Dalgarno INSTITUTE

25 Years of…

‘Harm Minimisation’ – how far have we come?

Third Edition

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Harm Minimisation, how far have we come?

"Even the most 'rational' approach to ethics is defenceless if there isn't the will to do what is right!" ***Alexander Solzhenitsyn***

What does 'care' look like in the current 'substance use/illicit drug' theatre? What is currently the emerging consensus for compassionate response to the damage done by illicit substances on the lives of Australian Citizens? Who or what is driving the definitions and frameworks?

These are questions that all need answering, and answers that transcend the one dimensional hyperbole that is currently being broadcast via a manufactured and tenuous consensus.

I think the average Aussie mum and dad don't have a clue at what is being not only defined but promoted as responsible care in this arena of drug use and if they really saw what was being peddled as 'best practice', they would be nothing short of outraged!

In 1985 a group of perhaps well meaning (perhaps malevolent) folk got concession for what was touted as a progressive strategy – ***'Harm Minimisation'*** a clever term that at first glance emits a certain nuance of responsible care. But around what was this 'care' focused? Was it of concern for illicit drug use, or even illicit drug users? No, the primary focus for this care, which in reality underpins the policy, was not drugs, but HIV/AIDS.

> "What were the major areas of interest of ANCA (The Australian National Council on AIDS Strategies)? The first and most urgent was the recognition that HIV infection represented a greater threat to the community than drug use itself" [1]

However, one thing was to become quickly obvious, that regardless of definitions or even intent, the first major step down the slippery slope of 'drug normalisation' was taken.

Definitions

According to the National Centre for Research into the Prevention of Drug abuse and the "National Drug Strategy" the original mission of this stated policy was *"to minimise the harmful effects of drugs and drug use in Australian society"* [2] and a key policy goal is: *"to minimise the level of personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the inappropriate use of alcohol and other drugs".* [3]

According to Stephen Milgate, former Executive Director, The Australian Doctors Fund discovered that by early 1998 this statement had been removed from the Internet and replaced with the following *"Sorry, the page you are looking for does not exist"* [4]

By at least 2005 the policy reemerged and, if not by name, then by nature, in a more functional mode (largely due to efforts of conservative government and wider community input) and consequently mandated in the **National Drug Strategy.** Harm Minimisation was clearly defined in the following way….

*"Involves a range of approaches to **prevent** and **reduce** drug-related harm including **prevention**; **early intervention**; **specialist treatment**; **supply control**; **safer drug use**; and **abstinence**."* [5] *[emphasis added]*

It is clear in the now National Strategic plan that the term 'Harm Minimisation' was here to stay, but also clearly mandated key components, of which only one was to do with permitting or tacitly promoting drug use; '*safer drug use'*. The other components of the strategy are all prevention, reduction and recovery focused, if not in direct statement, then in intent.

Whilst this new 'framework' had clear intentions to try and introduce another option for the recalcitrant or enslaved drug user (other than cessation and recovery), that might perhaps limit one door to accidental death – the policy still had enshrined in letter, that ***Prevention, early intervention and even abstinence were still key elements of the policy.*** However, were these elements promoted, engaged or promulgated? Well no! Over time the policy has been hijacked and completely undermined, to the point that prevention is ostensibly ignored and abstinence just plain ridiculed, by the pernicious pro-drug lobbyists of this new emphasis.

The new 'harm min' framework had become synonymous with the promotion of 'safer drug use' and the passive promotion of 'normalised' illicit drug taking – This, of course is an absolute genius move from the social architects of the 'Harm Reduction' Lobby, as evident in the following ever morphing definitions/assumptions around this growingly nebulous term. By 2007 definitions and interpretations were becoming widely independent of National Strategies. Or were they? For example, Hume Health in Victoria has had no problem in leaping completely away from the National Drug Strategy's focus and intent as the following reveals.

> *"A harm minimisation approach **accepts** that:*
>
> - ***Drug use will continue to be part of society***
> - ***The eradication of drug use is impossible***
> - ***Continued attempts at eradication may well result in increasing harm to society.***
>
> [emphasis added]
>
> *Drug and Alcohol counselors work from this principle of harm minimisation. The primary aim is to help the person to survive their drug use and reduce the damage associated with the drug use. Advocates of harm minimisation do not take a position on whether drug use is intrinsically a good or bad thing; they seek neither to punish or cure the drug user. This approach accepts that people make choices whether to use drugs or not, and that some will choose to use them, while others will not. The focus remains on preventing harm while a person uses the drug, not on whether they made the right choice. Therefore workers don't pressure a user to give up a drug if they don't want to, rather they aim to change dangerous practices associated with their drug use."*[6]

So how did that brazen departure from the need from *'prevention, early intervention and even abstinence'* happen? Well you have to look beyond statements and at the spin around interpretation and, of course, who is the gatekeeper of recommendations, inclusions, omissions and promotion.

AS this excerpt from 'The winnable war on drugs' reveals…

The NDS [National Drug Strategy] notes that the key features and principles of harm reduction include:

- *that the primary goal is reducing harm rather than drug use per se;*
- *that it is built on evidence-based analysis (strategies need to demonstrate, on balance of probabilities, a net reduction in harm);*
- *that there is acceptance that drugs are a part of society and will never be eliminated;*
- *that harm reduction should provide a comprehensive public health framework;*
- *that priority is placed on immediate (and achievable) goals; and*
- *that pragmatism and humanistic values underpin harm reduction.*

The acceptance of illicit drug use within the harm minimisation framework is unacceptable. The New South Wales Government highlights such an attitude by announcing in its state plan its target to 'hold the proportion of people using illicit drugs below 15 per cent'. It is similarly unacceptable that this view of 'success' is shared by some drug treatment service providers:

> *One Australian family support service redefines the concept of 'success' and utilises harm reduction in its work with families. 'Our definition of success does not incorporate drug-free status as a definite and primary outcome. Instead we find that the byproduct of having support, collective wisdom and coping skills is that the drug user is often healthier and moving more positively and quickly through his or her 'Stages of Changes'.*

Further, the Australasian Society of HIV Medicine considered that:
A harm minimisation approach, as it is applied to drug use, considers the actual harms associated with the use of a particular drug (as well as, but not exclusively of the drug itself), and how these harms can be minimised or reduced. It recognises that drugs are, and will continue to be, a part of our society and that prohibition has historically been a counterproductive policy.
This approach was also referred to by Youth Substance Abuse Service, who considered that:

> *While the National Drug Strategy 2004-2009 reinforces non-use as a desirable option it retains a level of pragmatism and recognises legal and illegal drug use and misuse will occur, despite the best efforts of all who seek to address illicit alcohol and drug use in the community.*

The committee condemns these views and believes that they highlight the intrinsic ambiguity of the harm minimisation approach. Of further concern to the committee were comments by Professor Margaret Hamilton, a deputy chair of the Australian National Council on Drugs (ANCD), that the harm minimisation approach accepts that:

- *psychoactive substances are and will continue to be part of our society;*
- *their eradication is impossible; and*
- *the continuation of attempts to eradicate them may result in maximising net harms for society.*

Other elements of harm minimisation cited by Professor Hamilton were that 'harm minimisation assumes that an acceptance of abstinence is irrelevant',48 and that it was a value-neutral term that avoided moralistic arguments about whether drug use is inherently 'bad' or 'good', noting that:

> *From the perspective of harm minimisation, drug use is neither good nor bad … This morally neutral stance has made it possible to begin to move away from a punitive and condemnatory approach toward a more humane framework.*

Professor Hamilton has also questioned the Prime Minister's policy stance of zero tolerance, stating that:

> *Debate about [the application of harm minimisation] to the education area and to young people has continued. This has included the articulation by the Prime Minister John Howard of an apparently inconsistent policy stance of zero tolerance in the drug area and a subsequent explanation that this referred to a policy approach in the school context.* ***

As you can see in the aforementioned how simple it is to highlight only one component of Harm Minimisation – 'Harm Reduction' to the point where it personifies the policy and robbing the policy of any preventative capacity!

Of course for us to make clear to the reader what is so logically, legally and epistemologically incongruent with their website statement and the selective policy nuance behind it, as outlined in the Family and Human Services committee report revealed, would take too many words, suffice to say their clear understanding is that taking a currently illegal drug, that does irrefutable damage to not only the user, but their psycho-social environments (just for starters) is a completely amoral, impact neutral and private activity, is quite frankly ludicrous! However, what is disturbing is the blatant declaration that *'drug use will continue to be part of society',* and that *'eradication is impossible.'* sending a clear and wantonly irresponsible message to the unwitting and largely ignorant population that drug use is 'normal'.

What is of even greater concern is the unambiguous message this sends to our young – the vulnerable - that we are supposed to protect. It declares drug use an *inevitability*. You could not possibly reinforce drug 'normalisation' any more emphatically than this!

In 2010 we had a member of one of our Dalgarno Institute Campuses approach a senior official and overseer of a Department of Education Region, who was interested in looking at our School incursion program – "NO Brainer". Once she heard that our program was 'Harm Prevention' focused (best practice for people under age of 25 at least) she stated she could not permit the use the program. However, what came next was even more disturbing; she went on to say that she thought it might even be 'illegal', under current government policy, to use Harm Prevention education curriculum. This is how pervasive this redefinition has become; even chief gatekeepers of our children's education believe prevention education is 'illegal' and permissive elements of 'harm minimisation' practices are the only option available to the most vulnerable of our population.

Pro-drug use lobby

Speaking at the International Harm Reduction Association Conference held in April 2010 in Liverpool UK, Professor Dirk Korf of the University of Amsterdam intimated that one of the best ways to get permissive drug reforms through is to *'normalise'* the issue. Once drug use is 'normalised' it is easier to bring about legislative change, such as decriminalization of substances. Then once backed by legislation, substance users can then claim their human right to 'privacy, autonomy and health care' to enable them to use drugs.

Another key element to getting policy changed is also the removal of stigma from the drug user…. *"It's not the quantity of people, just that it becomes accepted as normal…Policy should try to avoid*

marginalisation of users!" Now whilst a compassionate individual may not want to denigrate a drug user, the effort to remove the stigma from drug users isn't out of concern for them getting off drugs, but endeavours to further the cause of 'normalisation', giving another 'tool' to manipulate legislators into sanctioning these substances that destroy both the individual and community.

Another 'hothouse' academic observer Professor of Public Health and Sociology at London University, Tim Rhodes in his presentation "*Fear and structural violence as barriers to harm reduction - Qualitative case studies on police violence in Russia and Serbia",* drew some provocative conclusions from his 'evidence based' foray into the seedy underworld of Soviet-Serbian drug culture…***"Fear of moral/social disorder drives policy, not evidence!"; "Criminalisation enables vulnerability to violence!"; "Fear and fear based policy, induces an environment of risk!"***

What is fascinating about this diatribe is that none of these claims were made about drugs, or the fact that people have chosen to not only break the law, but self-harm in using these psychotropic biological time bombs. In fact these claims were made about the mismanagement of a prevention drug policy, by corrupt and dysfunctional management agencies. Clever really, to turn all negative attention away from the very thing that started the problem and turn onto an, albeit shocking example, of not necessarily bad policy, but bad implementation and management. It sounded convincing and no doubt much of it was clearly happening, however, in what context was this evidence real? In the context of people participating in biologically and socially irresponsible activities, in an environment of severe corruption and systemic mismanagement, all failing to implement best harm prevention practices - which include supply reduction, demand reduction and the offering of adequate recovery focused rehabilitative services?

The wielding of 'fear based' policy was standard fare in presentations, no doubt another emerging mantra of the pro-drug lobby. However, what is cleverly concealed by this lobby group is that the basis for their policy drive is also very much 'fear based', underneath the majority of this lobby lies the AIDS/HIV issue. Fear of this disease, and fear of its spread, doesn't lead to a passionate push to see people free of activities that precipitate the spread, no, the push is to enable them to continue the destructive activity, whilst attempting to negate the clear and present danger of HIV/AIDS. Of course, I haven't even mentioned the burgeoning hepatitis C epidemic, which has flourished under 'harm minimisation' principles, it would appear their one dimensional fear focus, has missed yet another major health catastrophe facilitated by a permissive, enabling and yes even drug promoting policy platform.

What these presentations did was move the audience to a place where the context for the study/findings could easily be forgotten (i.e. corrupt eastern European organised crime dominated culture) and thus the data from the study presented in a wider 'harm reduction' context. In other words let's just take the principles and presumptively apply them unilaterally and in essence affirming *'we can stop the problem by decriminalising drugs in all societies!'*

As disturbing and unacceptable as that is, the action recommended was not to address that problem and remove/reform that corruption, abuse and threat. Rather it was seemingly 'easier' to decriminalise another destructive activity. The consequences of this strategy would maintain the corruption, violence

and abuse (toward drug users/dealers) as well as even easier access to illicit drugs and drug use. Corruption and bad practice by a stakeholder with power will not be changed by the addition of further permissibility of another socially, medically and fiscally damaging activity. So you then have to wonder if this call for reform is really about 'health and safety' or about protection for and validation of illicit drug use?

Another presentation touted 'qualitative evidence' but proceeded to use case studies peppered with anecdotal evidence. I have no problem with this as long as the playing field is level and community/ public interest based groups can do the same.

One presenter failed to really highlight that the policing agencies were corrupt and used violence to extract bribes etc. What he did do was use the term '*moral discipline'* as a header for the shame based abuse meted out by the corrupt authorities. Again, clever spin, as this further marginalises the terms '*morality'* and '*discipline'* as potentially healthy and beneficial vehicles for change and puts them instead, into the realm of dysfunction, further bolstering the notion that damage management and not prevention and recovery as the way to go.

Progressive Care…really?

All this posturing around 'harm minimisation' is touted as a form of progressive care which was supposed to try and fix the problems that occur after alcohol or other drug use. (The ambulance parked at the bottom of society's cliff). However, and as pre-warned by many of the caring professionals who favour the prevention and rehabilitation model, these so called 'caring' endeavours have seemed to morph into a very concerning 'harm sponsorship' space.

The introduction of these radical reforms couched in emotive terms like 'life saving' and 'humane' have meant an , even reluctant, embrace by the anthropologically ignorant, time poor, 'system focused' and often budget constrained legislators/politicians who want to be 'seen' to be doing something 'concrete' to show their electorate.

Harm Minimisation (or 'reduction') (in its now limited one dimensional definition) has clearly failed to deliver any real reduction in drug use. Australia is still the highest prevalence of Illicit drug use amongst OECD Nations (UN Drug Report 2007) What it has done is facilitate a more permissive attitude toward drug use, contrary to United Nations CONTROL BOARD statement: *"The creation of a culture that is predominantly against drug abuse is the most promising form of prevention in the long term."*

Much in the misnamed 'harm-min/reduction' playbook has, as mentioned, little to do with drugs and more to do with other issues – particularly post drug use issues. This paradigm has been overtaken by damage management, which may seem noble, but at a closer look, much of the damage being 'managed' is a result of failed assumptions of the basic 'Harm Reduction' dogma.

As we have seen 'Harm min/reduction' has shifted context of the issue and quickly became about trying to 'offset' the ultimate damage of drug use (death) and at the expense of even trying to stop, let alone

prevent drug use. However, in so doing this dogma has increased and/or for the most part entrenched the drug use this policy platform was originally supposed to help to reduce.

For instance, needle exchange programs (NSP), have now become distribution programs. Methadone reduction programs, have not only become methadone maintenance, but often poly-drug use sustaining programs. Injecting facilities have only one unambiguous outcome - the permitting and empowering of drug use – there is no other spin for this. (more on this later)

Street sex workers have gone on record*as identifying 'NSP's as the only really 'useful' service for them, and not for the reason that such programs were supposedly set up for, that is the so-called 'safer' practice of drug use – in and of itself an antithesis to good health practice and upholding of human dignity. No, the service was useful to these sex workers because it gave them free condoms and 'lube' to continue to illegally earn the money to purchase the illegal substances they need to cope with the illegal activity of prostitution that provides them with the illicit income they need to service the illicit drug habit they have…. And oh yeh, by the way, the occasional clean fit is useful for shooting up to help them cope with the maelstrom they are *being empowered to stay in!*

At no point in this merry-go-round are these precious human lives either given real alternatives or enabled through socio-legal processes to at least detox, let alone rehabilitate. What is done more often than not, as seen in the above scenario, is that instead 'clients' are empowered and enabled to continue with the not merely illegal, but dehumanising and pernicious practices that drug use has enslaved them to.

There are a couple of legal principles, if you like - foundational tenants of law. The first I want to table here is the following… "*Law seeks to assign liability for harm".* This is an important 'after event' pillar that ensures at least two things a) that those causing harm are bought to account and held responsible (more punitive) b) to determine what, if anything, could be or have been done to negate, prevent or remove that harm.

This of course, is a good thing. When harm is caused by something or someone, then that cause needs to be held accountable. Responsible, safe, caring and functional societies need this to keep their communities just that.

However, within the legal framework there are also expectations that pre-empt the facilitation of harm and endeavour to place social impositions to minimise the precipitation of harm. One such imposition is what is called **'duty of care.'** There have been a number of renditions of this, but a couple of landmark legal cases saw the emergence of the following definition of 'duty of care' under what is known as the 'neighbour' principle.

> *"To avoid acts which you can reasonably foresee would be likely to injure persons who are so closely and directly affected by your act that you ought reasonably to have them in contemplation as being so affected when directing your mind to act in question."*
>
> *(taken from cases, Donaghue v Stevenson, and Caparo Industry PLC v Dickman 1990)*

* Taken from Presentation of Ben Durant Aust Catholic University presentation "Survival Stripped Bare: Young people's participation in sex work…' presented 3/5/11 at 6th International Conference on Drugs & Young people

This understanding of the duty of care should be at the very core of legislation that has to do with alcohol and other drugs. We would argue that it is this principle of law that should be the platform for all Australian Drug Laws.

If avoiding acts that are easily seen to facilitate injury to members of the community then the contemplation of potential harms by drugs that may be released, facilitated, presented or permitted, should be at the forefront of consideration in legislator's minds. What should also be intently focused on by these legal architects is not only emerging families, but as importantly the vulnerable – the young, mentally ill, socially isolated, poor, homeless etc. Drug legislation that has such communities, families and individuals in mind, will ensure all measures of 'care' are taken to avoid these potential harms being perpetrated.

Now, the application of this Law or Legislation regarding 'duty of care' in the Alcohol and other Drug arena will not only intervene to break the cycle of conduct we now see, but further compels the self-destructing person into a healthier and safer drug-free focused recovery process. In this scenario anti-drug legislation cannot be viewed as punitive and harm sustaining – no, it's quite the opposite. It is the aforementioned legal 'duty of care' that aids and abets care focused, harm preventing rescue and restoration.

Any health-care professional worth their salt would see this as their proper duty of care and would shun conduct that facilitates, empowers or enables continued dysfunction as we are seeing in this growing 'harm-reduction dogma' empowered 'industry'. By industry, we mean the productive enterprises of activities that generate 'business' in the maintenance or perpetuation of social, physical and psychological harms.

Why is this empowerment and enabling to dysfunction so willingly fostered? Despite the increasingly noisy propaganda of Pro-drug reformers, there has been a long decline in illicit drug use in the USA based on prohibitive policies. However, there has been a recent upsurge in illicit drug use. This has been attributed to the success of one of the pro-drug lobby's other tactics, and that is generation of the perception that illicit drugs, particularly Cannabis, are harmless and using 'medical' spin to inflate taht perception. Dr. Rober L Dupont, President of the Institute for Behaviour and Health Inc and author of the Commentary... *'Learning from Experience: Implications of Long-term Trends in Illegal Drug Use in the United States'* penned the following...

> *In 2009, use of illicit drugs took a sharply upward turn….Advocates of Harm Reduction were energized by their continuing successes in changing the way Americans think about illegal drugs – that they were less harmful – and in changing state laws, particularly the growing acceptance of medical marijuana.*
>
> *…Many supporters of medical marijuana were dropping their camouflage and outwardly advocating for the ultimate drug policy goal of the legalisation of marijuana. Starting with marijuana, their objective was to remove the role of criminal justice system in drug policy.*

> *Based on past experience, the* ***success of Harm Reduction****, if continued, will* ***result in rapidly rising rates of illegal drug use, including but not limited to marijuana, since drug using behaviours (and therefore drug use rates) often are linked to perceptions of the relative harmfulness of illegal drug use.*** *With the increase in marijuana use in 2009, the perception waned of the associated harm of marijuana use. However, it is important to note that rates of alcohol and tobacco use also declined among youth, confirming that the prohibition of illicit drugs did not cause an upswing in legal drug use. The nation appears to be at a tipping point as drug policy has emerged as a major public policy focus.*[emphasis added]

This, though of great concern, is no surprise, when one considers how the first world west has not only failed to afford the emerging generation sustainable frameworks for meaning and context, but abandoned them to a pernicious market forces that seek only to play up the so called 'fun' and down play any negatives or side effects of illicit drug use; leaving the hapless underprepared young person an easy target for pro-drug lobby propaganda. Yet when the inevitable damage is done to the emerging generation and future generations have to bear the health, financial and social costs of these nefarious policies, where will the current noisy pro-drug lobbyist be? Dead, dysfunctional, certainly unaccountable, but that seems to be the point – the denying of social, physical and moral responsibility for the sake of egocentric pursuits.

Talk about 'Human Rights!'

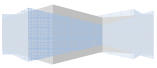
What continues to be a growing concern is that this policy subterfuge has placed Australia in not only the auspicious category of having one of the most liberal drug policies on the planet, but more disturbingly in clear contravention of Principle 2 of the International Declaration of the Rights of the Child which states...

> *The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration.* [7]

The first question one must then ask of any policy decision made by legislators/governments, is ... 'will the policy/law we are considering prevent, inhibit or place at risk the healthy and normal development of the physical, mental, moral, spiritual and social development of the child; and will these same laws foster and give the best opportunity for freedom and dignity for that child? If the answer is no, or even unlikely, then the policy must be reconsidered.

If this is a little to ambiguous, then deferring to the United Nations 1989 Convention on the Rights of the Child will bring into sharp focus the priorities that legislators must set. Article 33 of this charter states that...

> *Parties shall take all appropriate measures including legislative, administrative, and education measures to protect children from the illicit use of narcotic drugs and psychotropic substances,*



For a more complete insight on this refer to *"The right of children to be protected from narcotic drugs and psychotropic substances – A Human right and international law perspective."* By Dalgren & Stere May 2010

> *as defined in relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances* [8]

This article must also be interpreted with and alongside Article 3 of the same charter which declares...

> *In all actions concerning children whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration.* [9]

It is clear that the intent of article 33 is to protect children in three specific areas and that any policy creation/proposal must have the welfare of the child (and children of any community/society) as the first consideration in any policy decision.

Protecting children from exposure and/or involvement in the latter two aspects of drug use could be argued as easily defined; being 'production' and 'trafficking' of illicit drugs. However, it is the first consideration that is key – 'The protection of the child from *'illicit use'*.' Again, the interpretation of this cannot be subjective in the context of these charter points. The child has to be protected from involvement in/with illicit use and this will include exposure to and promotion of illicit drug use. Any other legislation that fails to negate or prevent these outcomes will facilitate a contravention of the right of the child.

The collaboration of these Human Rights charters insists that all measures be taken by responsible societies to protect its children from the dangers of and exposure to illicit drugs. Protection of the child not protection of the 'user' is what is imperative and as such cannot be ignored. To highlight just some of the hidden damage being done by the growing use of illicit drugs under the confused and often hijacked 'Harm Min' regime we have the following comments from a Western Australian agency. Dept of Child Protection case worker, Katherine Fendley was quoted in June 13 2009 Edition of the *West Australian Weekend Magazine* in an article titled ***'Behind closed doors'*** saying that… *"There are 3000 children in care in WA…Most cases her team deals with are drug related"* If that wasn't enough At the end of 2010 the WA Minister for Child Protection the Hon Robin McSweeney publicly stated in the media *"that by 2011 DCP will have 4000 children in WA DCP "Care". And all this in only one State!* **(for more data go to page 26 & 27)**

Harm minimisation characteristics, interpretations and attitudes (as we saw in the example on the *Hume Health* website) that facilitate by either neglect or promotion, the denial of Australia's children maximum protection from physical, moral, mental, spiritual and social abuse because of illicit drugs are in breach of the Rights of the Child. This failed policy platform of 'Harm Min' has also put at risk health, freedom and dignity of the child to be free from the exposure to or promotion of drugs. The best interests of our children are being cast aside for the best interests of a group of adults who wish to self-destruct using their 'human right' to invest in substances that destroy lives, families and relationships in fact only adding to that which makes them less than human.

The ambivalent and at times just plain contradictory 'harm minimisation' message seriously undermines the social, emotional and physical wellbeing of our society's most vulnerable. On one hand it gives a low

key message that illicit drugs can damage you, then, on the other hand give children cues and even instructions on how to use these same prohibited substances. Harm minimisation at the public face says we don't want you to harm yourself, but then says let us help you try drugs and we'll show you how to minimise the consequences. This passive playing down of substance impact and the instruction of 'how to' creates at best cognitive dissonance in the already confused adolescent, at worst it is a 'green light' to the already accelerator prone frontal lobe of the child's brain, to 'have a go'! All you need now is pop-culture reinforcement (party scene) and a few 'dabbling' peers (recruited pushers) to convince the hapless youth, and they're 'in'!

Of course, these social and cultural reinforcer's, now empowered by a confusing harm min policy precipitates, at least the 'trying' of substances once, and then the pro-drug lobby come along and use the 'tried once' demographic that they have been architects of creating and then say... "See young people have always been experimenters, they will do this and look the 'evidence' proves it!"

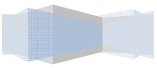
Talk about set up! Our young people deserve and, yes as we've just read, have a right to something much better than this irresponsible and manipulative model.

Harm Minimisation – a convoluted and confusing message in our communities.

Here are some classic examples of this confusing message that helps set kids up!

1) In 2008 the booklet "A User's guide to SPEED" was made widely available to students. This booklet gave recommendations from how to take it to prompts on how to ensure a good 'dealer'.*
2) In 2010 another 'Harm minimisation' literary treasure was made freely available to students, through local library's and other public areas. The brochure '*Drug Safety – a guide to a better night*' didn't only expect that 18-29 y.o. would be taking illicit drugs, but recommending ways to do it 'safely', even going as far as suggesting people try different drugs to find one that better suits! *
3) Again in 2010 a 'postcard' campaign by the State Health officials promoting illicit drugs in a 'theme park' manner that appeal to the most vulnerable. Colourful images of fun and terms like 'nose candy'. On the back of the publicly available postcard was more information that could lead children the idea that illicit drugs are ok and that authorities are perceived limited in some areas. What is utterly ridiculous by comparison, is that a packet of cigarettes (the other legal drug) have to have clear and graphic messages on them warning of the dangers of smoking.*
4) Drug Syringe sites unlocked and open to access by anyone in broad daylight in Marrackville, Sydney. In January 2010 young people were pictured taking the syringes from the public access unlocked dispenser. *

These examples are only a few, but overall there is a constant stream of propaganda from the 'normalisation of drugs' lobby that is allowed to slip into the community psyche. Yet this ever increasing permissive policy is failing our young by:



* http://www.darrenmarton.com/Content_Common/pg-clearly-exposing-the-problem.seo)

- Creating confusion in young people.
- Promoting the use of illicit drugs.
- Adding further leverage to social contagions, such as peer pressure.
- Hampering enforcement measures but sending a message of permissibility.

But what of the impacts to the wider community? These permissive measures have seen the following also burgeon:

a) '**Needle exchange' programs** to attempt to minimise infections, have now become 'needle distribution' programs. There is now little to no exchange of needles, and referral requirements in this process have largely gone by the wayside. There is now a further development of the push for the installation of syringe vending machines in public places, where **anyone** can insert a $2 coin into a slot and obtain syringes without question, accountability or referral [10]
According to Hepatitis Australia around 9700 people contract this infection every year and by 2007 over 260,000 people have been exposed. Sadly three quarters of these people will struggle with this virus throughout their lives and have high risks of liver failure and liver cancer. The majority of these infections can be attributed to the sharing of drug injecting equipment. [11]

Now, the needle exchange lobby in their one dimensional AIDS/HIV focus did not consider this potential epidemic. However, one would have thought that a needle exchange program would have prevented both occurrences. Clearly the anomaly creates at least one serious problem for this endeavour. Do needles get exchanged? Are all needles accounted for? If not, then does the proliferation of needles mean easier discarding and more prolific sharing? And if so, does this alleviate or add to other public health concerns? We have spoken to street workers who are paid, in part by Local Councils, to go around known drug use areas and 'collect' the discarded needles and these are then recorded as 'exchanged'. By as early as 1997 this problem was clearly entrenched, "...injecting drug use with the sharing of injection equipment accounted for transmission in 76% of all people with hepatitis C". [12]

Even with all the information about and prolific availability of NSP program users continue to share equipment with National Drug and Alcohol Research Centre's 10th Illicit Drug Reporting System (IDRS) revealing that this year alone at least *"10% of respondents borrowed needles, while the sharing of injecting equipment was common"#* This single, yet incredibly serious 'glitch' even moved one of the architects of this failed endeavour to rethink this methodology. Dr. Alex Wodak one of the architects and current champions of 'harm reduction', who even in early days in breach of all known government regulations distributed 'free' syringes to anyone who wanted them, had not in his zeal seen this hepatitis C problem coming. At the 1989 **Drugs, The Law and Medicine Summit** Wodak stated:

> *Attempts to discourage intravenous use of drugs should have the highest priority. Substitution from injecting to other forms of administration is preferable to continued injecting with the inevitable consequence of HIV infection.*

#Taken from "*Of Substance",* vol 8, no 3 2010 www.ndarc.med.unsw.edu.au "Drug Trends"

By 1994 with the emergence of hepatitis C, Dr Wodak's anti-injection stance was even stronger. He wrote:

> *Most new infections of hepatitis C in Australia occur among drug injectors. About 60% of drug injectors in Australia are already infected with hepatitis C. This means that there are 30 times as many drug injectors infected with hepatitis C than HIV. Hepatitis C is also far more infectious than HIV. The implications of this, I believe, are that we must virtually eradicate drug injecting from Australia if we are to gain control of the hepatitis C epidemic.* [13]

Yet by 1999 Dr Wodak flip flops and does and about face on his own position by being integral part of setting up Australia's only 'shooting gallery' for drug users in Kings Cross –I wonder if that has more to do with which agenda is being funded and by whom, than It has do with recovery focused or prevention based health care? Without total and honest transparency, we'll never know.

A couple of years later, among other voices Professor G Farrell of the Gastroenterological Society, was quoted as saying

> *This is why the behaviour [injecting drug use] is so dangerous, and while harm reduction is important, I think strategies to prevent IDU behaviour are probably more fundamentally important.* [14]

So were these people listened too? Well, it would appear not. Rather than reduce this failed practice, we could add to it another component – 'shooting galleries', or the politically correct sanitized version 'Medically Supervised Injecting Rooms'. One advocate for this in the year 2000 was Professor Penington who not only made outrageous predictions, but spruiked erroneous data to back his endeavour. The following article, ONLY one, back in 2006 held Professor Penington to account:

> *GATHER round, children, for another big lesson from the past. This lesson is about, Panic, and how it is used to sell us plans as crazy as ... well, "safe" injecting rooms. You might have read this week that drug experts are "surprised" by how few people now die of heroin overdoses. Only nine have died so far this year, which Rob Moodie of the Premier's Drug Prevention Council says is "remarkable". But, ah, I remember Moodie. And remember even better his council, as well as its forerunner -- the Premier's Drug Advisory Council, then led by Prof David Penington. In particular, I remember how they and this council tried to sell us the lethally stupid idea of injecting rooms for addicts. It was 2000, and Penington in particular warned we faced a catastrophe. Heroin deaths in 1999 had risen to 359. And by 2005 they would soar even higher to 496, unless we did something. And perhaps the biggest something Penington and his committee had in mind was these injecting rooms.*
>
> *Penington claimed that thanks to such rooms overseas "death rates have fallen five to 10-fold". It was a claim repeated endlessly by others especially by The Age. The answer was so easy, they pleaded, and so refreshingly non-judgmental. Except it was untrue. In fact, overdose deaths in Switzerland the most touted example had tripled in the five years after it opened its first injecting room, and halved only after a police crackdown... After pointing this out again and again to Penington, I finally had a win. His committee's final report grudgingly conceded (in a footnote only, I recall) that, indeed, "the mortality rate tripled with five years". But The Age to this day has not conceded this.*

The Greens still even argue injecting rooms will "save lives". Yet Penington's committee still argued that tackling drugs by intensive policing could just make police corruption worse. "Harm minimisation" was the go, and the committee even suggested police and politicians privately agree not to prosecute drug users. So overwhelming was the hysteria that Liberal premier Jeff Kennett argued for injecting rooms. Labor, led by Steve Bracks, trumped him by promising five. There were even demands for free heroin for addicts. And see now: we've been so successful in fighting drugs that we didn't get the predicted 496 overdose deaths last year, but just 71.

But good golly, we've done this not with injecting rooms -- rejected overwhelmingly by the public -- but by policing smarter and judging tougher, as well as by treating addicts and putting more people in jobs. Fancy that. What we were told wouldn't work actually worked brilliantly. But Sydney, sadly, did give in and opened a $2.5 million-a-year injecting room in King's Cross. We now see what's happened there -- since 2001 it's helped junkies inject themselves 309,529 times, but in fewer than 1 per cent of those cases did it refer the "client" to treatment centres. Its users have injected on average for 12 years. It proves the point some of us fought so hard to make: that injecting rooms were an excuse to simply give up on addicts. To hide them. They would legitimise the way these users destroyed themselves and their families. Most people, I'm sure, agreed with us. Ask yourself why so many who preached at you back then did not, and why they still won't admit their mistake. [15]

b) **The Methadone 'Reduction' Program** intended to wean the addict off heroin and then off methadone has now, not surprisingly morphed into the 'Methadone Maintenance' program. This has seen an increase in poly-drug use, a new addicted demographic of 'methadone users' and an ever increasing number of people addicted to these life controlling and dysfunctional-creating substances. Under this one dimensional 'harm minimisation' strategy, Governments have been seduced into giving an even higher priority to Methadone Maintenance and even greater subsidies to users by reducing the personal cost to them. What is more concerning is that around the world methadone use is not decreasing, rather increasing and also proving ineffective. In Scotland, for example, where evaluation of the Methadone Program saw only 3% of heroin users getting off methadone and more than that the number of addicts of methadone had quadrupled in a 10 year period. There have even been reports of child deaths due to methadone overdosing. [16]

A study by Dr James Bell, of three private clinics dispensing methadone revealed that:

- Urine testing, the means of determining a drug free status was considered inaccurate in all three clinics.
- It was not rare to hear of people selling and injecting take-away doses of medication.
- While half the subjects in one clinic were said to continue to use heroin infrequently, in a third clinic "there was no reduction in heroin use with increasing duration of treatment".
- The study states that: "In treatment use of non-opioid drugs there was usually a continuation of pre-treatment pattern use. There was no dramatic change on entering treatment. About one-third of cannabis smokers increased their level of

consumption during treatment. Persistent cannabis use was associated with greater social dysfunction and involvement in crime." [17]

According to the National Drug and Alcohol Research Centre at the University of NSW latest study almost 90% of Methadone users want to get off the substance. The study also has shown that the high level of interest in coming off methadone, but this seems at odds with the, now emphasis of methadone programs, of keeping people on treatment as a benchmark of success. People are not being encouraged to get off Methadone, whether deliberately or inadvertently, methadone users aren't, it would seem, being actively encouraged to be substance free, but, tacitly encouraged to maintain addiction. [18] Methadone makes up about 70% of pharmacotherapy use with Buprenorphine being the other major OST. In NSW alone there been an over 450% increase in registered Methadone users since 1986. Then there were 2700 registered users, but by only 2004 there were 12700 users. The latest data from the Australian Institute of Health and Welfare numbered reported the numbers legally using pharmacotherapy has jumped nationally to over 43,000 which is double the registered legal users from only 10 years ago and this was a statistic taken from a 'snapshot day'. **(see table below)** [19]

Table 2: Total number of pharmacotherapy clients receiving pharmacotherapy treatment on a 'snapshot/ specified' day by state and territory, 1998–2009

	NSW	Vic	Qld	WA[a]	SA[b]	Tas	ACT	NT	Australia
1998	12,107	5,334	3,011	1,654	1,839	306	406	—	24,657
1999	12,500	6,700	3,341	2,449	1,985	370	559	2	27,906
2000	13,594	7,647	3,588	2,140	2,198	423	615	32	30,237
2001	15,069	7,743	3,745	2,307	2,522	464	641	25	32,516
2002	15,471	7,700	3,896	3,602	2,417	513	590	21	34,210
2003	16,165	8,685	4,289	4,079	2,486	498	686	98	36,986
2004	15,719	10,003	4,470	4,137	2,706	576	748	82	38,741
2005	16,469	10,753	4,440	2,883	2,857	588	764	183	38,937
2006	16,355	10,736	4,637	2,388	2,823	602	790	134	38,965
2007	16,348	11,051	4,309	2,322	2,834	600	765	114	38,843
2008	17,168	11,821	4,899	2,908	3,052	588	786	125	41,347
2009	17,868	12,576	5,116	3,187	3,151	634	797	121	43,445

We are trailing Scotland (or are we?) where prescriptions for methadone have risen from 98,131 in 1994 to 411,339 in 2005. As we've just read they are reviewing their methodology only after utter failure to produce drug free clients – so do we have to get that bad before we review our policy? The annual cost to the Scottish NHS of methadone is about £12m**.** [20]

c) **Light or even suspended sentences** for most drug traffickers – there is little or no deterrent in the legal system and there is also a lack of consistency in drug laws across Australia.
d) **The permanency** of the ineffective 'Supervised Injecting Facility'.
e) **Long waiting lists** because of a lack of funding for recovery-based rehabilitation.

f) **Government funding continues** for drug user organizations – for example an organization called 'Australian Injecting Drug Users' League (AVIL) continues to receive funding for 'peer education' to help people use drugs 'safely'. [21]

g) **An emerging push** to have Cannabis legalised where at most, people are given a warning, or charged and penalised with a mere expiation fee. [22]

h) **The use of poorly presented and utilised 'education' documents/programs** that create cognitive dissonance in young people because of the mixed messages they send i.e. *do not use, it will damage you, but if you do use, then use safely.* There is no such thing as 'safe use' of drugs for the developing adolescent brain. This needs to be unequivocally stated and not undermined by tacit permission for children to use drugs by teaching them drug use techniques.

Wasn't this inevitable?

However, as I earlier indicated, this process was inevitable from the outset. In fact it is difficult to prevent this 'slippery slope' ideology from being anything but slippery! Attempting to get traction for 'recovery' from these addiction maintenance models is, and will remain, virtually impossible if substance users have been influenced to believe that their behaviour is not only permitted but tacitly accepted as normal.

'Safe Injecting Rooms' - once pejoratively coined 'shooting galleries' - have now morphed into Medically Supervised Injecting Centres! Again, these endeavours are promoted as progressive, humane and 'life saving', yet with each strategy there is a growing entrenchment of the 'normalisation' of drug use as part of society's activities.

Again, this clearly affirms, if not the intent, then consequence of the existing 'harm minimisation/ reduction' strategy.

In fact many adherents to the International Harm Reduction Association espouse this notion as a key strategy for the changing of cultural perspective to these society and life destroying substances.

Here comes the question, a simple question, but one that everyone seems to be avoiding…

Why are people not only stepping into this health and psycho-social maelstrom known as drug use, but now wanting to have it established as a human right?

The Elephant in the room!

From our perspective there are really only three factors that would facilitate a step into this space of willful self harm; **Damage**, **Deficit** or **Dysfunction** in an individual. The person has emotional psychological damage incurred from their environment. The individual has Socio-emotional or affective deficit; key social/emotional components necessary for a healthy child were missing. Or there is a combination of the two with other bio-chemical issues; that mean an individual willingly chooses to intake psychotropic toxins. These issues will in turn impact and be impacted by one of these five arenas:

1) Relational
2) Emotional
3) Psychological
4) Physical
5) Paradigmatic

Now in the first four of these arenas, we see that if pain, trauma or deficit are experienced, then an 'alleviation' is sought – a respite from incessant emotional, psychological, physical pain or gnawing emptiness. Of course there are other vehicles for the management or rectification of these states (mostly non-chemical), but our framework for identifying them or even the terms 'dysfunctional' or 'deficient' have been eroded. You see you need some sort of standard/value by which to juxtapose the so called 'normal' and 'abnormal' – the 'broken' and the 'whole' if we are going to determine what is 'good' and what is not!

And now we come to the 5th arena – the paradigmatic space. The how and why I see the world, the 'context' for my existence and the 'what and who' that may have informed and/or shaped these.

It is in this arena that a new demographic is trying to emerge. A contingent of persons who deny or reject the idea of dysfunction, deficit or even damage, this group declare their choice of illicit drug use a volitional one and an act of recreation alone, with no other predicative elements influencing that 'choice'.

This new willfully ignorant space (there is no other term to describe this) can only fall into one of two categories – Hedonistic or Nihilistic; living for pleasure or living to self destruct. Regardless of category, the choice to take psychotropic toxins is an act of a self-indulgent or damaged psyche who declares personal 'rights' at the total disregard for personal health or of anyone else for that matter.

Now nowhere in any of these lists is there room for legitimisation of any kind, well at least not a legitimacy based on the notion of fiscal health, mental or physical health, values, ethics and responsible citizenry, as the following comment by acclaimed Sociologist Amitai Etzioni affirms.

> *"Above all, people abhor an ethical vacuum, one in which all choices have the same standing and are equally legitimate, when all they face are directions among which they may choose, but no compass to guide them. In short, after a point, the quest for an ever greater liberty does not make for a good society."* (Etzioni, A, *The New Golden Rule,* Preface p xv)

Again, in a cultural and values vacuum that enshrines 'selfism' as the new socio-religious code, anchored to a nihilistic view that we are no more than biological units with no intrinsic value other than what our immediate personal culture grants us, then feeling 'good' at whatever price, seems to be one of the products of such ideology. However, as anthropology 101 dictates, the 'individualisation' of rights at the discount of, and disconnection from, other human beings is one of the key markers of a culture preparing to implode. At least in this light 'humanity' is losing a 'humane' element.

The flow-on effect: Burgeoning Mental Health Issues.

Let us go back to some of the emotive markers that led us into the labyrinth of sponsored harm – 'caring, compassionate, humane'. Yet are the results compatible with the things we believe these qualities should produce? We need to determine the definition and context of these terms.

We can understand a term by defining what it doesn't conjure up in the minds of the average citizen. Does the maintenance of addiction and the facilitation of health, fiscal and life destroying substances in any rational mind denote 'care, compassion and humane' qualities?

I was listening to prominent psychologist Dr. Michael Carr-Gregg at the Annual ACCESS Dinner in November 2010 and he was talking (with some passion and concern I might add) about the growing mental health issues in our young people. Declaring that Dysthymia* amongst the young is growing with approximately 40% of students suffering from it, he went on to say that a little over half of these incidences will emerge into depression. Now these diagnoses, these clinical pronouncements are statements that dysfunction, damage or deficit exist – so we have an evidence based platform by which we can assess such ailments. Carr-Gregg went on to cite one of only a very few studies on the progressive decline of mental health in the first world by Professor Jean Twenge, who discovered that in 1938 there was a 5% figure of young people struggling with psychopathological deviance and/or anxiety/hypomania. By 2007 this level was averaging around 27%. Remember this is in the most affluent and technologically advanced nations in the world!

Of course Carr-Gregg is not the only voice on this issue. Any serious clinician with an understanding of the entirety of human condition knows there has been this growing problem, as outlined by Stephen Milgate in a 1998 address…

> *The major problem with our 13 year policy of 'harm minimisation' I believe, lies in the fact that for the past decade we have not been fighting the right epidemic…The real epidemic driving the demand for addictive substances of all types in relatively affluent societies is the epidemic of emotional depression driven by increasing social isolation.*[23]

And borne out by Dr. Leanne as quoted in the Medical Observer…

> *Despite the advances of health care in Australia and our lip service to the importance of young people, statistics show that the health of young Australians is getting worse.* [24]

And the latest student text book for students of psychology

> *Another study based on similar surveys' conducted in Puertorico, Canada, Italy, Germany, France, Taiwan, Lebanon and New Zealand, suggests this trend toward developing depression at increasingly early ages is occurring worldwide…. Kessler and colleagues 2003 compared four age groups and found that fully 25% of people 18-29 years had already experienced major depression a rate far higher than the rate for older groups when they were at that age.* [25]

* Dysthymic Disorder is a chronic condition characterized by depressive symptoms that occur for most of the day, more days than not, for at least 2 years. In children, the mood may be irritable rather than depressed, and the required minimum duration is only 1 year. http://www.mentalhealth.com/dis/p20-md04.html

As you recall earlier in this paper that we have no less than a UN Charter to protect our children, quoting again from the charter…

> *The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him/her to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration.*[7]

So what is it about our emerging society that is failing to create the *'opportunities and facilities'* to *enable 'physical, mental, moral, spiritual and social health'*?

It would appear, at least from the illicit drug arena, that this imperative doesn't even make the list of priorities. But again, why would it? "If 'my rights' are all that matters, then the wellbeing of another is of no consequence to me, least of all, those with no political voice"!

It is abundantly clear that our first world culture – empitomised in Australia – has a social malaise that has become increasingly more difficult to define with shrinking fields of social science and oppressive speech codes that 'gag' debate. We have societal dysfunction. We have an emerging generation suffering from an epidemic of almost sociopathic narcissism. We have socio-emotional deficits abounding, and what is the response? Let us create an even greater access and availability of a 'thing' that will guarantee, not only an addition to, but acceleration of, the very malady's we are already struggling with!

True Compassion Means….

The absolute truth is that there are so many better 'care' and 'compassion' options available to our community and particularly the substance user. We have devolved to the point now where all that is left in the tool kit of our current values ignoring, morally vacuous one dimensional care space are **'toleration'** and **'alleviation'.** This mode, now left unchecked has ushered in a new raft of permissive vehicles that only empower drug use and foster growing and now easily predicted dysfunction; a dysfunction that is then paraded as a volitional pursuit of personal liberty.

This, however, puts even greater importance on the need to move away from the negative expectations and capitulation model that is Harm Reduction and move toward health and wholeness pursuing prevention models. What is needed at this fragile point in our history, is the social, intellectual and, in the most loving sense, 'moral will' to implement them that must be rediscovered!

I have heard a number of sweeping statements from some prominent people in the field of Alcohol and other drugs that in essence believe that certain things are inevitable, and consequently there is little or no point in trying to prevent drug use.

The following are statements I've had made to me….

a) Kids are risk takers, always have been, experimentation is inevitable!

b) Morality is off the table!
c) Education doesn't work!
d) Users are considered losers and don't get the support they need!
e) Forced rehab has shown to be ineffective!

Whilst I concede these may all have some truth in them, or even at certain times may appear correct, all these statements can be equally the opposite… it depends on who you talk to, where you look and how much of history we are deliberately trying to forget!

Karl Marx, the father of yet another failed ideology said… "*A people without a heritage are easily persuaded."* Os Guiness stated correctly, *"Without truth, all you have left is manipulation."* Voltaire once coined … *"if you can get people to believe absurdities, you can get them to commit atrocities!"* And with the anthropological sabotage taking place in our society at the moment, any real cultural anchor points are being almost systematically removed so that heritage is abandoned and manipulation can flourish. Cultural cement like the institutions of marriage, family and church; coherent and sustainable meaning with rites of passage that encouraged personal responsibility and the community good have vanished. In their stead we have the deification of the 'self', the creation of new rite of passage, that being egocentric 'choice', and the now enshrined dual values of 'alleviation' and 'toleration'. Consequentially this rampant individualism has only fostered the ever increasing social isolation that also adds immense pressure to the all ready frail psyche, particularly of our 'spiritually malnourished' young.

Social Commentator Richard Eckersley bemoaned in his work 'Well & Good: How we feel and why it matters' that, [quoting Harman]*"The modern worldview, which is characterised by materialism, exploitative attitudes and faith in manipulative technology, is being challenged by an emerging worldview that reinstates the spiritual and holistic view…the central question we must address in terms of* ***meaning****."* and he went on to illuminate the 'Elephant in the room', so to speak when he wrote, *"Young people have a particular vulnerability to the failure of the modern Western Culture to do well what cultures are supposed to do:* ***provide webs of meaning that shape the way people see the world, locate themselves within it and behave in it.****" (emphasis added)*

And if that wasn't clear enough. Dr. Michael Carr-Gregg famously declared, *"Our young people are spiritual anorexics."* Learned clinicians acknowledge that the development of healthy spirituality is a key preventative measure to mental health decline, particularly for our societies young.

The remedy to the predicament our culture finds itself in is not going to be found in one dimensional physiological alleviation. The solution must be a holistic one and it requires the fortitude of a culture to ask of itself the hard questions.

Of course, what is inevitable in a culture taught to ignore all its history and its key lessons, is that people don't ask the question;

What did we do before the notion of Supervised Injecting Facilities, OST's and permissive Alcohol and other drug legislation?

Even a quick foray into the history and impact of groups such as the Twelve Step Programs, Salvation Army, Teen Challenge, Jackie Pullinger and other welfare agencies (pre 'easy-out' legislation) shows remarkable and lasting impact in both recovery of addicted persons and more importantly the proactive work of prevention policies, included Demand reduction, Supply Reduction and better policing! But it seems that our first world western culture is enamored with the notion of humanity's need to attempt all forms of self destruction or risk anything for a new 'buzz' or even just to 'feel something', and believing itself able to self repair. At the same time a growing disdain for anything to do with a functional and healthy socio-moral paradigm, as we have to this point known it!

So back to the issue of compassionate caring responses to the hapless individual trapped in addiction. An addiction precipitated no doubt by a number of factors, but one they still had *choice* in creating!

There are, as I see it, now three prominent 'players' in this arena of cultural management in the illicit drug arena. Each one is predicated on some philosophical perspective and informed by some ethical/moral code (no matter how poorly thought through).

a) The **'Fence Builder'** - The people who want to see harm prevented in the culture and people be given the best opportunity for the safest and healthiest society - socially, physically and spiritually. (A Good and noble space).
b) The **'Ambulance Driver'** – For some of these people, they are often driven by what G.K. Chesterton said was the least of all virtues; Tolerance*. 'Tolerance'*, he said, '*was the only virtue left for those with nothing to believe in!'* However, let us believe they are instead, people of 'Grace', giving genuine care to people who have lived selfishly, carelessly or naively reacting to life's circumstances. They have done whatever has pleased them and lived in such a way as they find themselves falling from the cliff's top and being near destroyed on the rocks below. These caring folk come with their metaphorical Ambulance, and their heart is only for repair and restoration, so that this hapless, yet self determined 'victim', has the chance to go back to the cliff top and live a life that doesn't repeat the same destructive patterns! (Arguably a good and noble space!)
c) However, there's another 'participant' positioning itself at the bottom of the metaphorical cliff of societal dysfunction. A new player. This participant doesn't carry the victim/broken/damaged to a place of healing, health or restoration; it doesn't even administer any preventative first aid. No this vehicle ensures the person stays at cliffs bottom with no repair, merely the offer of minimising discomfort and the staying of death, if only for a while. This new contributor of 'sponsored harm' is well disguised by a glossy facade with the words ***'non-judgemental kindness'*** emblazoned across it. In this, only recently invented cultural space, a poorly defined version of *kindness* is the only sentiment permitted, along with an indifferent tolerance. Alleviation, medication and toleration are all that is permitted here, and from this cultural space Love is banned because love is the highest moral virtue in its origin, operation and outcome. But at this cliff bottom, morality has been banned, so love too has been prohibited!

As stated each of these paradigms is predicated on something, informed by some 'thing', of that there is no escaping...but what is the informing agency?

If these human beings who find themselves caught in these destructive places are, as previously stated, by secular standards a mere one dimensional biological unit whose sole purpose for existence is to exist in a space of simply maximised pleasure and minimised pain, and when that is spent, be given the option to self destructing; then compassion in this context, is simply an acquiescence to the 'felt need'. If they want to commit slow suicide or engage in passive euthanasia, then, again in this narrow context, our only response is to help them do so 'kindly', but by that we mean minimal pain!

From another perspective, if the precious human being has intrinsic value not merely because they are human, that won't work if we are in a secular space, rather they have intrinsic value because of supra-cultural elements, then a whole new paradigm opens up and 'love' finds a more profound and powerful context.

I think the great author and brilliant thinker, Clive Staples Lewis puts one of the best perspectives on the issue of kindness and love in the following extract from his landmark work *'The problem of pain'*:

> *I might, indeed, have learned, even from the poets, that Love is something more stern and splendid than mere kindness; that even the love between the sexes is, as in Dante, "a lord of terrible aspect". **There is kindness in Love: but Love and kindness are not coterminous,** and when kindness…is separated from the other elements of Love, it involves a certain fundamental indifference to its object, and even something like contempt of it. Kindness consents very readily to the removal of its object – we have all met people whose kindness to animals is constantly leading them to kill animals lest they should suffer. Kindness, merely as such, cares not whether its object becomes good or bad, provided only that it escapes suffering… **It is for people whom we care nothing about that we demand happiness on any terms; with our friends, our lovers, our children, we are exacting and would rather see them suffer much than be happy in contemptible and estranging modes.***[26]

We all live in certain spaces, some 'greater' in perspective than others, but what we are immersed in will inform us and if we don't look beyond the insistence of the 'felt need', then we'll only see one dimensionally. If, however, there are better options and /or even best practice and we fail to explore that option and fail to present it, or if they chose to ignore it and make poor decisions about better options, then our next responsibility is, at the very least, to help protect the vulnerable, the young, families and community's who chose not to engage in destructive practices…rather than doing the unthinkable and resourcing and enabling those participating in this psycho-social and biological damage who carelessly continuing to do so.

There is an immutable law of life it is the ***'Law of sowing and reaping'.*** Whatever one plants will produce after its kind. Whatever an individual does will produce a consequence. Now this law is irrefutable it cannot be stopped, however it can be diverted. Interference with this process will not change the fact that consequences will happen, however the interference can change who experiences the consequences. In most cases, well meaning interference means that the one acting inappropriately does not experience the consequence, but the one interfering does.

For example the pain, angst, debt, violence, abuse, neglect and so on, that should be experienced by the one being rebellious/irresponsible/selfish/broken, is experienced by the parent who acts in mere 'kindness' and not love. However, and this is where real compassion is so powerful, INTERVENTION can see that law produce something redemptive or restorative, not mere resignation or even the remedial. When people love enough to ensure the 'addicted' is not spared the consequences, but rather confronted with and compelled to chose better options, then one can see tremendous change, as has been borne out by innumerable cases through groups like Twelve Step Programs and others as previously mentioned.

However, the failing to do this, shouldn't mean the default of 'reaping' then lands on the family or wider community, it still must rightly land in the hands of the one making the decisions. To negate the process to this inappropriate end is to deny justice to both the addict and more importantly the vast majority of the community that don't participate in this behaviour. All we do, when we fail in this area is to send a tacit message of reinforcement, that an individual is not responsible for their actions and there is no need for change, as someone will always suffer my consequences for me… and we wonder why Generation next is ever more selfish, narcissistic and careless!

The Harm Prevention Lobby also have a paradigm with many informing agencies. The data we keep bumping into (both anecdotal and empirical) sees that anyone who is struggling with addiction (arguably the demographic that would present at a Supervised Injecting Facility (SIF)) are, if not desperate, at the very least yearning for change. These people, in their weakest moment want change, but instead in the S.I.F they are assisted in 'self-medication'; they at this point then 'feel' little need to seek change, because the 'now' is numbed – the cycle is perpetuated.

Certainly, we may concede that if no other option existed then stopping these people from dying sounds noble, but if there are other options - **and clearly there are** - from drug free rehabilitation, to recovery focused rehabilitation, then with loving, caring, compassionate, yet *compulsory* support, these individuals can be free from addiction to these life destroying substances.

If, on the other hand, there is a willing and determined desire by any substance user to maintain addictive habits then it is morally, ethically and legally reprehensible to furnish them with the opportunity and means to prolong this damaging behavior to themselves and society!

If we claim to be caring, compassion or just responsible welfare/health professionals, then we need to consider the options, and above all we need to encourage our welfare community peers to operate beyond the inhumane limits of mere one dimensional distortion of biological kindness and give, if not the current substance user, then most certainly the next generation, a genuine chance at wholeness and function that every emerging Australian citizen should be granted.

I'll leave you with an excerpt from an address given by Stephen Milgate, past Executive Director of The Australian Doctors' Fund at *The International Drug Prevention Symposium*, University of New South Wales, July 1998.

Aiming Too Low

"The undeniable fact is that the policy of harm minimisation is not, was never and will never be the answer to Australia's growing drug abuse problem.

Nor should we forget that in the case of needle exchange its primary aim was to limit HIV/AIDS infection not drug addiction. This misunderstanding has been at the centre of a much confused debate over the future direction of Australia's drug policy.

Messages that may be appropriate for long term drug addicts namely "here's how you do it safely" are not appropriate for high school students let alone primary school students. Worse than this, the wrongly targeted "safe use" message has caused us, as a nation, to lower our sights.

We all know that we will never achieve for every individual a totally drug free society. But unless we adopt this as our aim we will sell ourselves short. Worse still, we will sell millions of future young Australians short by expecting less and less of them.

Any mixed messages by governments that drug abuse is somehow "inevitable" feeds into other messages of despondency that young people are fed on a daily basis. We need more optimism and less defeatism if we are to get results."[27]

Shane Varcoe – Executive Director

Dalgarno Institute.

A Snapshot Evaluation:

Has the liberalisation of Drug Policy in Australia, via the Harm Minimisation platform ...

(Circle One)

Increased or Decreased **Drug use** **I** **D**

Data

- Based on 2004 figures, 38% of Australians aged 14 years and over had used an illicit drug in their lifetime and 15% had done so in the last 12 months. By far the most commonly used illicit drug is cannabis which 34% of Australians aged 14 years and over admit to having used in their lifetime and 11% had used it in the last 12 months.
- Methamphetamines had been used by 9% in their lifetime and 3% had used methamphetamines in the last 12 months.
- The third most commonly used illicit substance was ecstasy – used by 8% ever and 3% in the last 12 months.
- Heroin use was relatively rare with only 1.4% having ever used this drug and 0.2% having used it in the last 12 months. **[Dalgarno Institute Note - This drug was the main motivator for Harm Minimisation principles, but harm prevention measures such as supply reduction and policing have had a far greater impact on the reduction in use of this drug]**
- Use of illicit drugs within the last 12 months among the general population is at the same level as in 1991 (15%), although this figure reached a high of 22% in 1998.
- Recent cannabis use (previous 12 months) decreased from 13% in 1991 to 11% in 2004 whereas recent use of ecstasy increased from 1% in 1991 to 3% in 2004.
- Among the 18-29 age bracket, as many as 31% had used an illicit drug in the last 12 months and one in four had used cannabis in the last 12 months.
- In addition, about one in eight Australians aged 20-29 years had used ecstasy and one in ten had used methamphetamines in the last 12 months.
- Illicit drug use was also higher among Indigenous Australians of whom, in 2004-05, 28% had used an illicit drug in the previous 12 months.
- Among the prison population, as many as 59% had a history of injecting illicit drugs in 2004.
- Among juvenile detainees in 2003-04, 88% had used an illicit substance within six months prior to their arrest.
- One in ten Australian sentenced prisoners in 2004 were imprisoned for drug-related offences.
- In 2003, an estimated 2% of the burden of disease in Australia was attributable to the use of illicit drugs. This is the same net percentage as alcohol but significantly less than the estimated 8% of the burden of disease attributable to tobacco use.
- The death rate from overdose of opiates among persons aged 15-54 years increased from 36.6 deaths per million persons in 1988 to 101.9 in 1999 before falling rapidly again to 34.6 deaths per million persons in 2001. It subsequently declined to 31.3 deaths per million persons in 2004. **1**

1 http://www.relationships.com.au/resources/pdfs/rest/trvol69.pdf

Increased or Decreased **Exposure of children to Illicit drugs** **I** **D**

Data

- *Parental substance misuse is increasingly seen as a factor in child well-being and protection in Australia and elsewhere (Dawe et al. 2007; Laslett et al. 2010; NSW Ombudsman 2009; Ritter & Chalmers 2009). One Australian Study suggest that up to 80% of child notifications involve concerns about parenting being affected by substance misuse (Ainsworth 2004), while in another, parental substance misuse was linked toe 70% of case where children entered alternative care (Jeffreys et al. 2008) Both AOD and family and child welfare sectors have recognised the relationship between AOD misuse, childhood and adolescent development, and child well-being and protection.*

2 *Battrams, S NCETA Of Substance, vol 8 no. 3 2010*

- More than 40,000 children aged 12 years and under (or about 2.3%) live in a house where an adult uses cannabis daily.
- More than 14,000 children aged 12 and under (0.8%) live in a household with an adult using methamphetamines at least monthly and reports doing so in their home. **3**

3 http://www.relationships.com.au/resources/pdfs/rest/trvol69.pdf

Drug addict baby numbers rise **- ANGELA POWNALL, The West Australian February 10, 2011**

The number of pregnant women who were treated for a serious drug or alcohol addiction at the State's main maternity hospital has jumped 37 per cent since 2006....Dr Melissa O'Donnell, from the Telethon Institute for Child Health Research, said its research showed the number of WA newborns who suffered serious drug withdrawal symptoms was 40 times higher in 2005 than it was in 1980....Last year, 154 pregnant women were treated by KEMH's Women and Newborn Drug and Alcohol Service for serious addictions...WANDAS executive director Dr Amanda Frazer said the clinic treated around 200 women last year before and after they gave birth.

http://au.news.yahoo.com/thewest/a/-/newshome/8808278/drug-addict-baby-numbers-rise/

Increased or Decreased — Drug use maintenance — I — D

Data

Methadone : The number of addicts accessing OST's on any given day is over 44,000 which is double that of only 10 years earlier **4** Taken from page 10 of *'National Opioid Pharmacotherapy Statistics: Annual Data Collection 2009'* http://www.aihw.gov.au/publications/aus/125/11417.pdf)

"Methadone typically intensifies addiction by leaving opiate receptors permanently coated with opiates. Methadone patients frequently experience secondary side effects, especially anxiety, so that many series report 50-70% incidence rates of also putting these patients on strong benzodiazepines, particularly alprazolam - a strong drug frequently associated with fatal overdose. The exacerbation of addiction by such programs clearly needs to be factored in to any rational evaluation of them."

Source: **When Harm minimization is not harm minimization – Australia as a Case Study** *(Section 2.1.19)*
Stuart Reece MBBS (Hons), FRCS (Ed.), FRCS (Glas.), MD, FRACGP – The Journal of Global Drug Policy and Practice

Needle and syringe programs: Needle and syringe programs (NSPs) were introduced to Australia in 1986 due to concerns about the increasing HIV prevalence among injecting drug users. There are currently over 3,000 needle and syringe programs, of varying types, across Australia….In 2005, almost 30,000 units of injecting equipment were distributed in Australia, with the majority distributed in NSW (29 per cent), Victoria (25 per cent) and Queensland….It was estimated that, in 2002-03, state and territory governments spent $33.7 million on NSPs with the Commonwealth contributing $4.6 million. The Commonwealth's current commitment to funding of supporting measures relating to NSPs totals $48.1 million over the 5 years from July 2003 to June 2008.

5 The winnable war on drugs - The impact of illicit drug use on families. House of Representatives Standing Committee on Family and Human Services p 134 September 2007
http://www.aph.gov.au/house/committee/fhs/illicitdrugs/report/fullreport.pdf

Increased or Decreased — Non-recovery Welfare — I — D

Data

Increased or Decreased Burden of Disease I D

Data:

In 2003, an estimated 2% of the burden of disease in Australia was attributable to the use of illicit drugs. This is the same net percentage as alcohol but significantly less than the estimated 8% of the burden of disease attributable to tobacco use.

The death rate from overdose of opiates among persons aged 15-54 years increased from 36.6 deaths per million persons in 1988 to 101.9 in 1999 before falling rapidly again to 34.6 deaths per million persons in 2001. It subsequently declined to 31.3 deaths per million persons in 2004.

SOURCE: Australian Institute of Health and Welfare. (2007). *Statistics on drug use in Australia 2006*, Drug Statistics Series Number 18, Canberra: AIHW as cited in Relationships Australia, 'The Rest' Vol. 69 – May 2007. **http://www.relationships.com.au/resources/pdfs/rest/trvol69.pdf - Points 13 and 14**

"The impact of drugs on disease is not only greater than usually supposed, but also more severe. Several analyses now have demonstrated consistent findings that the addicted require disproportionately far more medical and psychological health services than controls of the same age…Currently, many Hepatitis C patients are becoming increasingly unstable and are beginning to decompensate in important ways including cirrhosis. This suggests that Australia's encounter with Hepatitis C and the management of its 197,000 cases [2] is only just beginning…Australia's rate of new HIV infections has been rising since its low point in 1994. It is now double this level, and as reports come in from all over the country of new infections, this rate of increase seems inevitably set to rise quickly in the coming years."

Source: **When Harm minimization is not harm minimization – Australia as a Case Study** *(Section 2.1.3)*
Stuart Reece MBBS (Hons), FRCS (Ed.), FRCS (Glas.), MD, FRACGP – The Journal of Global Drug Policy and Practice

Increased or Decreased OHS issues among E S P [1] I D

Data: Alcohol fuelled violence continues to see paramedics put at risk across Queensland. Assaults have increased in excess of 50% since 2002, becoming increasingly violent with perpetrators resorting to the use of weapons in some cases

It is a sad indictment that in 2008 – 2009, 107 assaults were reported against paramedics whom for six years in a row have been identified as societies most trusted professionals.

In 2008 the Liquor, Hospitality & Miscellaneous Union (LHMU) successfully lobbied government to change legislation to define assaults against paramedics as a serious assault. This provided the judiciary with the ability to impose custodial sentences for all assaults against paramedics.

Unfortunately the strengthening of legislation has proved no deterrent to assaults with attacks on paramedics continuing to increase. Alcohol has played a significant contributing factor in more than 90% of assault cases examined by LHMU.

LHMU News Wed 28 Oct 09, Ambulance officers at risk as alcohol fuelled violence continues

Emergency services personnel, tired of dealing with drinkers suffering the effects of excessive alcohol consumption, recently lobbied councillors to introduce the **Last Drinks** initiative in Orange. PLANS to tighten restrictions on Orange hotels (in NSW) are about improving community safety, not an attack on publicans, says Orange City Council.

Last Drinks would force hotels to have earlier curfews and closing times and would ban the sale of some alcohol.

Councilors this week voted to have senior staff and liquor industry representatives meet to consider if an initiative floated by police, nurses and paramedics would combat alcohol-related violence better than the existing Orange Liquor Accord.

Source: Bevan Shields - Central Western Daily - **Call for last drinks** – NSW- 05 Nov, 2010 07:55 PM

Increased or Decreased Care for 'Rights of the Child' I D

Data

Australia ratified the United Nations Convention on the Rights of the Child in December 1990. It remains one of the most ratified international conventions with only two countries -the United States and Somalia - yet to have made a full commitment (The Federation of Community Legal Centres 2001). The Convention theoretically reflects Australia's collective view of the importance of children within the community. The Convention on the Rights of the Child spells out the basic human rights that children everywhere, without discrimination, have the right: to survival, to develop to the fullest, to protection from harmful influences, abuse and exploitation and to participate fully in family, cultural and social life (United Nation1989). In becoming a signatory to the convention, Australia is required to report every five years to an international monitoring committee of the United Nations on its progress in respect to the standards set out in the convention. To date, it seems that the promise made to the declaration and the words of community leaders are not matched by a commitment of resources to ensure the well-being of children, both generally and particularly when there is problematic parental drug use.

The effects of parental illicit drug use on children has implications for Australia's commitment to the Convention on the Rights of the Child. The growing incidence of drug use within the Australian community necessitates the introduction of policies and strategies to address the issue of parental illicit drug use in accordance with the Convention on the Rights of the Child.

The Federation of Community Legal Centres in Victoria (2001) assert that it is necessary to develop realistic action strategies to improve compliance with the obligations set out in the Convention. Articles 3, 4 and 33 of the Convention are of particular importance to the rights of children affected by parental drug use.

Article 3 of the Convention on the Rights of the Child requires signatories to include the best interests of the child as a primary consideration in all actions concerning children, including those by public or private welfare institutions, courts of law, administrative authorities or legislative bodies. Additionally, the article requires signatory parties to ensure the protection and care of children, taking all appropriate legislative and administrative measures necessary for the welfare of children. This article has relevance for Victoria's child protection system and the Children's Court who do not recognise parental substance abuse as a protective concern per sé (DHS 2002) and refuse to acknowledge that parental substance abuse poses a significant risk to children (Gleeson 2000).

Article 4 of the Convention requires signatories to undertake all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the Convention. In Australia this has not yet happened in relation to children affected by parental drug use. Clare (2001: 1) notes that "Whilst the Federal Government has formally recognised that children are equal members of our society we are still awaiting the translation of the Convention into Australia's domestic law. Meanwhile Australian children continue to suffer…".

Policies and strategies need to be implemented at a federal, state and local government level in relation to the rights of children affected by parental drug use.

Article 33 requires states to take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances. Brook et al (1996) assert that governments need to recognise that the effects of parental drug use increase the likelihood of children using substances themselves. Appropriate measures need to be taken to protect children from the effects of parental illicit drug use, thus breaking the cycle of drug use in Australia's community….

Children affected by parental illicit drug use have much in common with other minority groups of children in the community, particularly children living with parents with an intellectual disability or parents experiencing mental health issues. Along with the commonalities amongst the three groups, it is also interesting to examine the disparities between them. There is much to learn from the studies conducted on other groups within the community where parental drug use is not initially identified as a concerning factor. These studies can inform practice and contribute to the greater knowledge base promoting equal treatment of children regardless of living situation. In a prospective study of 7103 parents, Chaffin, Kelleher and Hollenberg (1996) for example, explored the psychiatric and social risk factors associated with child abuse. They consequently found that substance abuse disorders appeared to be the most common and powerful factor associated with physical abuse and neglect in the parents investigated. It appears that many parents experiencing mental health issues, intellectual disability or substance abuse are identified as providing less-than-adequate parenting to their children. One third of all cases appearing in the Children's Court in

New South Wales where applications had been made to remove the children from their parent's care involved parents with either an intellectual or psychiatric disability (Jacobsen 2000). In Victoria, it has been identified that 94 per cent of the cases dismissed from the Children's Court noted that substance abuse was an issue (Gleeson 2000).
Parental Drug Use – The Bigger Picture - A Review of the Literature (pp 11-12) by Nicole Patton: The Mirabel Foundation – Researching for Positive Change

Increased or Decreased — Children under Child Protection — I — D

Data

According to recent Paper by the Mirabel Foundation; " Parental Drug Use– A Recent Phenomenon by Nicole Patton.
"Between 1996 and 2003, there was a 45 per cent increase in the number of children in out-of home care in Australia (Reddy 2004). In a 2003 review, the Department of Human Services found that 62 per cent of new child clients to their child protection department were being placed in kinship care (Department of Human Services 2003a).

The Mirabel Foundation, established in 1998 to assist children who have been orphaned or abandoned due to parental illicit drug use, recently published two excellent literature reviews, *Parental Drug Use – The Bigger Picture A Review of the Literature and The Effects of Parental Drug Use – Children in Kinship Care A Review of the Literature* [Patton 1. and 2. 2003] They include commentary on Australian and overseas research. For example, in an audit of formal kinship care in Victoria the Department of Human Services [in 2000] found that at least 52 per cent of abusive parents were known to misuse substances. Likewise, in a study of grandparents raising grandchildren, Kelley et al [USA in 2001] found that 72 per cent were raising grandchildren due to maternal substance abuse. [Patton 2. 2003 P.4]

Taken from Australian Government Website http://www.fahcsia.gov.au/sa/families/pubs/parenting-grandparents_raising_grandchildren/Pages/p5.aspx

Increased or Decreased — Drug use in prisons — I — D

Data: One in ten Australian sentenced prisoners in 2004 were imprisoned for drug-related offences**.** Among the prison population, as many as 59% had a history of injecting illicit drugs in 2004. Among juvenile detainees in 2003-04, 88% had used an illicit substance within six months prior to their arrest.

SOURCE: Australian Institute of Health and Welfare. (2007). *Statistics on drug use in Australia 2006*, Drug Statistics Series Number 18, Canberra: AIHW as cited in Relationships Australia, 'The Rest' Vol. 69 – May 2007.
http://www.relationships.com.au/resources/pdfs/rest/trvol69.pdf - Points 13 and 14

Increased or Decreased — Mental Health problems — I — D

Data In 2004, 9.1 per cent of Australians were diagnosed or treated for a mental illness in the last 12 months, inclusive of depression, anxiety, bipolar disorder, an eating disorder, schizophrenia, and other forms of psychosis.
Of those who had used an illicit drug in the last month, this figure was substantially higher: 16.0 per cent for ecstasy users, 16.5 per cent for cannabis users, 19.8 per cent for meth/amphetamine users, and 50.1 per cent for heroin users.
Those who had used illicit drugs in the last month reported double the rate of high or very high levels of psychological distress compared to the general population.7 Most notably, 31.1 per cent of recent users of methamphetamines and 64.9 per cent of recent heroin users reported high or very high levels of psychological distress, as against 9.9 per cent of the general population.

House of Representatives Standing Committee on Family and Human Services - pages 243-262

http://www.aph.gov.au/house/committee/fhs/illicitdrugs/report/fullreport.pdf

Increased or Decreased Family Function I (D)

Data: In recent years there has been a significant expansion of the number of children in out-of-home care (steadily increasing from about 14,000 in 1996 to more than 25,000 in 2006). The significant involvement of parental drug use in the child protection caseload would suggest that many of these children have been temporarily removed from a family member using illicit drugs.

http://www.aph.gov.au/house/committee/fhs/illicitdrugs/report/fullreport.pdf page 73

Increased or Decreased Domestic Violence (I) D

Data: More than 40,000 children aged 12 years and under (or about 2.3%) live in a house where an adult uses cannabis daily. More than 14,000 children aged 12 and under (0.8%) live in a household with an adult using methamphetamines at least monthly and reports doing so in their home. According to the Australian National Council on Drugs report, evaluated levels of substance use are also linked to other risk factors such as exposure to violence, mental health issues and criminality.

SOURCE: Dawe, Sharon. (2006). *Drug use in the family: impacts and implications for children*. ANCD Research Paper 13. Canberra: Australian National Council on Drugs as cited in Relationships Australia, 'The Rest' Vol. 69 – May 2007
http://www.relationships.com.au/resources/pdfs/rest/trvol69.pdf/

It has been estimated that 33% of parents involved in substantiated cases of child abuse or neglect are affected by illicit substance use (compared with 31% with alcohol abuse) 30% abused or neglected children go on to maltreat children in some way when they are adults. Source: ***Australian Institute of Family Studies report 2008:***

Increased or Decreased Community Violence (I) D

Data

Increased or Decreased Crime Rates (I) D

Data

Increased or Decreased Number of addicted persons (I) D

Data

- Based on 2004 figures, 38% of Australians aged 14 years and over had used an illicit drug in
- their lifetime and 15% had done so in the last 12 months.
- By far the most commonly used illicit drug is cannabis which 34% of Australians aged 14 years
- and over admit to having used in their lifetime and 11% had used it in the last 12 months.
- Methamphetamines had been used by 9% in their lifetime and 3% had used methamphetamines
- in the last 12 months.
- The third most commonly used illicit substance was ecstasy – used by 8% ever and 3% in the
- last 12 months.
- Heroin use was relatively rare with only 1.4% having ever used this drug and 0.2% having used it
- in the last 12 months.
- Use of illicit drugs within the last 12 months among the general population is at the same level as
- in 1991 (15%), although this figure reached a high of 22% in 1998.
- Recent cannabis use (previous 12 months) decreased from 13% in 1991 to 11% in 2004
- whereas recent use of ecstasy increased from 1% in 1991 to 3% in 2004.
- Among the 18-29 age bracket, as many as 31% had used an illicit drug in the last 12 months and
- one in four had used cannabis in the last 12 months.
- In addition, about one in eight Australians aged 20-29 years had used ecstasy and one in ten
- had used methamphetamines in the last 12 months.
- Illicit drug use was also higher among Indigenous Australians of whom, in 2004-05, 28% had
- used an illicit drug in the previous 12 months.

SOURCE: Australian Institute of Health and Welfare. (2007). *Statistics on drug use in Australia 2006*, Drug Statistics Series Number 18, Canberra: AIHW as cited in Relationships Australia, 'The Rest' Vol. 69 – May 2007.
http://www.relationships.com.au/resources/pdfs/rest/trvol69.pdf - Points 1 to 11.

Overall per capita, Australia's illicit drug use rates are one of the highest in the OECD.
For example the prevalence in the population aged 15-64 years for abuse of:

- Cannabis - 13.3%, is a higher rate than the US and twice the European average.
- Amphetamines - 3.8%, is second only to the Philippines and more than double the rate for the USA and the UK.
- Ecstasy - 4%, is the highest in the OECD and more than double those in USA and UK

SOURCE: United Nations World Drug Report 2008

Increased or Decreased — Communicable diseases — I — D

Data: While the objective of needle and syringe exchange programs is to reduce the risk of infections, the number of new HIV diagnoses has increased steadily in recent years.

Possible explanations for rising infection rates given to the committee include that there is trivialised view of illicit drug taking, and an increasing incidence of risky behaviour (attributed partly to the rise in the consumption of ice).
Among injecting drug users, the number of newly acquired hepatitis B infections has declined in recent years with the number of newly acquired hepatitis C infections remaining relatively stable

p 135 **The winnable war on drugs - The impact of illicit drug use on families. House of Representatives Standing Committee on Family and Human Services** September 2007 http://www.aph.gov.au/house/committee/fhs/illicitdrugs/report/fullreport.pdf

Increased or Decreased — OST [2] Use — I — D

Data

Table 2: Total number of pharmacotherapy clients receiving pharmacotherapy treatment on a 'snapshot/ specified' day by state and territory, 1998–2009

	NSW	Vic	Qld	WA[a]	SA[b]	Tas	ACT	NT	Australia
1998	12,107	5,334	3,011	1,654	1,839	306	406	—	24,657
1999	12,500	6,700	3,341	2,449	1,985	370	559	2	27,906
2000	13,594	7,647	3,588	2,140	2,198	123	615	32	30,237
2001	15,069	7,743	3,745	2,307	2,522	464	641	25	32,516
2002	15,471	7,700	3,896	3,602	2,417	513	590	21	34,210
2003	16,165	8,685	4,289	4,079	2,486	498	686	98	36,986
2004	15,719	10,003	4,470	4,437	2,706	576	748	82	38,741
2005	16,469	10,753	4,440	2,883	2,857	588	764	183	38,937
2006	16,355	10,736	4,637	2,888	2,823	602	790	134	38,965
2007	16,348	11,051	4,309	2,822	2,834	600	765	114	38,843
2008	17,168	11,821	4,899	2,908	3,052	588	786	125	41,347
2009	17,868	12,576	5,116	3,187	3,151	634	792	121	43,445

Taken from page 10 of *'National Opioid Pharmacotherapy Statistics: Annual Data Collection 2009'* http://www.aihw.gov.au/publications/aus/125/11417.pdf)

Increased or Decreased — Financial burden to society — (I) D

Data: A 2003 estimate shows the total cost to Australia of illicit drugs to be at least $6.7 billion. Of that figure of $6.7 billion, business costs were $3.3 billion (representing almost two per cent of total Australian corporate profits).

Drug use-caused reductions in business productivity are estimated to have cost $800 million, through a reduced workforce, and a further $339 million through absenteeism and reduced on-the-job productivity.

Source: ('The 3 Billion Dollar Question', 2007 report, Collins, Lapsley and Marks).

Social costs - the overall costs are higher: i.e $12.5 billion is more than 70% higher than Collins and Lapsley's 1998/99 estimate in real terms. Opiates account for the largest proportion of costs, while amphetamines and cannabis also account for sizeable proportions.

Source: *At a Glance - Costs of Illicit Drug Use in Australia* – Drug Free Australia, March 2009

Increased or Decreased — Poly-drug use — (I) D

Data

Increased or Decreased Data	**Community Wellbeing**	I	D
Increased or Decreased Data	**Use of Pharmaceuticals**	I	D

Written and compiled by Shane Varcoe, Derek Steenholdt M,Ed, Jo Baxter

Dalgarno Institute

Legend
1 = Emergency Services Personnel (including Hospital, Fire, Police and Ambulance)
2 = Opiate Substitute Treatments (including Methadone, Buprenophrine, etc)

Current Harm Minimisation Strategies – an overview of their effectiveness on reducing/elimination of drug use - with a focus on **ILLICIT DRUG USE** only (and excluding other issues such as HIV, Hep C, etc)

Current Harm Min. Strategy - For Illicit Drug Use	Level of Promotion (Rate 1-5)	Reduces DRUG USE	Increases DRUG USE	Maintains DRUG USE	Eliminates DRUG USE	Comfort Focus	Restor –ation Focus
Needle Syringe Programs (NSP)	5			☑		☑	
Methadone Programs (OST)	5			☑		☑	
Medically Supervised Injecting Rooms	4			☑		☑	
Demand Reduction Strategies	1	☑					☑
Supply Reduction Strategies	3	☑					☑
Voluntary Rehabilitation	2	☑					☑
Public Media Education Programs	2	☑				☑	☑
Stronger Policing	2	☑					☑

Ratings: 1 = LOW .....5 = HIGH

Current Harm Minimisation Strategies – an overview of their effectiveness on reducing/elimination of drug use - with a focus on **LICIT DRUG USE** (Tobacco and Alcohol) (and excluding other issues such as HIV, Hep C, etc)

Current Harm Min. Strategy - For Alcohol & Tobacco	Level of Promotion (Rate 1-5)	Reduces DRUG USE	Increases DRUG USE	Maintains DRUG USE	Eliminates DRUG USE	Comfort Focus	Restor –ation Focus
Public Media Education Programs	4	☑				☑	
Nicotine Patches (Smoking)	5	☑					☑
Limits to Trading Hours (Alcohol)	1	☑				☑	
Ban on TV advertising (Smoking)	5	☑				☑	
Health Warnings (Smoking)	5	☑					☑
Pregnancy & Alcohol Warnings	2	☑					☑
Non smoking in public places	5			☑		☑	
Stronger Policing	3	☑					☑
Increase Taxes on Alcohol/Tobacco	5/2	☑				☑	
Demand Reduction Strategies	1	☑				☑	
Education & Early Intervention	2	☑					☑

Ratings: 1 = LOW .....5 = HIGH

Endnotes

[1] Professor Ron Penny, Chief Commonwealth Education and Services Advisor on AIDS - Drugs, The Law & Medicine Summit 17-18 November 1989

[2] National Drug Strategy, http://www.curtin.edu.au/curtin/centre/ncrpda/info/strategy.html The National Centre for Research into the Prevention of Drug Abuse, 24 February 1998.

[3] Ibid.

[4] ibid

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[6] *http://www.humehealth.com.au/haod/browse.asp?page=351*

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Appendix One:

Lessons from the Swedish illicit drug experience - Prevention is a very effective strategy!

What can we learn from the experience of Sweden in dealing with consumption of illicit drugs which went from being one of the first European countries to experience a large scale drug problem in the 1960's to now being a country with one of the lowest rates of marijuana and hashish use amongst only 7% of 16 year olds? In contrast, based on survey data in 2007, four times the amount of teenagers in the Netherlands (28%) and the United Kingdom (29%) admit to consuming hashish or marijuana by 16 years of age[1].

Firstly a brief look at history shows that Sweden's drug epidemic in the early 1960's became much worse when in 1965, the government allowed for physicians to prescribe stimulant drugs to keep individuals from obtaining them through illegal sources. Initially 110 drug-addicted people were enrolled in the program for whom more than ***4 million doses*** were prescribed, mostly stimulants or opiates. Many of these prescribed drugs were given to friends or resold flooding Stockholm with drugs and spreading the drug epidemic in Sweden instead of limiting it as the program's sponsors naively expected. In 1967, the tragic and widely publicized death of a 17 year old offered drugs by one of the patients in the program led to an abrupt halt to this legal prescription experiment.

Official drug prevention policy at that time directed police to concentrate on trafficking and smuggling and not arrest drug users for drug possession, hoping that it would be attractive for individual to voluntarily seek treatment and other help from social services providers or hospitals. People dealing in small amounts of drugs were overlooked until, after much publicity and public debate, the Swedish Prosecutor General issued a directive in 1980 that waivers of prosecution for small amounts of narcotic drugs would not be allowed any longer. However, drug users were not subject to any prosecution … until after another period of debate and lobbying by concerned individuals and organisations, the Swedish law was changed (in 1988) so that consumption of narcotic drugs was made illegal. By 1993, police were given powers to use drug tests (using urine or blood samples) to obtain evidence of drug consumption. The punishment for illegal consumption is a monetary fine related to the offender's income. Drugged driving can lead to imprisonment.

Not only did the legislation and enforcement need to be maintained, but with a minor recession impacting on Sweden in the 1990's, the focus in school programs and community education strategies warning of the dangers of using illicit drugs declined and consequently drug use amongst teenagers increased (up to 10% of 16 yo boys and girls) despite the drug preventative legislation being in place. In 1998, the Government appointed a Narcotics Commission which put forward many suggestions for action and change including demand reduction strategies and other educational measures which resulted in a flattening out of the increasing uptake and subsequent decline of illicit drugs amongst teenagers. Increased vigilance in enforcement of existing legislation and policies also contributed to regaining control of the illicit drug use across the community.

With that history in mind of Sweden's move from tolerance of private drug use to more proactive prevention strategies, both in trafficking and private drug use, it is now very clear that when in 1976, the government in the Netherlands went the opposite way to Sweden by allowing permissive enforcement of ***soft*** drug use and a more restrictive enforcement of ***hard*** drugs, under a banner of tolerance and hoping for individuals to voluntarily seek treatment, they were setting the scene for large scale experimentation in drug taking and a blow out in the number of teenagers participating in drug taking (now at 28%). As Sweden discovered through hard experience, simply focusing prosecution of those dealing with drugs is not enough.

To sum up in the words of the Secretary General of the Swedish National Association for a Drug Free Society, Per Johansson:

> "One of the common stereotypes in global drug policy debates is that successful welfare states adopt permissive drug policies as part of their commitment to compassion and tolerance of diversity. Sweden, a country noted for its liberal views stands out as an exception to this stereotype and offers a model for a more restrictive drug policy, not because it is repressive politically but because it promotes the public health and lowers both drug use and the harms caused by drug use.[2] [3]"

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Taken from: ***A synoptic look at Sweden's National Drug Strategy – A Harm Prevention Focus***
Dalgarno Institute 2010

Appendix Two:

PORTUGAL - THE TRUTH ABOUT DRUG DECRIMINALIZATION

Drug use was decriminalized in Portugal in the year 2000? Was it a resounding success? Not according to Manuel Coelho, Chairman of The Association for a Drug-Free Portugal and member of the International Task Force on Strategic Drug Policy. He reports the following:

- Portugal remains the country with the highest incidence of IDU (Injection Drug Users) related AIDS and is the only country in Europe with an increase; 703 newly diagnosed infections followed from a distance by Estonia with 191 and Latvia with 108 reported cases.

- The number of new cases of HIV/AIDS and Hepatitis C in Portugal recorded 8 times the average found in other EU countries.

- Homicides related to drug use have increased 40%, and is the only EU country to show an increase from 2000 to 2006.

- Portugal recorded a 30% increase in drug overdose deaths, and along with Greece, Austria and Finland has one of the worst records in the EU, one every two days.

- The number of deceased individuals that tested positive for drugs (314) in 2007 registered a 45% rise, "…..climbing fiercely after 2006 (216)."

- Behind Luxembourg, Portugal is the European country with the highest rate of consistent drug users and IV heroin dependents. (Portuguese Drug Situation Annual Report 2006)

- Drug use increased 4.2% between 2001-2007, with life time use going from 7.8% to 12% (66% increase.) Individual drug use grew as follows:

Cannabis	12.4 to 17% (37% increase)
Cocaine	1.3 to 2.8% (215% increase)
Heroine	.7 to 1.1% (57% increase)
Ecstasy	.7 to 1.3% (85% increase)

- While cocaine and amphetamine consumption rates have doubled, drug seizures of cocaine have increased sevenfold between 2001 and 2006, sixth highest in the world. (World Drug Report, June 2009)

Says Coelho, "The statistical results have been insidiously manipulated by institutions controlled by the government. The banner of "harm reduction" cannot be an ideology and an end in itself. It is extremely disturbing to promote the correct use of drugs *safely….."* He goes on to say that 70% of Portuguese addicts are in treatment programs that simply substitute one drug for another, and subject countless addicts to a life of dependency.

As reported by Manuel Pinto Coelho, Chairman of APLD, Portugal

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Written by Roger Morgan, Exec Director of the Coalition for a Drug-Free California www.drugfreecalifornia.org

Taken from: ***'Evidence based data' and the failed Portuguese Experiment.*** Dalgarno Institute 2010

Appendix Three:

Bioethics Research Notes (vol 11 issue 04 - December 1999)
Performance Indicators of Harm Minimisation:
Drug Policy Outcomes in Sweden, Australia, and the United States

By Lucy Sullivan

"Harm minimisation" policy in Australia, in deference to the formal illegality of [the] psychopathic drugs, has an ostensible meaning, but also a not-so-hidden agenda. Harm minimisation, if it is accepted that drugs are harmful, must mean following policies which will achieve the lowest possible level of drug use; and also, in that it is close to impossible, at least in the short term, to eradicate drug use entirely, it means establishing policies which will ensure the lowest possible harm, as a result of drugs, to those who continue to use them, and also to non-drug-users who may be adversely affected by the behaviour of those who do.

Such a policy, if intelligently implemented, requires acknowledgment that policies which are most effective in minimising usage may have a poor rating as regards minimising the harm caused by drugs in the persisting minority of drug users; and that policies which are most effective in minimising self-inflicted and social harm of persisting drug use may, contrariwise, raise population levels of drug usage. The weight to be given to the two aspects of the policy needs to be made explicit. On the whole, it would be sensible not to follow policies for the reduction of harm to and by drug users, if in the process the number of drug users will be raised, although if the harm avoided is substantial and the associated rise in drug usage insignificant, a case could be made for an overall beneficent outcome.

The inference of a hidden agenda in Australia's "harm minimisation" policy derives from the fact that the problem of this interaction has not been explicitly addressed, and that its key policies represent the second component only (reducing harms of usage) of a balanced harm minimisation policy. The rationale behind the harm minimisation policy we actually have is that the psychopathic drugs *need not* cause harm (can be purely recreational), and therefore should not be illegal, and hence harm minimisation policy should concern itself only with drug users who have slipped over the line into abuse. On this premise, only the second component of a balanced harm minimisation policy should, logically, be activated. The possibility that the chosen policies may result in greater prevalence of usage is, therefore, inconsequential. That they may, hence, result in higher overall levels of harm is ignored or denied.

Proponents of "harm minimisation" are opposed to a continuing presence of the primary component of a balanced policy, which is nevertheless maintained via illegality, policing and the justice system, and argue that these strictures are antagonistic to harm minimisation itself. Meanwhile, their favoured policies persistently undermine the effectiveness of these primary strategies. This mutual antagonism need not occur. In Sweden the two components of a genuine harm minimisation policy work hand in hand.

Sweden and Australia

A comparison of drug policies in Sweden and Australia, and of drug usage and associated problems in the two countries, is highly suggestive of the comparative efficacy of the two approaches.

***Sweden**:* Sweden has, since the resurgence of psychopathic drug usage in the 1960s, adopted drug policies at various points in the spectrum of harm minimisation, and changed them in response to unpredicted outcomes (just as Australia so singularly has not). The first initiative, in the sixties, was a trial of the liberal prescription of drugs to those who claimed to be addicted, complemented by access to health care. The project was abandoned after three years because of the escalating numbers of participants, who were also found to be supplying the drugs they received to friends and traffickers. Despite ready access to drugs, the crime rate increased among those on the programme.

From 1968, Swedish policy concentrated on law enforcement, treatment and education, with the goal a drug-free society, and there were increasingly severe penalties for infringement. However, in the 1970s it was again forcibly argued that it is counter-productive to target personal use. But by the mid-seventies, heroin had gained a footing for the first time, and the duty of society to intervene on behalf of the individual at risk again gained ethical precedence.

Coercive care of adult drug abusers was introduced in 1982, but treatment is more generally an optional alternative to imprisonment. The coercion provided by the law and the care provided by treatment are used cooperatively. Methadone-assisted rehabilitation of heroin addicts has been implemented, with a strict limit on numbers.

Drug use was criminalized in 1988, and a maximum penalty of six month's imprisonment for illicit drug use was introduced in 1993. Possession of small quantities of cannabis or amphetamines may result in only a fine, but possession of heroin or cocaine receives a strict term of imprisonment. Drug trafficking may be punished by 20 years imprisonment. Police target street trading so that known centres for obtaining drugs cannot develop.

Schools and municipal social services provide extensive education against drug use. Harm minimization, in the Australian sense, has been rejected, on the grounds that such policies as needle distribution would convey an ambiguous message about society's attitude to drug abuse. The response to the HIV threat was to increase programmes of rehabilitation.

Australia: *"*Harm minimisation", in its limited second component sense, has been the driving force in Australia's National Drug Strategy since the mid-eighties. Despite the fact that these policies have produced nothing but escalation, not only of use, but of harm, there has been no move to reverse them.

As an educational policy, "harm minimization" is defined as teaching safe use of drugs - abstinence is not seriously addressed. Much of what has passed for education has since proved to be poorly substantiated. A generation of ex-students now believes that alcohol and cigarettes are more dangerous than cannabis, while in fact the worst health effects of all three develop after a few years of heavy use of cannabis, compared with a 20-40 years delay for alcohol and tobacco, respectively, and the immediate and long-term effects of cannabis on motivation and mental stability are far worse. The only side-effect of heroin was initially said to be constipation. The question of "safe" dosage has not been specifically addressed. Drug use is presented as normal. For example, material prepared for NSW schools encourages children to make their own choices from various levels of use of drugs - and this in a society in which such drugs are illegal. The choice not to use drugs is reluctantly admitted as a possibility, in a manner that suggests it is an eccentric choice.

Other features of Australia's harm minimization policy are free methadone maintenance for heroin addicts and an extensive free needle exchange programme. Treatment and rehabilitation, important features of the second component of harm minimisation in Sweden, have had no place in Australian "harm minimisation" policy. Methadone clinics make no serious attempt at treatment. The number receiving methadone trebled between 1987 and 1998, rising from 5,000 to 15,000. Contrary to hypothesis, free methadone has not reduced opioid deaths. As was the case in Sweden, clients are often poly-drug users and engage in trafficking.

Similarly, free needle distribution is not used as a window for rehabilitation. Under NSW policy (1994), although condoms are supplied in needle packs, and clients are encouraged to introduce friends to the service, staff must *not* provide information on drug treatment services unless requested.

The introduction of free needle distribution was justified on the grounds of preventing transmission of HIV among intravenous drug (ID) users. Incidence of HIV remains low, but the evidence that it is due to availability of free needles is unconvincing, as Hepatitis C (HCV), which is also blood-borne, has spread alarmingly among ID users and has prevalence among them of 50-60%. Thus abundance of free needles has not prevented needle-sharing. As with free methadone, needle distribution has escalated since its inception, and deaths from injected drugs have escalated over the same period.

In Australia generally, the maximum penalty for possession of small amounts of cannabis is two years imprisonment. In South Australia and the Australian Capital Territory, however, possession of small amounts of cannabis has been decriminalized. Trafficking in illegal drugs may be punished with life imprisonment. Through the late eighties and most of the nineties, there was a movement, in the allocation of funding, from law enforcement to "education".

Where Sweden retreated from liberalising policies in response to their evident lack of success, "harm minimisation" proponents in Australia seek their extension and the addition of further policies which similarly dilute the position on illegality - namely, free heroin and injecting rooms.

***Outcomes**:* The following Table provides comparative statistics for Sweden and Australia which can be taken as indicators of the relative success of the two policy approaches, given the considerable similarity of the two countries in culture, general civility, and standard of living.

	Sweden	**Australia**
Lifetime prevalence of drug use in 16-29 year olds (Sweden) & 14-25 year olds (Australia)	9%	52%
Use in the previous year, as above	2%	33%
Estimated dependent heroin users per million population	500	5000-16000
Percentage of dependent users aged <20	1.5%	8.2%
Methadone patients per million population	50	940
Drug-related deaths per million population	23	46
Percentage of all deaths at age <25	1.5%	3.7%
Drug offences per million population (Sweden - arrests; Australia - convictions)	3100	1000
Average months in prison per drug offence	20	5
Property crimes per million population	51000	57000
Cumulative AIDS cases per million population	150	330

The above figures are drawn from the *United Nations World Drug Report 1997* (adjusted where necessary to a rate basis), and indicate that Australia's policy of "harm minimisation" has induced widespread drug usage - 52% lifetime usage (i.e. used at least once) in Australia compared with 9% in Sweden among young people. The highest prevalence of lifetime usage in Sweden occurs in the 30-49 years age group. In Australia, rates of usage are minimal above age 40, while the greatest increase in use has occurred in the 14-24 years age group. This demonstrates the effectiveness of Australia's drug education policies in encouraging drug use, particularly in the age group most exposed - school children.

Further data indicates that the change from the liberal to the prohibitive in Swedish policy has been effective in reducing the initiation of young users, whereas usage by young people in Australia has been rising over the same period. Only 1.5% of Swedish young people (aged < 20) are drug dependent, compared with 8.2% of Australians in the same age group.

The information conveyed in "harm minimization" education is clearly unable to counteract the effect of higher rates of usage - drug-related death rates are twice as high in Australia as in Sweden - 46 *versus* 23 per million population. Moreover, the share of under 25 year olds in drug-related deaths in Sweden is very low - only 3.6%. The Australian figure in this category was not available, but the higher percentage of all deaths at age <25 (3.7% compared with 1.5% in Sweden) indicates a higher presence of trauma for Australian young people, of which drug-taking undoubtedly forms a part.

While the proportion of methadone patients to heroin addicts is similar in the two countries, one may conjecture that the use of methadone for *rehabilitation* in Sweden, rather than for maintenance as in Australia, contributes to the dramatically lower rate of heroin addiction there (less by a factor of at least 10).

Property crime rates are not higher in Sweden than in Australia, despite the more stringent enforcement of drug illegality.

Free needle distribution in Australia does not appear to have resulted in better control of the AIDS epidemic here, with our cumulative AIDS rate more than twice that of Sweden.

Thus it seems clear that Sweden's attention to b*oth* components of genuine harm minimisation, reducing usage to a minimum and following policies, in relation of the minority of continuing users, which do not reduce the effectiveness of the primary goal, has produced far better outcomes in minimising harm than has Australia's concentration on the second component to the detriment of the first.

The United States

It is often claimed by Australian lobbyists that the United States' concentration on the first component of harm minimisation, and rejection of the second, has shown itself entirely ineffectual. America's drug policy has been less unified and internally consistent than Sweden's, due to the capacity of the various States to introduce some of Australia's favoured "harm minimisation" policies on an independent basis, but equally this independence has allowed a greater presence of rehabilitation approaches in the US than we have had in Australia.

Policy distinguishes "casual" and "hard core" users, the latter being targeted for treatment services and law enforcement. At the Federal level, use of drugs is not an offence *per se*, but *possession* is punishable by law. A first offence for personal use attracts a maximum of one year's imprisonment, and repeated offences a three year maximum. Penalties for manufacture and trafficking can be life imprisonment or death (depending on State laws).

Drug use rose to greater heights in the US than in Australia in the course of the seventies, but fell considerably in the eighties, over a period when usage in Australia was rising. As reported in the *United*

Nations World Drug Report 1997, compared with Australia's lifetime prevalence of drug use in 14-24 year olds of 52%, the US has a 57.5% usage in 19-28 year olds. Use in the previous year in 14-25 year olds in Australia was 33%, compared with 28% in 14-24 year olds in the US. The average age of current illicit drug users rose steadily between 1979 and 1994, although maximum usage is still at less than age 21.

The estimate of dependent heroin users in the US, which has never had free methadone or needles on the scale we have in Australia, was 1,900 per million populations, compared with Australia's 5,000-16,000. Cocaine has a level of usage in the US which it has never achieved in Australia. The estimate of heroin plus cocaine users was 10,500 per million population, and 49% of drug deaths in 1994 were caused by cocaine overdose. Both countries had drug death rates of 46 per million populations.

These figures are far from convincing evidence that Australia's concentration on the second component of harm minimisation is more successful than America's perceived concentration on the first in law enforcement - in fact, rather the reverse, particularly given America's less favourable background levels in health and general social well-being, and higher starting point.

***Cannabis**:* Lifetime prevalence of cannabis use among Year 12 students fell in the US from 60% in 1980 to 33% in 1992, but between 1992 and 1994 it rose slightly from 33% to 38%. In Australia, according to Household Surveys, it rose from 27% in 1988 to 39% in 1998.

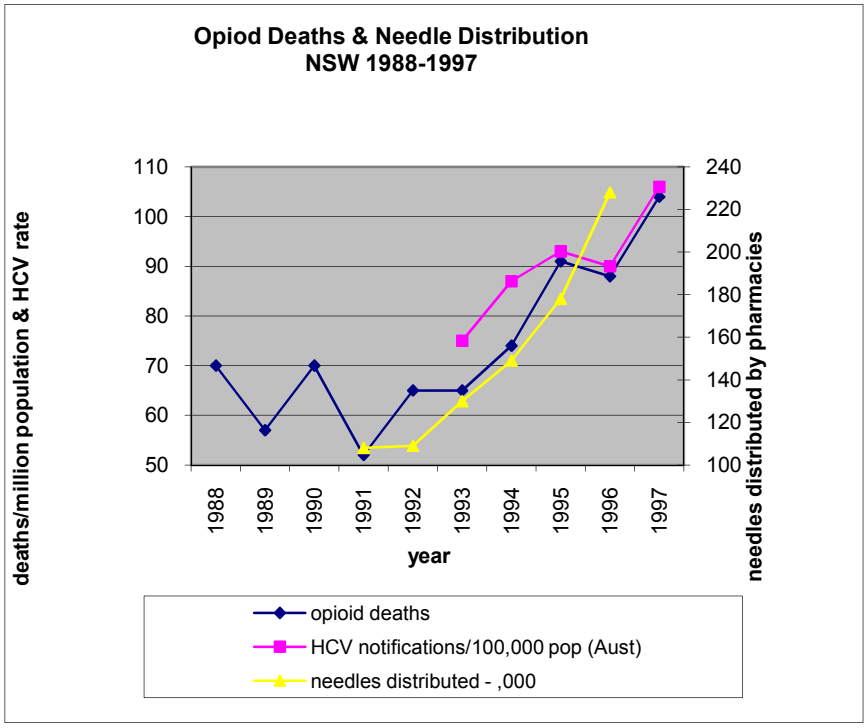
The *UN Report* remarks that a change in usage generally follows a change in perceived harmfulness with a one year time lapse. The rise in cannabis use in 1994 in the US, reversing more than a decade's downward trend, followed a decline in the perceived risk of cannabis (as reported in surveys) in 1993. This provides highly suggestive evidence that the continuing rise in cannabis use across the late eighties and nineties in Australia has been due, at least in part, to educational efforts to establish its relative harmlessness, and equally the escalation in heroin deaths (see below) may result from the message, reinforced by needle distribution, that ID use is not in itself dangerous.

Needle distribution, heroin deaths, and HCV infection

Needle distribution to ID users in New South Wales was piloted in 1987 and began formal operation in 1988. By 1989, there were 40 public outlets in NSW and by 1994, 250, supplemented by 500 distributing pharmacies. Thus the programme was firmly established by the early nineties, and its growth has shown no sign of stabilizing. Two million needles were distributed in 1989, 3.5 million in 1994, and 5.5 million in 1996. Detailed documentation of needle distribution is not readily available, but the Pharmacy Guild of New South Wales reports an increase in distribution via pharmacies from 106,000 in 1991, to 226,000 in 1996, an increase which parallels that of total distribution.

The accompanying Graph plots needle distribution by pharmacies in NSW from 1991 to 1996 against NSW opioid overdose deaths from 1988 to 1997. It also shows Hepatitis C (HCV) notifications (incident and unspecified), primarily occurring in the ID-using population, for Australia from 1993 to 1997. (Tests for HCV became available in 1990 and infection rates are reported to have increased steadily between 1991 and 1993. New South Wales and South Australian data are included for the first time in 1997).

It can be seen that, for both outcomes, increases in pathology have accompanied increases in needle distribution, and in particular have occurred about a year after substantial rises in needle distribution, matching the pattern described for the US of a decrease in perceived risk resulting in increased exposure. Thus it appears that rather than the promised safety of clean needles reducing the harm of ID use, the resultant increased usage increases its harm as well.



False predictions

In each instance of the instigation of a new phase of "harm minimisation" policy, its proponents have confidently predicted that harm to users and to the community will be reduced, and a certain face validity in their arguments has enabled them to carry their case. Yet each time they have been wrong.

It seems likely that the source of error lies in their misunderstanding and interpretation of the motivational elements in the interaction of their policies and the actual behaviour of both potential and current drug users. The antipathy to prohibition and the belief that to legalise drugs will improve matters appears to arise from a belief in a non-cooperative or anarchic streak in human nature which means that to forbid something is to make it more attractive; and that to permit it is to make it unappealing. This element in human nature no doubt exists, but other factors are at work too.

Firstly, there is that in drugs which makes them appealing, once experienced, whether they are forbidden or not, even when they offer only demoralisation and death. And secondly, to forbid something has a semiotic impact, signaling danger, and while to permit it signals safety. To rational man (not yet on drugs), the prohibition, if perceived to be founded in fact, will function more strongly than the tendency to non-cooperation. Only if, as "harm minimisation" and drug education have sought to portray, what is believed to be harmless is forbidden, will the former predominate. We do not fail to notify the public of a dangerous rip in the surf, or of live electric wires, nor decline to take steps to prevent the foolish nevertheless putting themselves at risk. Equally, it is important not to "cry wolf". The "harm minimisation" lobby have believed that prohibitionists are crying wolf as regards drugs, but it is now transparently clear that their belief is dangerously wrong.

Our current Prime Minister is resisting the Australian version of harm minimisation and attempting to implement the more balanced Swedish model. Unfortunately, Australia is in the position that the majority of positions of public influence in the drug policy field are held by proponents of "harm minimisation", who thereby have a substantial ability to block research or argument which is likely to undermine their position. The practice of directing Commonwealth research grants to specific areas, which began in the seventies, allowed those with a particular interest in a field with socio-political as well as scientific ramification (such as AIDS and drug use) to set up the first specialist research units, and

thereafter, as the established experts, to prevent the development of contradictory expertise and alternative approaches.

Thus, although established with the best of intentions for a more balanced policy, the Commonwealth's *Australian National Council on Drugs* has only two non-"harm minimisation" committee members, who are powerless against a large majority committed to "harm minimisation". And the outcome of the NSW Government's recent *Drug Summit* was a foregone conclusion should any voting on policy occur, simply because of the much greater attendance of "experts" promoting "harm minimisation".

Perhaps, as a young colleague says, the most his generation can hope for is damage containment, while they wait for the ageing radical Baby Boomers, with their dysfunctional social theory and obsessions, to eventually get out of the way.

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