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Dealing With Death – A Theory of the Bleeding Obvious

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Dr Alex Wodak is the Director of Alcohol and Drug Services at St Vincents Hospital, Sydney.

Mr David Stanley is the National Program Director for Convenience Advertising, the Family Support Director of the Raymond Hadder (Drug Rehah) Clinic in Melbourne and the Treasurer of the Australian Drug Law Reform Foundation.

Mr Peter Cleeland, when he was a federal member of parliament, chaired the Joint Parliamentary Committee on the National Crime Authority from 1987 to 1990 and from 1993 to 1996. He was a member of the Victoria Police for a decade and is a barrister & solicitor of the Supreme Court of Victoria and a solicitor of the Supreme Court of NSW.

In the preparation of this paper I called upon these three people often. They have cheerfully supplied me with substantial assistance and, in two cases, with copies of significant works in progress with the invitation to use the material as I see fit. I have done more than use the material, I have plundered it. So it is only proper that, from the outset, I acknowledge their generous assistance.

INTRODUCTION

Thursday the 16th. of April 1998 - between the hours of 6pm. Thursday and 3am. Friday 32 overdoses were reported.

Friday the 17th. of April 1998 - between 3am. to early evening, 26 overdoses were reported.

Sunday Age the 19th. April 1998 - "Smacked-out people are so common place on Smith (Smith St.) you cease to notice after a while"

Monday the 20th. April 1998 - A detective who allegedly gave keys to the Victorian drug squad storage compound as part of a conspiracy to make and sell amphetamines faced the Melbourne Magistrates Court.

Just four days in Melbourne - four days in which prohibition has failed.

In this paper, I shall argue that the total prohibition in Australia of heroin and cannabis has been wholly ineffective in terms of the prevention of illicit drug use, and insidiously counter-productive because it has led to an enormous black market and unacceptable levels of other forms of crime at enormous cost to the community. I conclude therefore that prohibition must be lifted and in its place rational policies be adopted similar to those operating in the Netherlands and Switzerland.

The present policy of prohibition aims to reduce the use of illegal drugs by preventing supplies of such drugs reaching those in Australia who might wish to use them. At the time such policies were introduced Australia had little or no experience with wholesale illegal drug use and abuse and little or no experience with international organised crime.

In a sense, prohibition was seen as a harm reduction policy in that the prevention of supply would remove the ability to use the drug. But, instead of being a harm reduction policy prohibition, by increasing the profit available to those who would supply a demand market, artificially inflated the price and set into train the growth of the market and of the criminal groups that control it.

Prohibition, as this submission argues, has maximised harm to both the user of drugs and to the social structure of Australia.

The present policy of prohibition has clearly failed to reduce harm, for it has failed to reduce supply. A continuation of the present policy will mean a continuation of unnecessary deaths among the illegal drug using population. In Australia in 1997 overdose deaths claimed 800 lives.

Policies which aim for harm reduction by prohibition are not achieving their aims. They are, and were always was doomed to be, a failure. Harm reduction can only be achieved by accepting that abusive drug use is a medical problem to be solved by medical policies.

If law enforcement measures were having an impact in the marketplace, the illegal drugs would be in short supply, their prices would rise and the purity of the product at street level would fall. The evidence points to the opposite; illegal drugs are increasingly available, the price has, and is, falling, and the purity of the product at street level has never been higher.

HISTORY

Historically Australia's policy of prohibition did not arise from a careful root and branch assessment of the effectiveness of previous policies and a rigorous evaluation of policy options. Rather the prohibition of cannabis and heroin arose for litte other reason than as an obsequious response to pressure from the international community.

At the 1925 Geneva Convention, Australia agreed to enact laws to "limit exclusively to medical and scientific purposes the manufacture, import, sale, distribution, export and use of "medicinal opium, cocaine, morphine, Indian hemp and heroin."(1) Although the use of "Indian hemp" (or cannabis) was virtually unheard of in Australia at that time, authorities responded to the call for conformity to the new international framework. Not everyone agreed with the logic of prohibition however: the then under-secretary of the Colonial Secretaries Department claimed that "the omission of that drug from the operation of the Act would possibly be of small moment, but having been considered by the conference as requiring to be included, it might perhaps be as well, if practicable, to bring it within the purview of the dangerous drugs laws." In this haphazard way was created the mighty edifice of cannabis prohibition.

During the first half of the twentieth century in Australia, the occasional cases of heroin dependence were managed by the medical profession under the supervision of state or territory health departments. In the early 1950's Australia came under increasing international pressure to prohibit the use of heroin even though problems consequent on consumption of the drug were not evident and notwithstanding local opposition to such a move (2). The Director-General of Health in New South Wales said that "heroin .. is quite effectively controlled in this state and .. I see no justification to enforce absolute prohibition". The Australian Federal Council of the British Medical Association, the predecessor of the Australian Medical Association, argued that there "should be no curtailment of availability". The Royal Australasian College of Physicians and the Royal College of Obstetricians and Gynecologists both declared in 1953 that "the use of heroin should not be prohibited". Nevertheless the Commonwealth advised State Premiers in May 1953 that the importation of heroin was to be absolutely prohibited. Thereafter, doctors prescribed drugs other than heroin when managing painful conditions.

Ten years later, in the 60's, some US Servicemen on rest and recreation leave from the Vietnam war brought heroin with them and introduced young Australian men and women to the drug and the practice of injection. The Bourbon and Beefsteak bar in Sydney's Kings Cross became the first centre of Australia's heroin trade. Over the following years, heroin injecting spread to all Australian states and territories and the number of young men and women injecting heroin increased inexorably.

PRESENT SITUATION

Australia officially adopted a national drug policy of "harm minimisation" at the Special Premiers' Conference held in Canberra on 2 April 1985. The meeting was convened by the then Prime Minister and attended by all State Premiers and both Chief Ministers. The term "harm minimisation" was not defined at that time, however, a national commitment to harm minimisation has been endorsed on several subsequent occasions by the Ministerial Council on Drug Strategy, Australia's paramount drug policy making body.

What has government, however, done to achieve "harm minimisation"? A short analysis of where government has placed its resources is instructive:

'According to a 1997 United Nations World Drug Report, Commonwealth and State government expenditure in response to illicit drugs is estimated at $620 million. Of this not inconsiderable sum, 84 percent was allocated to law enforcement, only 6 percent to treatment and 10 percent to prevention and research. Although these figures are somewhat imprecise, they represent the best indication available of the proportions of government expenditure allocated to supply reduction and demand reduction.

How can Australia's response to illicit drugs be best understood at the end of the twentieth century? The lion's share of a great deal of money is being spent on policing prohibition and a miniscule amount on research, education and treatment.

What outcomes or benefits, if any, is this not inconsiderable expenditure buying for the community? It was estimated that in 1997 in Australia there were 100,000 regular injecting drug users with an additional 175,000 occasional injecting drug users, that the number of injecting drug users had increased at a rate of seven percent per annum from the 1960s and that this rate represents a doubling time of just 10 years (8).

In addition there are a number of indications that the rate of increase of injecting drug use in Australia during the last years of the twentieth century is occurring at an even faster pace. This perception is based on:

Firstly an increase in the number of drug seizures and the amounts of drugs seized,

The 1997 Annual Report to Parliament of the Australian Customs Service intercepted 169kg of heroin in 96/7 compared to 64kg in 95/6. 1998's figures are not yet available but a single bust last year yielded 400 kgs.

Secondly an increase in deaths from drug overdose,

Drug overdose deaths in Australia have increased rapidly during the last twenty years of the twentieth century. These deaths increased from 70 (10.7 per million) in 1979 to 550 (67 per million) in 1995 to about 800 in 1997. Between 1991 and 1997, overdose deaths in Australia doubled (10). In 1999, drug overdose deaths in Victoria are expected to equal or exceed all road crash deaths in that state and are currently 40% higher than at the same time last year.

Thirdly an increase in demand for drug treatment and a rapid increase in the demand for sterile syringes.

Three years ago the major providers of inpatient detox services in Melbourne - Odyssey, Windana and Moreland Hall- sometimes had waiting lists and sometimes addicts waited from ten to fourteen days for a bed. Today they are commonly on the waiting list for four to six weeks. This month the manager of the Melbourne Inner City Needle Exchange reported a 100% increase in the number of people accessing syringes in the last 18 months (11).

People with illicit drug habits almost inevitably turn to crime in order to generate funds to support their habits. There can be little doubt, as other speakers have commented, that drug related property crime in Australia is exceedingly common and at the end of this century increasing rapidly (12).

'Rampant official corruption has also been linked to illicit drugs. This linkage was confirmed in recent times in a number of official enquiries and Royal commissions including the Fitzgerald Royal Commission in Queensland and the Wood Royal Commission in New South Wales. Both Royal commissions concluded that official corruption was widespread and linked to the enforcement of laws relating to illicit drugs (13).

If our national drug policy has been designed fundamentally to decrease drug use, decrease deaths, decrease crime and decrease corruption, Australia's drug policy in the latter decades of the twentieth century is clearly not achieving these objectives. It is important to recognize not only the failure of drug policy, but the magnitude of this failure. Failure to this extent in the corporate world would result in inevitable bankruptcy. Military failure on this scale would almost certainly result in court martial of those responsible. Governments are often very concerned to emphasise the importance of drug users accepting responsibility for their own individual actions. But governments seem less inclined to accept responsibility for the consequences of their own policies.

The final word on the effectiveness of total prohibition goes to the conservative Australian Bureau of Criminal Intelligence (14) who recently reported that "heroin remains generally available in Australia and anecdotal information suggests that law enforcement efforts are having only a limited effect on the amount of heroin offered at street level...it is a serious concern and it is obvious that current policies are not working".

Let us now accept that we've lost an unwinnable and inappropriate war. We need now to run up the white flag and look around for other ways to achieve peace in our time. We don't have to explore new frontiers alone, we have only to look to the Netherlands and Switzerland for the lead. First the Netherlands.

NETHERLANDS

In the Netherlands in 1972 the Baan Commission drew a clear-cut distinction between drug users and traffickers and also between acceptable harm level drugs (cannabis) and unacceptable harm level drugs (heroin, amphetamine, cocaine etc). This led to a "depenalisation" of cannabis (3). By the late seventies the illicit drug market in the Netherlands split. Policy makers at regional and national levels tolerated cannabis in order to reduce the harm in their communities caused by heroin (overdose, blood borne viruses, drug related nuisance & crime). The point was to prevent kids who wanted to acquire cannabis from coming into contact with those who wanted to sell them heroin.

Since the early eighties Dutch youth have been able to access cannabis in a controlled way within a safer context than before, from retail outlets styled as coffee shops. The policy is administered at local government level by a Triangle Committee which involves the Mayor, the Chief of Police and the Chief Prosecutor.

In the Netherlands 30% of young people aged 14 and over have tried cannabis and 15 % smoke it regularly (4). Use by Australian youth is of the same

'order' of magnitude with the Victorian Education Department estimating that 50% of high school aged youth have tried cannabis. (7)

In the Netherlands, however, cannabis can be obtained from any one of two thousand coffee shops who open their doors by local government permit with strict operational guidelines which include:

- sales of no more that 5 grams of cannabis product per customer per day
- no more than 500 grams of cannabis product to be held as stock
- absolutely no hard drugs
- no aggressive behavior
- sale of teas, coffee & snack foods
- provision of health related information

The extraordinary outcomes achieved over the last 17 years in the Netherlands are attributable in part to and really commenced with the separation of markets policy that has been in practice since the late 70's.

These outcomes are three fold (5):

1. Drug overdose fatalities remain steady at less than 50 per annum. In 1997 in Australia, a country of similar population, we lost around 800!
2. The average age of problem drug users (users mainly of heroin) attending drug services has gone from 26 years in 1981 to 36 years in 1995 and is increasing at the rate of 10 months per annum.
3. The percentage of clients, usually with heroin problems, presenting to drug service providers under the age of 22 has gone from 14.4% in 1981 to 1.6% in 1995.

The Dutch experiment has unquestionably worked. The evidence is that there are few young heroin using recruits and that the heroin using population is getting old and is diminishing.

As Commissaris Zee of the Amsterdam Police recently commented "The addicts are all old hippies,, the kids think the drug is uncool."(6) To Switzerland...

SWITZERLAND

In Switzerland health problems, public nuisance and crime related to drugs all increased steadily during the 1980s and early 1990's. HIV was poorly controlled among injecting drug users. Authorities in many cities appeared to have lost control of public order due to widespread drug injecting in public places. Following a vigorous national debate, Swiss policy changed in the early 1990s and improvement soon followed. Drug overdose deaths in Switzerland halved from 419 in 1992 to 209 in 1998. Public nuisance related to drug injecting in public places declined steadily during the 1990s. Drug related crime has also been declining in Switzerland during the 1990s.

A crucial stage in the development of today's Swiss policy was the now internationally famous heroin trial which was initiated by Swiss Government decree in October 1992. The controversial trial, conducted by Zurich University's Institute for Social and Preventative Medicine, studied firstly the impact of prescribed narcotics on the health, social integration and dependant behavior of the research participants; secondly the suitability of

this treatment for heroin dependants whose previous therapy had been unsuccessful, and thirdly the effectiveness of this treatment compared with that of other available therapies.

An independent research team devised the research protocol, data collection procedure and analysis and write-up of reports. The research plan & protocol received the approval of the Ethics Committee of the Swiss Academy of Medical Sciences. At the request of the International Narcotics Control Board, a specialist group was appointed by the World Health Organization to appraise the overall research program and results.

The study was based on the prescription of heroin to over 1,100 heroin addicts in 15 Swiss cities and one penal institution. The participants all:

- Were at least 20 years of age
- Had a history of heroin dependence of at least two years, and
- Had unsuccessfully participated in other treatments on several occasions.

The injections of prescribed narcotics had to be given under supervision and injectible narcotics could not be taken home. The treatment had to also involve the provision of good quality psychosocial care. These are some of the results of the study which was conducted over a three year period from 1994 to 1996 inclusive(9):

1. Both the number of offenders and the number of criminal offences decreased by about 60% in the first six months of treatment.
2. Court convictions decreased significantly (according to the central criminal register)
3. Most illicit drug use, including that of cocaine, rapidly and markedly declined, whereas benzodiazepine use decreased more slowly but alcohol and cannabis consumption hardly declined at all.
4. The number of participants unemployed fell by more than half (from 44% to 20%)
5. One third of patients who, on admission, were dependant on welfare required no further support and came off welfare. On the other hand, the numbers who were dependant on illicit income dropped dramatically from 59% to 10%.
6. Participants' housing situation rapidly improved (in particular there were no longer any homeless)
7. Physical health improved during treatment (in physical terms, this relates especially to general and nutritional status and injection-related skin diseases).
8. Retention rate in the study, 89% over a period of 6 months and 69% over a period of 18 months, proved to be above average when compared with other treatment programs for heroin dependants.
9. More than half of the program dropouts switched to another form of treatment, including abstinence.
10. No disturbance of note was caused to the local neighbourhoods, or if so only temporarily.
11. There were no overdose deaths, only three new HIV infections, 4 new hepatitis B infections and 5 new hepatitis C infections.
12. The cost - benefit analysis took into account:
    - the costs of administering the program,
    - the saving to the public purse as a result of the improvement in the general state of health of the

participants, and
- reduction in policing, court and incarceration costs.

The yield was a net economic benefit to the public purse of $AUD 45 per patient day.

It is little wonder that in a subsequent national referendum in 1997 over 70% of Swiss citizens voted in favor of the adoption of prescribed heroin as national health policy.

By 1998, 1,056 patients were receiving treatment in the form of heroin prescription provided with considerable psychosocial assistance. The capacity of detoxification and rehabilitation residential centres increased from 1,250 in 1993 to 1,750 in 1997. By 1999, there were fourteen injecting rooms spread across Switzerland. In these facilities, drug injecting takes place under supervision with immediate assistance provided in the event of an overdose. No deaths have been reported from any Swiss injecting room to date.

GLOBAL

It was widely assumed during the second half of the twentieth century in Australia, that support for "tough on drugs" policies inevitably results in growing political popularity. However there is now increasing national and international evidence for the view that support for Draconian drug policies is becoming a political liability rather than an asset. In 1998, 63 percent of respondents in a public opinion poll expressed disapproval of the Commonwealth Government's handling of illicit drug issues. This poll was held after the Prime Minister had aligned himself with a zero tolerance approach and issued a number of "tough on drugs" policy statements. The strong political support for Victorian Premier Mr Geoff Kennett among young voters has been linked to the Premier's support for drug policy reform. In the United States, drug policy referenda were held in six states coinciding with the mid term congressional elections in November 1998. Majorities for reform were reported in all six states. In Switzerland, 71 percent of voters in a national referendum in September 1997 supported retaining heroin prescription with majorities in all 26 cantons.

The encouraging improvement in outcomes in Switzerland and the Netherlands during the 1990s suggests that evidence-based, pragmatic approaches can achieve improved outcomes. Consequently, there has been a growing interest in Western Europe in more public health oriented approaches, especially as countries with a historical commitment to belief-based moralistic approaches reported unacceptable and deteriorating outcomes.

CONCLUSION

The heroin prescription trial and injecting rooms have captured a great deal of national attention in Australia. The defacto legalisation of cannabis in the Netherlands has been notorious for decades although the extraordinary benefits delivered by Dutch policy are less widely known. In these two countries the fact is less often acknowledged that strenuous efforts have been made to expand the range, increase the capacity and improve the quality of drug treatment in both countries. For example, approximately ten times as much funding per person is allocated to drug related health interventions in Switzerland compared to Australia. It is not my thesis that reversing the

current prohibition against cannabis and heroin in our country will, by itself, eliminate current rates of illicit drug related mortality and morbidity.

But the evidence is in now that the reversal of prohibition must be an important part of the solution. In vain, we've spent enormous resource trying to crush a black market with an estimated annual turnover of $AUD 7 billion (15). That market would be starved of new heroin using recruits if our country's hundreds of thousands of cannabis users were not exposed to heroin when they endeavored to obtain their recreational drug of choice. That market will only seriously haemorage when addicts can get cleaner, cheaper and safer heroin from health professions who could provide a whole range of complementary treatments and supports. The funds currently pouring into the black hole of funding the "war on drugs" are there for diversion to constructive treatment programs.

Tragically in Australia illicit drug policy and funding has been based on ideology rather than evidence. The policy has become inviolable while politicians remain terrified of losing an election lest rationality be misinterpreted as "being soft on drugs." But if we really want to help drug users lead normal and useful lives and offer some hope to their families and their communities, the first step is an unswerving commitment to evidence-based policy and practice without political interference.

When he cancelled the ACT heroin trial in 1997 the Prime Minister claimed that a rigorous trial of medically prescribed heroin was tantamount to legalisation and would "send the wrong message."(16)

What messages of certainty did the Prime Minister and Cabinet send by extinguishing the heroin trial? Firstly, that the lucrative profits of illicit drug trafficking, the very engine of this problem, would not be threatened. Secondly, that this problem will continue to be dealt with predominantly by law enforcement, an approach now widely recognized to be prohibitively costly and hopelessly impractical (17).

It is time for a fundamental and thorough change of direction. Thank you.

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7 See discussion between Mr R Knowles, Victorian Health Minister, and Mr J Thwaites, shadow minister for health, The Age, 28 May 1999 p17.

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12 The Australian Institute of Criminology reported that 53 percent of property offenders said that they were using heroin at the time of committing the offence. In New South Wales, heroin dependence was considered responsible for a 33.4 percent increase in robberies committed with a firearm, a 76.8 percent increase in robberies with a knife and a 29.5 percent increase in robberies without a weapon. A survey of Sydney heroin users from 1995 to 1997, found that 70 percent had committed a property crime in the month prior to interview whilst 9 percent had committed a fraud and 4 percent a violent crime. Interviews with inmates convicted of burglary offences in New South Wales indicated a higher median rate of burglary (13.7 per month) among heroin users than among burglars who did not use heroin (8.7 per month). Median weekly burglary income for heroin users ($3,000) was far greater than for non-users of heroin ($1,000). Although a substantial proportion of heroin users commit crime before commencing illicit drug use, there can be little doubt that drug use prolongs and exacerbates criminal behaviour.

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