is a former commissioner of the Australian Federal Police and is a director of the Australia21 think tank.

THE CALL FOR MORE LIBERAL DRUG POLICIES MISSES THE POINT

Harm minimisation – not prohibition – is killing our kids and destroying families, asserts this article from Drug Free Australia

“...it is not the so-called ‘War on Drugs’ nor prohibition on illicit drugs that has failed our Australian youth. Rather it is a policy of harm minimisation (or harm reduction) that has sacrificed an entire generation. Australian families have endured almost 30 years of successive governments and their health policies that have failed to address primary drug prevention in Australia,” said Jo Baxter, Executive Officer, Drug Free Australia.

For example in 1987, cannabis was decriminalised in South Australia and there has been de facto decriminalisation in other regions. As a result, use increased in the 90’s and has remained high per capita in Australia ever since.

We must change our illicit drug policy to one of harm prevention, similar to the initiatives being implemented in Sweden. Sweden experienced high levels of illicit drug use, especially amphetamines in the 1960’s and moved toward a restrictive policy, based on prevention. Police, government, health workers and educators have worked together since then to develop a culture that rejects illicit drug use, including marijuana. Their law enforcement practices are compassionate, yet clear and their young police officers are more like social workers, who intervene early when they identify young people experimenting with dangerous substances.

Most importantly, Australia’s drug policy needs to re-focus on the UN Convention on the Rights of the Child, where Article 33 states that Member States “shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances”.

The recent report recommending the regulation of MDMA (ecstasy) and cannabis/marijuana will only exacerbate the problem and set up a framework that will destroy the next generation. We have seen this with alcohol and tobacco – the legal drugs that create the most harm in our society. Why would we add to the list?

The most recent National Drug Strategy Household Survey 2010 continues to show that legalised drugs far outweigh the illicit drugs in terms of consumption and acceptability.

The rates of use are as follows:

- Alcohol – 81%
- Tobacco – 18% (from 55-60%)
- Heroin – 0.2%
- Cocaine – 2%
- Speed/Ice – 2%
- Ecstasy – 3%
- Cannabis – 11% (up from 9%) – compared to worldwide average of 2.6-5%.

Low use of illegal drugs is the success of international cooperation and illicit drug prohibition controls worldwide.


Drug Free Australia recommends urgent proactive change to our illicit drug policies:

1. Reject any movement towards the further liberalisation of drug policies in Australia.
2. Prioritise, as has Sweden and the United Kingdom, demand reduction and recovery from illicit drug use, making harm reduction subservient to the aim of getting drug users drug-free.
3. Fund Naltrexone implants and suitable support networks for drug users who want to use them as a safeguard while becoming drug free, on the understanding that Naltrexone implants will not need to be, as for many methadone patients, used for life but rather for a year or two to ensure an ex-user has been stabilised.
4. Re-focus Australia’s drug policy to accord with the UN Convention on the Rights of the Child, where Article 33 states that Member States “shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances”.
5. Further to point 4, reverse the emerging trend of increases in child abuse and neglect, both to the unborn child, and those who are growing up in families where illicit drugs are used regularly. Specifically, there are too many examples of increased rates of births of drug-addicted babies across the board, in Australia.
6. Join together with more countries against a more permissive drug policy, and in so doing, hold our commitment to the United Nations Drug Conventions.

Drug Free Australia supports a balanced and humane illicit drug policy that aims at primary prevention and recovery-based treatment and rehabilitation. This can never be achieved if illicit drugs are condoned through their legalisation, or their so-called ‘regulation’. There is a maxim that remains constant — availability, accessibility and, of course, the key component – permissibility – all increase consumption.
Drug prohibition: moving to Plan B
The longer politicians delay reform, the more difficult it’s going to get, writes Alex Wodak, Emeritus Consultant at St Vincent’s Hospital, Darlinghurst

Australia21, of which I am one of the directors, released its second report on drug prohibition this morning. The report calls for a redefinition of how we deal with drugs to primarily a health and social problem.

Our first drug report, released in April, concluded that the war-on-drugs approach had failed comprehensively. It provoked a vigorous media response in which few commentators challenged the notion that heavy reliance on drug law enforcement had failed.

We invited prominent Australians who support a hardline approach to attend a meeting but all those approached declined. When someone of the stature of Mick Palmer, former commissioner of the Australian Federal Police, acknowledges that despite improvements in drug law enforcement, there has been little impact on the drug market, the debate has entered a new stage. This second report builds on the conclusions of the first one, attempting to provoke a national discussion about what our best options might be. There are several reasons why this discussion is now different from previous debates about drug policy.

Sooner or later, one side of politics in Australia will realise that drug law reform could be a vote-changing issue for young people.

Winds of change in the Americas
Vigorous debates about drug policy are now taking place in Europe and the Americas. The murder of 50,000 Mexicans since President Felipe Calderon declared a war on drugs in December 2006 has brought that country to a precipice.

Two previous Mexican presidents have called for legalisation and the current one has called for use of ‘market mechanisms’ – presumably a euphemism for legalisation.

Latin America is being torn apart by pressure from the United States to stop drugs heading north to the biggest drug market in the world. President Barack Obama was forced to bow to pressure from Latin America in April and acknowledge (in an election year) that it was entirely appropriate to debate the legalisation of drugs, although he added this was something the United States would never do.

In a world-first, Uruguay’s president has sent a Bill to legalise cannabis to the legislature for consideration. At the Summit of the Americas in Cartegena, Colombia, earlier this year (14 to 15 April), the United States and Canada were isolated on drug policy. Latin America now wants change.

The politics of drugs also seems to be changing in the United States. Primaries for a Democratic Congressional district in El Paso, Texas and a contest for the Oregon attorney general were both won by younger candidates supporting drug law reform, defeating older incumbents who supported a war-on-drugs approach.

And, the 2011 annual Gallup poll in the United States, asking “do you support the legalisation of marijuana?” reported that supporters (50%) now outnumbered opponents (46%). In 1969, 12% supported while 84% opposed legalisation of marijuana. Medical marijuana is now available in 17 states (and the District of Colombia).

The situation in Europe
There are now more countries providing models for how reform can be implemented. The Netherlands, Switzerland and Portugal have shown that reforms can be carried
out without breaching international drug treaties, and that an approach with more emphasis on health and social measures can produce better outcomes and achieve strong community support.

In contrast, Sweden is one of few European countries still heavily reliant on severe punishment and drug law enforcement. It claims a drug-free nation as the overarching goal of its drug policy and rejects safer injecting facilities and heroin assisted treatment.

Sweden still only has the same two needle syringe programs that were established 25 years ago. And it has the eighth-highest drug overdose death rate in the European Union while the Netherlands has the 19th and Portugal the 25th. Overdose deaths have been increasing in Sweden, are stable in the Netherlands and falling in Portugal. Still, the country seems to be slowly moving away from its hardline approach and gradually becoming more like other European Union countries. And it takes drug treatment seriously, as do all countries that have started reforming their drug policy.

Coinciding with a major expansion and improvement of drug treatment in Zurich, Switzerland, the estimated number of new heroin users declined from 850 in 1990 to 150 in 2002 with decreasing numbers of heroin overdose death, HIV infections and crime. The quantity of heroin seized by police also declined during this period suggesting a shift from the black market to the white market.

It’s increasingly difficult to explain why two to three million Australians are better off purchasing cannabis from criminals, corrupt police or outlaw motorcycle gangs than obtaining the same drug from regulated sources.

**Time to make the move**

Sooner or later, one side of politics in Australia will realise that drug law reform could be a vote-changing issue for young people. With the current and two previous presidents of the United States, and the current prime minister of Australia, and the current and previous leaders of the Opposition all known to have tried cannabis, it’s increasingly difficult to explain why two to three million Australians are better off purchasing cannabis from criminals, corrupt police or outlaw motorcycle gangs than obtaining the same drug from regulated sources.

Drug policy is a difficult issue for politicians. But the longer they delay reform, or even discussion of reform, the more difficult it’s going to get.

Alex Wodak is Emeritus Consultant at St Vincent’s Hospital, Darlinghurst.

Recommendations from the second Australia21 Roundtable on Illicit Drugs, which explored ‘how we can stop killing and criminalising young Australians’

**TO THE BOARD OF AUSTRALIA21**

1. This report should be widely distributed to influential networks, parliamentarians, church leaders, young people, businessmen and women, leaders of civil society, parents with young children and people who use drugs.
2. Australia21 should consult with a range of national peak bodies to develop plans for a National Summit on these issues to be held in 2013.
3. Australia21 should work closely with the Australian Parliamentary Group on Drug Law Reform to further promote bipartisan consideration of issues canvassed in this report.
4. Australia21 should meet with the chair and executive officer of the Australian National Council on Drugs to discuss the recommendations of this report.

**TO THE BROADER AUSTRALIAN COMMUNITY**

To assist opinion leaders, governments, police and the general community, including especially young people, to consider a range of realistic policy options, the Roundtable participants proposed the following:

- An Australian Drug Summit to be held in 2013.
- A COAG Committee to consider a range of possible options for drug policy.
- A meeting between Australia21 and the Australia and New Zealand Policing Advisory Agency (ANZPAA).
- A meeting between Australia21 and the Australian Parliamentary Group on Drug Law Reform. This might include discussion of the desirability of a Senate Committee Inquiry into Australian drug law.
- Active engagement with the Police Commissioners’ Conference members and with police unions about models of police activity in other countries to clarify which drug enforcement interventions are most effective in reducing drug-related harm and which are accompanied by minimal unintended negative consequences.
- Development of a network of concerned and informed church leaders, and another network of business leaders.
- Community discussion about modifying current international drug treaties.
- A meeting of experts in international law to determine the extent of flexibility available within Australia’s legal obligations under the current drug treaties.
- Discussions with community stakeholders and leaders of the medical and pharmaceutical professions regarding Professor David Penington’s proposal to regulate cannabis and ecstasy (MDMA) in Australia.
- Discussion with peak civil society and organisations involved in alcohol and other drugs and those representing people who use drugs about future ways of reducing drug use and drug harm to young people.
- Recommending to the Commonwealth Government that it responds positively to calls for the Productivity Commission to investigate and report upon the cost-effectiveness of illicit drug law enforcement in Australia.
- A respected academically-oriented body such as the Drug Policy Modelling Program at the University of NSW be invited to convene a meeting or meetings between leading drug policy researchers (including those from the disciplines of epidemiology and criminology) and the members of the IGCD Standing Committee on Illicit Drugs and the IGCD Research and Data Working Group. The aim would be to ascertain the degree to which Australia’s drug information systems provide the information needed to evaluate drug policy now, and to monitor and evaluate the outcomes of any future policy changes.

The drug law reforms that now need to be considered by all Australian Governments should have as their goals:

- Reducing deaths, disease, crime and corruption
- Improving the protection of human rights of all Australian citizens (including especially young people), and
- Reducing the burden on the criminal justice system, taxpayers and families.

**A RANGE OF DRUG POLICY OPTIONS**

Participants in the Roundtable agreed that there is no single magic bullet or ‘solution’ for the management of this complex problem.

Each of the four countries discussed has taken a different path. In the case of the Netherlands, Switzerland
and Portugal, significantly better outcomes seem to have been achieved than those currently observed in Australia. Relaxation of elements of the international approach has enabled the Netherlands, Switzerland and Portugal to derive positive benefits. Sweden remains one of the few European countries continuing to believe strongly in benefits to the community from strictly enforcing a prohibition of drug possession and use. But Sweden is now experiencing high rates of drug deaths and problematic drug use despite its strong commitment to the welfare state and support for marginalised populations.

The Australian response needs to be crafted in accord with Australian experience and culture. On the basis of international experience, we can choose from a wide range of interventions for which there is now good evidence. Some of the interventions listed below will be easier to implement than others while others may require legislative change and agreement across all of Australia’s government jurisdictions.

A key message emerging from our discussions of the European experience was the importance of political bipartisanship. The starting point for an Australian new deal on drugs should be cross-party discussion and agreement that there is a problem and that its solution should transcend political point scoring.

The recent coming together of parliamentarians across party lines to support a reference to the Australian Productivity Commission is an excellent beginning and it is to be hoped that this will carry forward into discussions at a National Summit of the following list of options for improvement in Australia’s drug policies.

As with our earlier roundtable on this topic, we believe that Australia21’s role should be to act as an honest broker to promote a continuation of the national debate and to bring together diverse stakeholders with differing perceptions and strengths.

**SPECIFIC REFORM OPTIONS**

The specific reform options could include:

- **Reducing demand for drugs:**
  - Ensure that the content and manner of education to prevent drug use is consistent with research findings.
  - Divert a proportion of resources currently committed to detection, prosecution and incarceration of drug users to systematic, objective and effective efforts to improve knowledge and understanding about drug use and problems in the community.

- **Strengthening support for high-risk populations**
  e.g. indigenous groups, the homeless, the mentally ill.

- **Criminal justice system:**
  - Remove sanctions for personal use and possession of drugs and drug-using paraphernalia.

- **Drug treatment:**
  - Increase the use of non-custodial sentences for drug offences.
  - Expand the use of diversion from the criminal justice system to treatment and education, and reduce or eliminate current perverse effects.
  - Explore alternatives to the criminal justice system to signify the community’s disapproval of drug use without further damaging some vulnerable young people.

- **Funding:**
  - Increase funding for health and social interventions towards current levels of funding for drug law enforcement.

- **Drug treatment:**
  - Increase capacity to meet demand.
  - Improve attractiveness and reduce costs to consumers.
  - Broaden the range of treatment options for dependent users.
  - Ensure quality of treatment matches quality elsewhere in healthcare.
  - Establish Heroin Assisted Treatment for people with severe heroin dependence who have not benefitted from multiple previous treatments.
  - Ensure that drug treatment and the prevention of drug complications for prison inmates is of at least the same high standard as that in the community.
• **Cannabis:**
  - Control through taxation and regulation.
  - Establish hard-to-get but easy-to-lose licenses for cultivation, wholesale and retail supply.
  - Packets required to be plain and have warning labels, help-seeking information and consumer information.
  - Proof of age for purchase (equivalent to alcohol).
  - Ban advertising and donations to political parties from companies and individuals engaged in the cannabis trade.
  - Hypothecate part of cannabis tax revenue to fund alcohol and drug prevention and treatment.
  - Establish and evaluate limited and regulated medicinal cannabis system.
  - Adopt national guidelines on less harmful consumption (modeled on NHMRC alcohol guidelines).

• **Injecting:**
  - Establish supervised injection facilities within major drug markets starting in major cities.
  - Increase the availability of sterile injecting equipment.
  - Deregulate injecting equipment sales.
  - Ensure that prison inmates have the same protection from infections as do people living in the community.

• **Re-integration:**
  - Encourage major employers to hire more people attempting to overcome alcohol and other drug dependence.

• **Research and evaluation:**
  - Accept commitment to rigorously evaluate reforms especially to estimate the nature and extent of benefits and harm (including unintended adverse consequences) of the new policy while attempting to maximise benefits and minimise costs.

Recommendations for Action section extracted from *Alternatives to Prohibition illicit drugs: How we can stop killing and criminalising young Australians* – report of the second Australia21 Roundtable on Illicit Drugs held at The University of Melbourne on 6 July 2012. Authors: Bob Douglas, Alex Wodak and David McDonald.

A new approach to drug reform: regulated supply of cannabis and ecstasy

Sixteen years ago the premier of Victoria, Jeff Kennett, asked me to conduct an inquiry into drug policy. At the time, deaths from heroin overdoses were high and the use of cannabis and other drugs continued to mount, despite prohibition. David Penington discusses

While there has been some improvement in the management of drugs over the years, both in Victoria and nationally, fundamental problems remain. It’s time to consider practical solutions to the problem.

I propose a novel system whereby Australians aged 16 and over have access to a limited, regulated quantity of cannabis and ecstasy from a government-approved pharmacy supplier – provided they are willing to go on a national confidential user’s register.

When dispensing the substance, pharmacists would also be able to give clients advice and, where necessary, refer them for counselling or treatment.

Why we need a new approach

Harm from illicit drugs is not only serious to users; it affects their families and entire communities, especially when addiction leads to crime and prostitution. Drug use is understandably perceived as a threat by the community because of the violent behaviour that is associated with some drugs.

Beyond this, the drug trade leads inevitably to growth in organised crime associated with serious violence and corruption of law enforcement officers, as we’ve seen in many states and jurisdictions. These issues led to the United States abandoning prohibition of alcohol in 1933.

Australia remains among the small group of nations which have the highest consumption of cannabis. And we have the dubious honour of being the greatest user of ecstasy in the world.

So how would the regulated supply scheme work? The production of a version of ecstasy, identifiable by shape and colour, could readily be contracted to a generic drug production company.

Australia has authority to produce opium under strict regulation in Tasmania, needed for the world’s pharmaceutical industry to make morphine for pain relief. Regulated production of cannabis, with coloured and tobacco are far more addictive than cannabis.

Young people will not listen to advice about drugs, which currently they regard as hypocritical, when society condones the use of alcohol, despite it causing many more deaths and violent behaviour than any of the illicit drugs. Education – of the kind young people will listen to – is the key missing element in our efforts to reduce use of the drugs which are part of the social environment for so many young people.

Australia remains among the small group of nations which have the highest consumption of cannabis. And we have the dubious honour of being the greatest user of ecstasy in the world.

New model for ecstasy and cannabis supply

Getting these two widely used drugs out of the hands of the illegal traffickers would be a start on dealing with drug use as a health issue, as counselling would be available.

Low levels of use do not present a risk to health any more than moderate and responsible use of alcohol. Long-established international evidence shows alcohol
markers, could be similarly controlled.

Alongside this production, a confidential electronic register of cannabis and ecstasy users would be established and accessed by pharmacists. The supply of cannabis and ecstasy would be tightly regulated, and limited to a monthly total representing a safe weekly amount – well below the quantities known to cause changes in the brains of adolescents and young adults. The register would prevent ‘shopping’ from multiple outlets.

**We need a new approach. A formal trial of ‘regulated supply’ associated with rigorous collection of evidence could represent a real start in examining alternatives. Other countries are making innovative changes. Why not Australia?**

Pharmacists are already important as a source of health advice in the community, dispensing methadone to former heroin users. Pharmacists could become really effective advisers to drug users. It would take time to prepare them for this task, but with discussion and appropriate dispensing fees, they might welcome the role.

Between two and three million Australians use cannabis every year. More than 50% of young people in some age groups have used cannabis. If the scheme reduced cannabis use by even 60%, and prevented young people moving to harder drugs by cutting off access to traffickers, that would be a huge benefit to young Australians, their families, and the community.

**What happens next?**

Because of the widespread and simplistic community view that drugs are ‘bad’, politicians recoil from any suggestion of their ‘legalisation’. But prohibition has manifestly failed for more than 50 years, and itself causes many problems.

Simply requesting the removal of all legal restrictions is currently a fruitless proposition, which I don’t believe any government will consider, especially when these are supported by international treaties to which we are committed.

We need a new approach. A formal trial of ‘regulated supply’ associated with rigorous collection of evidence could represent a real start in examining alternatives.

Other countries are making innovative changes. Why not Australia?

David Penington is Emeritus Professor at the University of Melbourne. He attended the Australia21 meeting as an invited participant.

ASSESSING THE COSTS AND BENEFITS OF LEGALISING CANNABIS

When government revenue is included, legalising appears to trump the status quo, finds Marian Shanahan and Alison Ritter

About one-quarter of Australians support the legalisation of cannabis. And advocates often point to the potential of raising tax revenue from sales as part of their argument. But there has been limited analysis of the economic costs and benefits of legalisation – until now.

A study we published today in the journal PLOS ONE compared the status quo with legalisation. We found that when using the standard cost-benefit framework which excludes government revenue, neither policy delivered substantially more economic benefits.

But when government revenue is included, legalising appears to trump the status quo.

TWO OPTIONS

The status quo in New South Wales is that juveniles found in possession of 15 grams or less of cannabis may receive a warning or a caution, and adults can receive up to two cautions. Those convicted for cultivation or for selling cannabis may get a fine or go to prison.

Our hypothetical legalisation policy, in contrast, was developed from a public health framework of regulation and harm minimisation. It incorporated some of the many lessons from tobacco and alcohol research including:
- Limiting outlet density
- No advertising
- Requiring plain paper packaging
- Requiring consumer licences
- Restricting sales to those aged 21 and over.

Other elements of the hypothetical policy included:
- Ongoing drug-driving testing
- Licensed commercial growers

We chose a government monopoly as a way to limit lobbying and avoid claims of anti-competition from the industry, as has occurred with the tobacco industry.

COSTS AND BENEFITS

A cost-benefit analysis such as the one we undertook provides an estimate in dollars of both the gains and losses to individuals and to the wider society for each policy. A policy is said to be socially desirable, and have a positive net social benefit, if the overall sum of the positive benefits outweighs the sum of the costs and harms.

Deciding whether something is a harm or a benefit is not necessarily straightforward ... However, less straightforward is stigma from a criminal record for possession or use of cannabis. Many see this as a harm whereas others see this as a benefit, and a way to deter cannabis use.
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possession or use of cannabis. Many see this as a harm whereas others see this as a benefit, and a way to deter cannabis use.

The list of costs includes the financial burden of legalising marijuana on the criminal justice system (police, courts, corrections services) and the health-care system (from dependence, mental illnesses attributed to cannabis, and death from accidents). Added to this are regulatory costs, and consumer education and quit campaigns.

We attributed a 2007 Australian dollar value to all these costs, harms and benefits and then summed each policy option to obtain the net social benefit.

THE VERDICT

The net social benefit (the difference between the benefits and the costs) was positive for both policies.

To illustrate the uncertainty around each of the estimates, we provided a mean figure and a 5-95% range. The mean net social benefit for the status quo was A$294.6 million (A$201.1 to A$392.7 million) and for the legalised-regulated model it was A$234.2 million (A$136.4 to A$331.1 million).

Both estimates fall within the same range. This indicates that both policies result in a similarly efficient use of resources.

But there's a difference in who bears the costs and who benefits. For the status quo, for example, expenditures within the criminal justice system are higher, whereas in the legalised option the negative impact on educational attainment is greater.

Not included in the above results are potential revenues to government, as they are considered transfers and not normally included in a cost-benefit analysis.

When the revenues were added – after removing payments to growers and the costs of operating the cannabis shops – the net social benefit increased. In fact, it more than doubled to A$727.5 million, as did the level of uncertainty (it could be anywhere in the range of A$372.3 million to A$1,113.2 million). This suggests there may be gains for government coffers under legalisation.

But while the revenues are potentially large, so is the uncertainty around these numbers. Other researchers have argued, for instance, that the price of legalised cannabis would likely have to fall substantially to undermine the existing black market. This drop in price would likely lead to a negative impact on government revenues, may result in additional consumption and increased harms.

We may soon see data emerge on the harms, benefits and revenues from the introduction of legalised cannabis in the US state of Colorado. But it may be some time before true figures are known, especially given the recent revamping of budgetary expectations in that state.

Given the uncertainty around the extent of the potential revenue gains and the similarity in net social benefits from both policy options, drivers for change are more likely to be political and based on public opinion, rather than economic arguments.

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THE CONVERSATION

Drug policy reform: moving beyond strict criminal penalties for drugs

In this *PolicyTalk* paper for the *Australian Drug Foundation*, Professor Simon Lenton offers a non-partisan overview of issues relating to reforms in drug policy and practice

**INTRODUCTION**

The term ‘decriminalisation’ can confuse the discussion about drug policy reform as it means so many different things to different people. Indeed, many confuse ‘decriminalisation’ with ‘legalisation’, that is, making some aspect of the drug possession/use no longer an offence. More correctly, the term is used to refer to what is termed prohibition with civil penalties, that is, much like speeding in a motor vehicle – illegal, not condoned, but only attracting civil penalties like a fine, with no further criminal actions taken if the fine is paid by the due date.

It is likely that others use it as a generic term meaning reducing penalties in comparison to total prohibition with strict criminal penalties. The confusion about what decriminalisation means is problematic for a number of reasons. Firstly, sensible discussion of drug policy options is impossible when the meanings of terms aren’t shared. Secondly, we tend to be scared of what we don’t understand. Consequently, it is unsurprising that the latest Nielsen poll has found that public support for ‘decriminalisation’ is low, at only 27%.

Previously it has been found that when the term was explained, support for applying prohibition with civil penalties to cannabis use increased from 64% to 72%.

According to the *National Drug Strategy Household Survey*, Australian public support for criminal penalties for possession of cannabis has remained low, ranging from 34% to 39%, in the four surveys conducted between 2001 and 2010. Interestingly, support for legalisation of cannabis use has been even lower, declining from 31% in 2001 to 25% in 2010.

On the other hand, support for allowing use of cannabis for medical reasons has been supported by approximately 69% of the general public since the question was first posed in the 2004 survey.

Drug policy reform has much more to do with politics than it does with research evidence. In translating research evidence into policy proposals for cannabis which contributed to cannabis law reform in Western Australia in 2004 it was decided that a concrete proposal would be most likely to be enacted if it was: (i) supported by a clear majority of the general public; (ii) seen as electorally survivable by politicians; (iii) supported by law enforcement stakeholders, notably the police; (iv) supported by cannabis users as better than the prevailing criminal regime; (v) supported by the research evidence; (vi) sustainable under the international drug treaties and conventions which put limitations on signatory countries capacity to implement non-prohibitionist drug law regimes; and (vii) subject to evaluation and review to increase the likelihood that it met the goals that it was designed to achieve.

This paper aims to: (i) clarify drug law reform terms, summarise the evidence and rationale behind drug law reform beyond strict criminal penalties; (ii) describe Australian experience of drug law reform and some international examples; (iii) briefly describe the impact of the international drug treaties on countries capacity to reform their drug laws (iv) and offer some politically viable and useful ways forward.

**TERMINOLOGY ON TYPES OF REFORM**

Firstly, what needs to be understood is that drug law reform can be undertaken by changing drug laws themselves (*de jure* change), or through leaving the drug laws unchanged *‘on the books’* but changing the way the laws are enforced by the police and others (*de facto* change). There are examples of both *de jure* and *de facto* reforms in the reform typologies described below.

Under total prohibition all behaviour in relation to drugs including even minor possession and use of small amounts, but also manufacture/cultivation and supply are against the law (illegal) and attract strict criminal penalties including a criminal record and possibly a custodial sentence.

Under prohibition with cautioning or diversion, sometimes called ‘depenalisation’ drug offences remain illegal, but under some circumstances penalties are reduced. For example, first offenders who plead guilty to minor possession/use offences may avoid a conviction being recorded if they attend and successfully complete an education or treatment intervention. Such schemes operate in the UK and in all Australian and some US states.

Under prohibition with civil penalties, sometimes called ‘decriminalisation’ all drug related actions remain illegal but certain offences (usually specified small possession offences, but not supply offences) are eligible for civil penalties (infringement notices, fines administrative sanctions) rather than strict criminal penalties. Such schemes apply for specified minor cannabis offences in SA, the ACT and the NT.

Under partial prohibition some drug related behaviours remain illegal, while others are permitted. This can be done either by *de facto* or *de jure* means. Under *de facto* legalisation also termed *prohibition with an expediency principle* all drug related activities are illegal according to the law, however, cases involving defined small quantities are not investigated or prosecuted by police.
Examples of this system operate for cannabis in Belgium and in parts of the Netherlands and Germany.

Under de jure legalisation some drug use and possession is permitted under the statutes. Examples include the ‘medical marijuana’ schemes of regulated availability which apply in parts of the USA and Canada, and in Alaska where cannabis possession in one’s home is not an offence.

AUSTRALIA’S 25-YEAR EXPERIENCE OF DRUG POLICY REFORM

Note that whilst many people think that total prohibition laws apply to drugs in Australia, it is clear from the above that this is not the case. Prohibition with civil penalties schemes were introduced for minor cannabis offences in South Australia in 1987, the Australian Capital Territory in 1992, the Northern Territory in 1996 and in Western Australia from 2004 to 2011.

Furthermore prohibition with cautioning and diversion schemes were introduced for cannabis in the non-civil penalty jurisdictions and for all other illegal drugs (heroin, amphetamines cocaine, LSD, ecstasy, etc.) for all Australian states and territories under the Illicit Drug Diversion Initiative (IDDI) introduced under the Howard Government in 1999. That is, for drug possession offenders, depending on the jurisdiction, for first, second or third offences drug offenders without prior violent offences are given the option of having their prosecution suspended whilst they complete an intervention, usually drug treatment, specified by the caution. Should this be successful, they are not prosecuted for their drug offence.

So, Australia has a 25-year history of drug law reforms beyond total prohibition. This has happened under both national and state and territory governments of the left and the right political persuasion. Granted, these reforms have been limited in scope, have rarely addressed the supply side of the drug issue, may only apply to first offenders, and still result in many drug users who come into contact with the law getting criminal charges. However, to describe the Australian experience as simply a ‘War on Drugs’ approach is a caricature which ignores and diminishes the attempts which have been made to mitigate, if not remove, the adverse impacts of the criminal law on drug users.

There are more sensible and practical things which can be done to reform drug laws in this country – without doubt. But in many ways Australia began moving beyond a ‘war on drugs’ at least two decades ago, and we will see below that the evidence is that, despite these reforms, ‘the sky hasn’t fallen in’.

THE EVIDENCE

Much of the evidence regarding the impact of policy options for drugs has been based on the most prevalent illicit drug – cannabis. There is no evidence that maintaining the illegality of cannabis (prohibition) but applying civil rather than criminal penalties to minor cannabis offences results in higher rates of cannabis use among the general population, school children, or apprehended cannabis users.

Support for this position comes from research evidence from a variety of converging sources (see 7) including: (i) criminological research on deterrence; (ii) studies of the impact of reducing drug penalties on rates of use; and (iii) studies demonstrating the impacts of being apprehended for a minor cannabis offence.

Deterrence theory and drug policy research

The theoretical underpinning of much of our criminal law, and general and our drug law in particular, is classical deterrence theory which asserts that “undesirable behaviour can be curtailed if punishment is sufficiently certain, swift, and severe”.

Much of the early criminological research showed that individuals’ perceptions of punishment likelihood, rather than punishment severity, deterred further offending. Furthermore, in situations where likelihood of detection is low, or hard to estimate, factors other than the law are likely to be more important determinants of behaviour. In mostly private behaviours such as illegal drug use, the likelihood of detection is extremely low. For cannabis, the likelihood of someone being apprehended for using the drug in any one year is between 1 and 3%. Given the number of episodes of use of the typical cannabis user in one year, the risk per episode of use is probably less than 0.01%. It is thus unsurprising that research shows there is little relationship between rates of cannabis and whether strict criminal penalties or civil penalties apply.

Studies of the impacts of reducing penalties on rates of drug use

Policy impact research on ‘natural experiments’ where penalties have been reduced for minor cannabis offences does not show that such measures result in higher rates of cannabis use in the general community. Eleven US States which ‘decriminalised’ cannabis during the 1970’s. Research showed that those states which removed criminal penalties did not experience greater increases in cannabis use among adults or adolescents, nor more favourable attitudes towards the drug, than those states which maintained strict prohibition against cannabis possession and use (e.g. 9).

Research on the impact of the South Australian Cannabis Expiation Notice system concluded that rates of recent (weekly) use, and use among young adults and school students had not increased at a greater rate in South Australia compared to other states which had not liberalised their laws. The experience of the introduction of
a prohibition with civil penalty scheme in WA in 2004, which was overturned in 2011 after a change of government, suggested that the scheme did not result in increased cannabis use in that state among the general public, regular cannabis users, nor school students, nor did it result in a ‘softening’ of attitudes to cannabis. Indeed the prevalence of cannabis in WA had been declining since the late 1990s as it has done elsewhere in Australia and there was a growing recognition of the health harms associated with the drug, particularly harms associated with heavy and early use.12

Beyond impacts on use and attitudes, a variety of studies have shown that applying civil penalties for cannabis use results in savings to the criminal justice system, with the size of the savings depending on the size of the jurisdiction and the way the scheme is implemented.13-15 A cross-national comparison between the Netherlands, other European states and the USA, showed that despite the introduction of de facto legalisation of cannabis through the cannabis coffeeshops, the Dutch did not have higher rates of cannabis use than these other countries.16 Separate to the legal changes, an increase in commercial access to cannabis, associated with the growth in numbers of cannabis coffeeshops from 1992 to 1996, may have resulted in growth in the cannabis using population, including young people (16-19) but this growth has put the rates of cannabis use no higher than that in the USA16 and declined when restrictions on the number of coffeeshops and the age of patrons were introduced.20 In 2004 the UK government reduced penalties for cannabis use downgrading it from a Class B to a Class C drug. Cannabis use among adults and children continued to decline after the change.21

In The Czech Republic, cannabis and other drugs were criminalised in 1998. A two year evaluation found that, while the implementation of the laws was far from universal, there was no evidence that it resulted in any reduction of drug use, but there were clear and substantial economic costs to the state.22 Liberalisation of drug laws in Portugal occurred in 2001. Under these reforms drug acquisition and possession became an administrative offence, but drug supply remained a criminal offence. The laws apply to use/possession amounts estimated at up to 10 days worth of all illicit drugs. Sanctions for the new offences are applied by specially constituted Commissions for the Dissuasion of Drug Addiction (CDTs). Their goal is to dissuade drug use and refer drug dependent people into treatment, whilst those assessed as being non-dependent or functioning users may have their proceedings suspended, be required to attend a police station, be referred for psychological or educational intervention, or receive a fine.23

In some ways this is the converse to the Australian prohibition with cautioning or diversion schemes which limit cautions and interventions to first, second or third offenders. In the Portuguese system, it is the entrenched drug offenders who are referred for treatment, and the less entrenched receive civil penalties. Whilst there has been conflicting claims that the Portuguese reforms have been a ‘resounding success’ or a ‘disastrous failure’, it is most likely neither are fair representations.24 Limitations with available data, means it has not been possible to definitively gauge the impacts of these changes, however, the Portuguese reforms do not appear to have led to a substantial increases in drug use or related harms.25

Another interesting alternative model are the cannabis social clubs which originated in Spain where, due to a quirk of law, cannabis possession and use by adults in private is not illegal, but supply for profit is criminalised. Under this arrangement, a collective of cannabis users band together to grow cannabis for their own consumption (and in some cases for gifting to medical users), but not for sale outside the closed-system of the club. The clubs monitor member’s health, and address the supply issue whilst aiming to mitigate against commercialism. However, the Spanish clubs are not subject to government regulation and have grown in number to around 300.26 Furthermore, there are reports of organised commercial distributors setting up new ‘clubs’ as a front for cannabis supply, which may undermine political and public support and the integrity of the original clubs.27 However, in Spain and elsewhere, proposals are being drafted to develop regulations to
support the integrity of the cannabis clubs as originally developed. It will be interesting to see how this approach develops.

**Impacts of being apprehended for a minor drug offence**

In a comparison of the social impacts of a conviction under strict cannabis prohibition, in place at the time in Western Australia, with that of an infringement notice, under the CEN system in South Australia, the experiences of 68 matched first-time apprehended cannabis users from each of these states were examined. Importantly, neither the infringement notice nor the cannabis conviction appeared to have much impact on subsequent cannabis use.

Rates of post-apprehension cannabis use were highly correlated with rates of use prior to apprehension, consistent with earlier Canadian research. However, those in the WA convicted group were significantly more likely than the South Australian infringement notice group to report: adverse employment consequences; further contact with the criminal justice system; relationship problems, and accommodation difficulties that could be attributed to their apprehension for the cannabis offence. Cannabis users arrested and convicted for the first time in Western Australia were more likely to report negative attitudes to police and the justice system and be less trusting of police than their South Australian counterparts who received an infringement notice – (see ).

**Impact of the international drug treaties**

Australia, like almost all countries, is signatory to the 1961 *Single Convention on Drugs* and the 1988 *Vienna Convention*, which together require what are defined as ‘narcotic’ drugs (effectively all illicit drugs including cannabis) to be treated as punishable offences under signature countries domestic law, except for medical and scientific purposes.

While interpretations of the drug conventions differ, most commentators agree that the conventions require trafficking offences to be criminal, but that cultivation and possession for personal use must be punishable, but not necessarily criminal. Beyond this, whilst it is clear that the treaties act upon national laws of signatory countries, the extent to which they are binding at the sub-national or state level is unclear.

Consistent with the above, there is experience showing that prohibition with civil penalty systems like those in place for cannabis in eleven US states and SA, the ACT and NT are not in breach of the treaties. Also consistent with the treaties are the prohibition with cautioning schemes that operate in the other Australian jurisdictions and the de facto legalisation or prohibition with an expediency principle schemes that operate for cannabis in Belgium, Germany and the Netherlands. The latter are consistent because the drug offences remain illegal on the statutes, even though cases involving defined small quantities are not investigated or prosecuted by police. The North American medical marijuana initiatives whilst de jure are permitted under the treaties as they invoke the ‘except for medical treatment’ clause.

However, clearly the international drug conventions have impeded countries from going beyond prohibition options to trial and evaluate more comprehensive legislative reforms. This is a significant barrier to accruing evidence to inform future drug policy reform.

### WHERE MORE EVIDENCE IS NEEDED

There is no doubt that all drug law reform options have their strengths and weaknesses (see ). Whilst the evidence for the minimal impact on rates of use moving from total prohibition with strict criminal penalties to prohibition with civil penalties is relatively strong, the evidence for the impacts of prohibition with cautioning schemes on populations or individuals drug use is relatively scant (e.g. ).

Although politically popular, and often supported by the drug treatment sector for who such schemes provide often needed financial support from government, evidence of their effectiveness is yet to accrue. Such cautioning schemes are far cheaper than incarceration, give offenders a chance to address their problems and avoid criminalisation, but there are concerns that tying up treatment places with minor drug offenders may not be the best use of this valuable resource.

Questions also remain whether most of those diverted engage effectively with treatment or may be more willing to do so in future. Also, given that only about 3% of cannabis
users have contact with the criminal justice system in any one year, it is questionable whether a system built around cannabis users is ideal, even if we assumed that the majority of those apprehended had significant cannabis use problems.

Whilst cogent arguments can be mounted in favour of legalisation of drugs under a strictly regulated model (e.g. 37) many public health experts have serious concerns about putting currently illegal drugs like cannabis in the hands of commercial interests and replicating the problems of promotion and high rates of use and harm that we have seen with alcohol and tobacco (e.g. 19). A major issue here is that evidence on which to base decisions about likely impacts of regulatory or commercial schemes is lacking and whilst attempts to estimate the impacts of such changes suggest rates of use will probably increase, the magnitude of such an increase and the impact on drug related harm are contested. 40-42

**A PRACTICAL WAY FORWARD**

**Building on the successful Australian approach**

As argued above, evidence is only part of the drug policy process. Yet sensible drug policy is not harmed by accruing new evidence. The Australian approach of cautious and evaluated reforms has, to date, contributed to accruing valuable evidence on which to base further reforms. As Australia is a federation and drug law is state law this has enabled diversity on drug laws to co-exist which has made this country an ideal laboratory for investigating and comparing different approaches to drug policy.

**Expanding the evidence base**

This is an approach which we should advocate for at the international level. In many countries the problems with the application of prohibition with strict criminal penalties to minor drug possession and use offences are apparent. Yet although application of civil penalties and cautioning schemes have mitigated some of these, and reduced the criminal justice costs, drug supply is left in the hands of the illicit market and significant number of citizens still get a criminal record as a result of using these drugs. Similarly, the de facto legalisation schemes in countries like the Netherlands and the medical cannabis schemes in place in North America are compromised by ‘workarounds’ which have been made to ensure their survival under the constraints of the international drug treaties.

**International treaties**

However, the capacity of Australia and other countries to carefully conduct and evaluate policy experiments beyond prohibition is limited by the current provisions of the international drug conventions. Elsewhere it has been suggested how the international treaties could be modified to allow carefully evaluated drug policy reform trials while allowing states to operate under the current treaties, if that is what they prefer.33 Australia, with its history of more than two decades of cautious and evaluated drug policy reforms, is ideally situated to advocate such an approach at the international level. If countries were freed from the constraints of the conventions and able to implement their own drug policy reforms, transitional comparisons would allow the evidence base to be expanded.

**Helpful public debate**

Public debate on drug policy is often polarised and this is fuelled by entrenched positions of some of the protagonists, a polarisation which is frequently exacerbated by the media’s framing of the issues. In this context public discourse about drug policy reform can be beneficial if it leads to an engaged and informed consideration of a range of policy options by the public and policy makers alike.

However, if the debate is going to be characterised by more light and less heat, then terminology needs to be clear. Using unclear terms like ‘decriminalisation’ will confuse the public debate, will be taken by many to mean ‘legalisation’ in a commercial model, and will lead politicians, who must be engaged in consideration of reform options, to run from the public debate.

**Engaging with policy makers**

Having a framework for the policy change process can assist in engaging political and policy stakeholders in the policy process. Kingdon’s Multiple Streams model has been useful in informing and describing drug policy reforms in Australia.44 In a nutshell Kingdon argues that windows of opportunity for policy change open when three streams come together: an understanding that there is a problem which needs to be addressed by a policy response, events in the political stream which allow political engagement with an issue, and emergence of economically feasible and politically viable policy responses.

Whilst all of these factors can
be canvassed in the public debate, engagement with active political and policy stakeholders often needs to be done out of the public spotlight within a trusting relationship where there is space to consider the evidence and craft viable political and policy positions.

Without this kind of engagement it is likely that public discourse about drug policy will remain a talk fest and won’t result in real further drug policy reform.

REFERENCES


Professor Simon Lenton is Deputy Director, National Drug Research Institute (NDRI).
EXPLORING ISSUES

WORKSHEETS AND ACTIVITIES

The Exploring Issues section comprises a range of ready-to-use worksheets featuring activities which relate to facts and views raised in this book.

The exercises presented in these worksheets are suitable for use by students at middle secondary school level and beyond. Some of the activities may be explored either individually or as a group.

As the information in this book is compiled from a number of different sources, readers are prompted to consider the origin of the text and to critically evaluate the questions presented.

Is the information cited from a primary or secondary source? Are you being presented with facts or opinions?

Is there any evidence of a particular bias or agenda? What are your own views after having explored the issues?

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WRITTEN ACTIVITIES 53
DISCUSSION ACTIVITIES 54
MULTIPLE CHOICE 55-56
Brainstorm, individually or as a group, to find out what you know about drug law reform.

1. What is the difference between a licit and an illicit drug, and what are some examples of both?

2. What is a synthetic drug, and what are some examples?

3. What is the difference between legalisation and decriminalisation of drugs?

4. What is harm minimisation in relation to drugs policy, and what are some examples?
Complete the following activity on a separate sheet of paper if more space is required.

Consider the following illicit drugs and discuss what you know about each. Include in your answer: other names used; information on what it does to the user; and their short and long term health effects.

MARIJUANA

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ICE

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ECSTASY

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__________________________________________________________________________________________
Complete the following activity on a separate sheet of paper if more space is required.

“The drug law reforms that now need to be considered by all Australian Governments should have as their goals: reducing deaths, disease, crime and corruption; improving the protection of human rights of all Australian citizens; and reducing the burden on the criminal justice system, taxpayers and families.”

Form two groups with which to debate legalisation versus decriminalisation as the most effective law reform response to illicit drugs in Australia. Include in your arguments the pros and cons, and how they would address the goals in the above statement.
Complete the following multiple choice questionnaire by circling or matching your preferred responses. The answers are at the end of the next page.

1. What type of drugs have the following names: Kronic, White Revolver, Ash Inferno and Black Widow?
   a. Cigarettes
   b. Depressants
   c. Alcohol
   d. Pharmaceuticals
   e. Amphetamines
   f. Synthetics
   g. Ecstasy

2. Which of the following are illicit drugs? (select all that apply)
   a. Amphetamine-type stimulants
   b. Ecstasy
   c. Tobacco
   d. Marijuana
   e. Alcohol
   f. Synthetics
   g. Codeine
   h. LSD

3. Which of the following drugs was first synthesised in 1912 and later used in psychotherapy?
   a. GHB
   b. Cocaine
   c. Heroin
   d. Codeine
   e. LSD
   f. Ecstasy
   g. Ice
   h. Ketamine

4. Heroin was legally available on prescription in Australia until what year?
   a. 1857
   b. 1912
   c. 1926
   d. 1953
   e. 1962
   f. 1985
   g. 1993

5. In what year was the first Australian drug law imposed as an import duty on opium?
   a. 1857
   b. 1912
   c. 1926
   d. 1953
   e. 1962
   f. 1985
   g. 1993
6. Match the following terms to their correct definitions:

1. ‘Legal high’
   a. An hallucinogen also known as synthetic LSD. It can look the same as LSD but can be up to six times the dose of that normally found in a single tab of LSD. Toxic effects can include seizures, hypothermia, organ failure and death.

2. Gamma-hydroxybutyrate
   b. A new psychoactive substance (NPS) or synthetic. This drug is new to the market, or has become more widely used in recent years. The effect of this drug can mimic those of more established drugs like LSD, cocaine and cannabis (but is sometimes much more potent).

3. ‘Speed’
   c. An amphetamine which generally comes as an off-white/yellowy powder, but can be pink or even brown. It also has the street names ‘zip’, ‘point’, ‘eve’ and ‘whiz’.

4. NBOMe
   d. An opiate originally developed to treat wounded soliders and send them back into battle as heroes.

5. Heroin
   e. A drug mainly used as a prescription medicine, although popular as an illicit or mood-altering substance. It can act as an anaesthetic to the central nervous system and can cause anything from relaxation, to sedation and total blackout.

6. Depressant
   f. A drug commonly found in the dance scene and is sometimes referred to as liquid ecstasy due to its stimulating, euphoric and supposed aphrodisiac qualities.
An oil called safrole, extracted from the roots, bark and fruit of sassafras plants is used to make MDMA. Use of sassafras in humans has been known to cause permanent liver damage and cancer. (p.1)

Ice accounts for 90% of all methamphetamine seized by police in Australia since the mid-’90s. (p.2)

Toxic gases produced during meth production include hydrogen chloride, hydrochloric acid, ammonia and phosphine – all highly poisonous to humans. (p.2)

The global area under opium poppy cultivation amounts to 236,320 ha, 14% higher than in 2011 (UNODC, 2013). (p.12)

The majority of clandestine drug laboratories continue to be detected in residential areas; however detections in commercial/industrial locations increased in 2012-13 (ACC, Illicit Drug Data Report 2012-13). (p.10)

The global area under opium poppy cultivation amounts to 236,320 ha, 14% higher than in 2011 (UNODC, World Drug Report 2013). (p.12)

The first evidence of people using the NBOMe group of drugs – sometimes known as ‘synthetic LSD’ – came from the United States in 2010. (p.13)

An oil called safrole, extracted from the roots, bark and fruit of sassafras plants is used to make MDMA. Use of sassafras in humans has been known to cause permanent liver damage and cancer. (p.1)

The first evidence of people using the NBOMe group of drugs – sometimes known as ‘synthetic LSD’ – came from the United States in 2010. (p.13)

The cost to Australian society of alcohol, tobacco and other drug misuse in the financial year 2004-05 was estimated at $56.1 billion (Ministerial Council on Drug Strategy, National Drug Strategy 2010-2015). (p.15)

Drug-related problems play a significant role in disparities in health and life expectancy between Indigenous and non-Indigenous Australians. (p.16)

The notion of making drug use illegal did not really emerge in western societies until the late 19th century. (p.18)

Most of today’s illegal drugs originally had medicinal uses. (p.18)

Cocaine was advocated by Sigmund Freud as a cure for heroin addiction (and it was also once an ingredient in Coca Cola). (p.18)

The Vietnam War contributed to the significant increase in drug consumption in Australia in the late 1960s, with American soldiers on ‘rest and recreation’ leave in Australia creating a market for heroin, marijuana and other illicit drugs. (p.19)

Australians in the 19th century were among the world’s biggest consumers of opiates. (p.19)

Heroin was legally available on prescription in Australia until 1953. (p.20)

Australia maintains an extremely low rate of HIV infection among injecting drug users, compared to infection rates of 60% or more among injecting drug users in some US cities. (p.20)

Less than one quarter of Australians support the legalisation of cannabis, heroin, ecstasy, and methamphetamine. (Ritter, A and Matthew-Simmons, F, Bulletin No. 21: What does the research evidence tell us about what Australians think about the legal status of drugs?). (p.22)

Men are more likely to support decriminalisation (31%) than women (24%). (Metherell, M and Davies, L, ‘Two-thirds opposed to easing of drug laws). (p.23)

Marijuana is the most used of all the illicit drugs. (p.26)

Sweden tried legalising and prescribing illicit substances as far back as 1965 and then abandoned it for a ‘restrictive’ drug policy when usage rates escalated. (p.27)

In the 1990s, Australia was among the countries at the leading edge of international harm reduction. (p.31)

The price of street heroin and cocaine decreased by more than 80% in the US and Europe in the past 20 years (Palmer, M, After 33 years, I can no longer ignore the evidence on drugs). (p.34)

Australia has authority to produce opium under strict regulation in Tasmania, needed for the world’s pharmaceutical industry to make morphine for pain relief. (p.41)

Between 2 and 3 million Australians use cannabis every year (Penington, D, A new approach to drug reform: regulated supply of cannabis and ecstasy). (p.42)

Prohibition with civil penalties schemes were introduced for minor cannabis offences in SA in 1987, the ACT in 1992, the NT in 1996 and in WA from 2004 to 2011. (p.46)
Abstinence
Not using or refraining from using a drug; being drug-free.

Amphetamine
A psychostimulant drug that speeds up the messages going from the brain to the body. Common amphetamines are speed, ice, and crystal meth.

Cannabis
A depressant and hallucinogen (in high doses) that comes from the Cannabis sativa hemp plant. Marijuana, hashish and hashish oil all derive from this plant. THC (delta-9 tetrahydrocannabinol) is the active chemical in cannabis.

Controlled substance
Refers to a psychoactive substance that is forbidden under the international drug control treaties or limited to medical and pharmaceutical channels.

Cultivation
The act of sowing, planting, growing, tending, nurturing or harvesting a narcotic plant.

Decriminalisation
Drug policy whereby possession of a drug for personal use is treated as a misdemeanour rather than a criminal offence. Often applied to substances considered to be less likely to cause dependence.

Demand reduction
The aim of reducing consumer demand for controlled substances. Demand reduction strategies seek to reduce the desire for, and preparedness to obtain and use drugs. These strategies are designed to prevent the uptake of harmful drug use and include abstinence-oriented strategies aimed at reducing drug use. Their purpose is to prevent harmful drug use and to prevent drug-related harm.

Diversion
Referring drug users from the criminal justice system into drug treatment.

Drug
A substance that affects the processes of the mind or body and changes they way they normally function. Legal drugs include alcohol, tobacco, caffeine and prescription medicines. Illegal drugs taken for recreational purposes include cannabis, cocaine and ecstasy.

Drug use/abuse
The use of any substance under international control for purposes other than medical and scientific, including use without prescription, in excessive doses, or over an unjustified period of time. Abuse includes the continued consumption of a substance despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Ecstasy
Street term for a range of drugs that are similar in structure to the synthetic stimulant MDMA (methyleneoxymethylamphetamine). The chemical structure of MDMA is related to stimulants (amphetamine) and some hallucinogens. Drugs sold as ‘ecstasy’ often contain a range of drugs such as amphetamine, caffeine, aspirin, paracetamol, ketamine, in addition to, or instead of MDMA.

Harm minimisation
Drug prevention that acknowledges abstinence as the most effective way to avoid drug-related harms, however that it is not always possible in certain individual circumstances. It entails minimising the adverse effects of drug use to individuals and the community through supply reduction, demand reduction and harm reduction strategies.

Illicit drug
An illegal drug; a drug whose production, sale or possession is prohibited.

Licit drug
A legal drug, whose production, sale or possession is not prohibited.

Methamphetamine
A stimulant drug available in a number of different forms. It is most commonly a colourless crystalline solid, and called a variety of names, such as crystal meth, crystal or ice. In its powder form it is most commonly known as ‘speed’.

New psychoactive substances (synthetics)
A range of terms have been used to describe new psychoactive substances (NPS), including new and emerging drugs (NEDs), synthetics, legal highs, herbal highs, party pills, herbal ecstasy, bath salts, drug analogues and synthetic cannabis. The laws surrounding NPS are complex and differ between states and between state and federal law. They are also constantly changing, so a drug that was legal to possess yesterday, could be banned tomorrow.

Possession
Having control or custody of a drug. Possession applies both to drugs found on the person or their property, unless it is proven the drugs do not belong to that person.

Prohibition
All behaviours related to drugs, including use, possession, cultivation/manufacture and supply are deemed to be criminal offences.

Risk reduction
Policies or programs that focus on reducing the risk of harm from alcohol or other drug use.

Stimulants
They stimulate certain chemicals in the brain and increase alertness, heart rate, blood pressure and breathing rate.

Supply reduction
Reducing the availability of drugs through legislation and law enforcement.

Trafficking
The selling, exchanging, agreeing to sell, offering for sale or having in possession for sale, a drug of dependence. If this is done in commercial quantities, the penalties are extremely severe.
WEB LINKS

Websites with further information on the topic

Australia21  www.australia21.org.au
Australian Crime Commission  www.crimecommission.gov.au
Australian Drug Foundation (ADF)  www.adf.org.au
Australian Drug Information Network (ADIN)  www.adin.com.au
Australian Drug Law Reform Foundation  http://adlrf.org.au
Australian Institute of Criminology  www.aic.gov.au
Australian National Council on Drugs (ANCD)  www.ancd.org.au
Count the Costs  www.countthecosts.org
Drug Advisory Council of Australia  www.daca.org.au
Drug ARM Australasia  www.drugarm.com.au
Drug Free Australia  www.drugfree.org.au
Drug Law Reform Australia  www.druglawreform.com.au
Families and Friends for Drug Law Reform  www.ffdlr.org.au
National Cannabis Prevention and Information Centre (NCPIC)  www.ncpic.org.au
National Drug and Alcohol Research Centre  http://ndarc.med.unsw.edu.au
National Drugs Campaign  www.drugs.health.gov.au
Turning Point  www.turningpoint.org.au

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Drug Law Reform Debate

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