DRUG FREE AUSTRALIA

Seven Central Issues for Legislative Assembly of the Northern Territory

Submissions - Select Committee for Reducing Addictive Behaviours

Claims that cannabis causes less individual harm than alcohol or tobacco

While the harms of cannabis have not been studied for as many years as the harms of tobacco and alcohol, it is already well-established that cannabis combines the harms of intoxication from alcohol with the particulate damage of tobacco. Cannabis presents a wide variety of additional harms.

- **Cannabis produces 1500 toxic chemicals when burned**
- **The ONDCP and NIDA note THC content is 2.5 times higher between 1983 & 2008, with the UK Home Office finding a 15% average**
- **Cannabis is an established gateway to other dangerous drugs, adding an additional gateway beyond the two existing legal drugs**
- **Cannabis users are 50% more likely to develop alcohol use disorder**
- **Cannabis use is associated with a 2.6 times greater chance of psychosis**
- **Cannabis use is associated with a 4 times greater chance of depression**
- **Cannabis is associated with Amotivational Syndrome**
- **Cannabis use associated with a 3 fold risk of suicidal ideation**
- **The Immune system of cannabis users is adversely affected**
- **VIOLENCE AND AGGRESSION are a documented part of its withdrawal syndrome**
- **Brain Function**
  - **Verbal learning is adversely affected**
  - **Organisational skills are adversely affected**
  - **Cannabis causes loss of coordination**

Associated memory loss can become permanent
Cannabis is associated with attention problems
Drivers are 16 times more likely to hit obstacles
Miscarriage is elevated with cannabis use
Fertility is adversely affected
Newborns are adversely affected with appearance, weight, size, hormonal function, cognition and motor function adversely affected through to adulthood
Cannabis use causes COPD & bronchitis
Cancers of the respiratory tract, lung and breast are associated with cannabis use
Cannabis is also associated with cardio-vascular stroke and heart attack, with chance of myocardial infarction 5 times higher after one joint

1. **Recognising the harms caused by drugs, Australians want LESS illicit drug use, not more, with 86% not approving the regular use of cannabis**

Almost all Australians, according to the 2016 National Drug Strategy Household Survey of 25,000 Australians, do NOT give approval to the use of the illicit drugs heroin (99%), cocaine (98%), speed/ice (99%), ecstasy (97%) and cannabis (86%).

It is safe to conclude from these statistics that Australians do not want increasing drug use, but less drug use.

With legalisation of drugs producing more drug use, Australian legislators need to legislate for the majority of Australians, not the minority 10% who use cannabis.

2. **Legalising the recreational use of cannabis in the United States has markedly increased cannabis use and associated social problems**

Colorado and Washington were the first states to legalise recreational use, having previously

legalised medical cannabis. Within a year of legalization in 2013 cannabis use by those aged 12-17 had risen 20% against decreases of 4% for all other states, rising 17% for college age young people against 2% for other states – all despite cannabis being illegal for all under age 21. Adult use rose 63% against 21% nationally.

When comparing three year averages before and after legalization, cannabis-related traffic deaths rose 48%. Hospitalisations related to cannabis went from 6,715 in 2012 to 11,439 in 2014. Notably, black market criminals found new sanctuary in Colorado, attracted by lower risks of enforcement. Governor Hickenlooper last year introduced House Bill 1221 to address the 380% rise in arrests for black market grows between 2014 and 2016.

3. **Two-thirds of Australians do not want to legalise cannabis**

   The 2016 National Drug Strategy Household Survey of 25,000 Australians found 65% did not want to legalise cannabis.

   Drug Free Australia asserts that if Australians were informed of the actual results of cannabis legalisation in the United States this percentage would be significantly higher.

4. **Loose controls on medical cannabis also markedly increased cannabis use in the United States**

   Any proposals to loosen centralised accountabilities for the prescription of medical cannabis will lead to a virtual legalisation of recreational use with increased cannabis use overall.

   In the United States, more than 90% of medical cannabis is used for self-reported chronic pain, something which doctors cannot objectively verify. While the profile for chronic pain sufferers is medically well established, with patients normally aged between 60 and 80, the profile of medical cannabis users is very different - and precisely the same as for US recreational cannabis users indicating that claims of chronic pain are nothing but ruse.

5. **Claims that taxation will cover the cost of the harms are false**

   According to Gil Kerlikowske, President Obama's drug Czar in 2010, alcohol taxes raised $15 billion against social costs of $185 billion and tobacco taxes raised $25 billion against social costs of $200 billion.

   The Lapsley & Collins analysis of Australian taxes versus the costs of illicit drug use is very deficient in modelling, failing to calculate the costs to families and others in the orbit of drug users, and failing to adequately cover the more recent science of harms caused by illicit drugs.

6. **There has been strong international and community support for 'saving people from themselves' for more than 100 years**

   International drug Conventions have been in place since 1912, with cannabis banned in 1925. These Conventions are precisely because of agreement across the international community that recreational drug users MUST BE SAVED FROM THEMSELVES, contrary to the liberalism of the proponents of this Bill.

The evidence supporting each of the seven central issues nominated here is found in the following pages

Gary Christian
Drug Free Australia
www.drugfree.org.au
Mobil 0422163141
Phone 0243629839

Position Statement - Updated August 2018

The Case Against Legalising, Regulating or Decriminalising Illicit Drug Usage in Australia

Drug Free Australia supports a balanced and humane illicit drug policy that aims at demand reduction, primary prevention and recovery-focussed rehabilitation. This can never be achieved if illicit drugs are condoned through their legalisation. There is a maxim that remains constant - *availability*, *accessibility* and, of course, the key component *permissibility* all increase consumption'. Legalisation equates to 'regulation' in the illicit drug context in this Position Statement.

Background

There is a growing, coordinated, well-funded movement in many parts of the world, (including Australia) that is committed to liberalising illicit drug policies, under the guise of public health and human rights for people who choose to use these substances.
The history and philosophy of this movement is well documented.[1] Known as the 'Harm Reduction' movement, it morphed into the 'Harm Minimisation' policy in Australia in the 1980's and has been the cornerstone of our drug policy for more than 30 years. This has resulted in Australia becoming one of the highest users (per capita) of illicit drugs in the world, particularly amphetamine-type-stimulants.[2]

More recently Harm Reduction has re-surfaced internationally in the form of the 'Global Commission on Drug Policy', which used high profile, often wealthy people, (such as Richard Branson) most of whom have no expertise in the complex issues related to illicit drugs and the harms they cause to our families and communities. From highly publicised media statements made by this so-called 'high level' group, other groups have emerged, including, in this region, 'Australia21', under the banner of 'drug law reform'. All who advise this group on illicit drugs in Australia are well-known members of the Harm Reduction movement[3].

The recurring statements from such groups include:

1. The law enforcement/prohibition approach to illicit drug control has failed
2. Legalisation (regulation) will take the criminal element out of the drug market
3. Legalisation will not increase consumption
4. Illicit Drug law reform (meaning legalisation/decriminalisation/regulation) should be incremental and evidence-based
5. Portugal's drug policy is the best model to be emulated
6. Marijuana and Ecstasy should be the starting point for drug law reform

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[1] Moffitt, A; Malouf, J; Thompson, C; *The Drug Precipice (1997);* Sullivan, L; *The Fallacy of Harm Minimisation* (2000); McKeganey, N; *Controversies in Drug Policy and Practice* (2011); DACA's UNGASS Submission - 2015 https://www.unodc.org/documents/ungass2016//Contributions/Civil/DrugFreeAustralia/UNGASS_submission_170715DACA.002.pdf

[2] United Nations World Drug Report, 2014; Lancet Report 2011;

[3] http://www.australia21.org.au/research-archive/australians-in-society-2/illicit-drugs-policy-2/#.VcGJV0kw9lY

This position paper will now examine these claims:

Harm Reduction (Drug Legalisation) stance # 1 - "*The law enforcement/prohibition approach to illicit drug control is failing*" - FALSE

DFA Evidence to the contrary is:
It appears that law enforcement is always taken to mean something that is 'draconian' and punitive. However, there are models of very compassionate law enforcement approaches. These are achieving reduced drug use rates, through early intervention and recovery-based rehabilitation. For example, Sweden has a police/social worker program, whereby young police officers are trained to intervene in a caring way, early at the experimentation stage of young people. In the United States, the outcomes of the Drug Courts are proving to be very successful in reducing recidivism and in recovery-based interventions.[4]

Illicit Drug Prevention through a combination of law enforcement, health and education strategies are working globally, with only 5% of the world's population having used illicit drugs, according to the 2012 World Drug Report (a drop from 6.1% in 2011).

Despite this, Australia has increasing rates of illicit drug use, because of a 27 year policy of 'Harm Minimisation' that neglects effective primary prevention. New Zealand is also a victim of a similar drug policy. The policy is hardly prohibitive when we see it being implemented with the following in practice examples:

- An injecting room in Sydney that supervises the use of drugs – currently costing $2.7 million p.a. where less than 11% of clients receive a drug treatment referral and where overdose rates run at between 35-42 times the rates inside as they do outside.

- Needle and Syringe Programs that lack accountability including no requirement for needles to be returned, and limited referral of people to treatment services. Syringe vending machines have reportedly even been installed in some public places where needles may be extracted on insertion of a coin. There is a strong push for needle programs in prisons, where taxpayer dollars would be used to provide prisoners with needles to inject illegal drugs, rather than helping them to recover from their addiction.

- Drug Traffickers who receive light or even suspended sentences – little or no deterrent in the legal system and a lack of consistency in drug laws across the country.

- Reduced funding for treatment services in the most recent Federal budget and no requirement to give priority to recovery-based rehabilitation.

- Government funding and support for drug user organisations – for example the 'Australian Injecting Drug Users' League continue to receive funding for 'peer education' to help people use drugs 'safely'. [5]

- The Australian Injecting Drug Users' League CEO was appointed to the former Australian National Council on Drugs – until 2014, the principal advisory body on drugs to the Australian Government.

- High priority to Methadone maintenance – with over 50,000 people now on this synthetic drug, it has become a lucrative industry. Many remain on methadone for life, and overdose rates are high. No serious support has been given by Australian governments to the alternative drug, Naltrexone implants, which have been documented as successful for over a decade[6].

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[4] Drug Courts' Fact Sheet, United States: ONDCP, 2011
https://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/drug_courts_fact_sheet_5-31-11.pdf

[5] Program Evaluation, Australian Injecting and Illicit Drug Users' League, (AVIL), 2005

[6] Hulse, G. K., Arnold-Reed, D. E., Ngo, H., & Reece, S. (2007). Naltrexone implants in the treatment of heroin addiction.

- Effectively dismantling the School Drug Education Strategy, by diverting resources from school drug education programs.

- Decriminalisation of Cannabis in SA and the ACT and de facto decriminalisation in others – where at most, people are given a warning, or perhaps charged an expiation fee. This has resulted in continued high use of cannabis in Australia.

- In addition, 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. Australia also had very well-funded and widely available harm reduction programs including Needle and Syringe (NSP) and Opiate Substitute Treatment (OST) Programs and yet despite these, HIV incidence continued to increase in the years preceding the 'Tough on Drugs' strategy, suggesting that harm reduction interventions that target it had little relevance. The pattern of HCV incidence in Australia shows a consistently increasing rate of HCV infections to a peak of 14,000 new HCV seroconversions in 1999. Despite the implementation of harm reduction strategies in Australia HCV rates increased. Surveys of IDUs using NSPs also found that HCV incidence declined in 2001 and 2002, followed by a plateau in 2004 and 2005. This decline coincides with the overall reduction in drug use following implementation of strongly enforced supply and demand strategies of the Australian 'Tough on Drugs' years, 2000-1997. (Degenhardt et al., 2009;Crofts, Aiken, & Kaldor, 1999).[7]

Sweden, which abandoned Harm Reduction and drug legalisation in the 1960's, in favour of a bi-partisan, restrictive drug policy, now enjoys the lowest drug use rates per capita in the OECD.[8]

These examples are clear indications that drug control (or prohibition) has succeeded in 'pushing back' against the international drug trade.

Harm Reduction (Drug Legalisation) stance # 2 – "*Legalisation (regulation) will take the criminal element out of the drug market*" – MISLEADING

DFA Evidence to the contrary is:
Crime would not be eliminated or reduced. Legalisation would not take the profit out of the drug trade as criminals will always find ways of countering the law. This would include the synthesis of new and more dangerous mind-altering substances than those legalised already; using aggressive marketing techniques designed to promote increased sales and use.

Legal drugs – alcohol and tobacco, are regularly traded on the black market and are an international smuggling problem; an estimated 600 billion cigarettes are smuggled annually[9].

Harm Reduction (Drug Legalisation) stance # 3 – *"Legalisation will not increase consumption"* – FALSE

DFA Evidence to the contrary is:
The most recent National Drug Strategy Household Survey 2010 continues to show that legalised drugs far outweigh the illicit drugs in terms of consumption and acceptability.
The rates of use are as follows:

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

[7] 30 Years of Harm Minimisation – How far have we come?, D. Steenholdt B.Sc.(Hons), Dip.Ed., B.Ed., M.Ed.St.
https://www.unodc.org/documents/ungass2016//Contributions/Civil/Dalgarno/30Years_of_HarmMinimisation_FinalUNGASS.pdf

[8] United Nations Office of Drug Control Policy; Sweden's Successful Drug Policy (2007)
[9] UN World Drug Report 2009

Low use of illegal drugs is the success of Prohibition controls world-wide.[10]

When **Sweden** liberalised its drug policy and effectively 'decriminalised' in the 60's they experienced spikes in drug use. This occurred again in the 90's when drug policy resources were reduced; as soon as Sweden noticed the spikes they took immediate steps to reverse the trend – based on a policy position of a 'Drug Free Sweden'.

Portugal: did not fully decriminalise; personal users still face fines, compulsory treatment and bans. In 2004 an official evaluation found that while heroin overdose deaths and HIV rates had fallen, there was an increase in drug use among young people and deaths related to drugs other than opiates.

The European Monitoring Centre for Drugs and Drug Addictions in 2011 reported that *'Surveys show a stable situation regarding cannabis use in Portugal but a possible increase in cocaine use among young adults'.*

"There remains a notorious growing consumption of cocaine in Portugal, although not as severe as that which is verifiable in Spain. The increase in consumption of cocaine is extremely problematic." (EMCDDA´s Executive Director, Wolfgang Gotz, Lisbon - May 2009).

The country still has high levels of problem drug use and HIV infection and does not show specific developments in its drug situation that would clearly distinguish it from other European countries that have a different policy.

"Portugal registered between 2000-2008 a growing number of older drug users (40 or more) entering treatment - the highest in Europe". (EMCDDA – "Selected Issues," November 2010)

"The highest HIV/AIDS mortality rates among drug users are reported for Portugal, followed by Estonia, Spain, Latvia and Italy; in most other countries the rates are low" (EMCDDA – November 2010).

The Office of National Drug Control Policy (ONDCP) in the United States has researched the current situation in Portugal and found that '*claims that decriminalization has reduced drug use and had no detrimental impact in Portugal significantly exceed the existing scientific basis… … The 'Cato Report' conclusions largely contradict prevailing media coverage and several policy analyses in Portugal and the United States.*[11] For a full report go to:
http://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/portugal_fact_sheet_8-25-10.pdf

In the **United States**, research by Dr Robert Dupont - who established National Institute of Drug Abuse (NIDA) - shows that from 1973-1977 when Marijuana was decriminalised in some states, use increased. Further, from 1980-92, the growth of strong parent movements that advocated that the gateway impact of marijuana was dangerous and supported by Nancy Reagan's 'Just Say No' campaign, use declined. Current research from Dupont's Institute of Behavior and Health on the impact of the legalisation of Medical Marijuana may be located at:
http://dailysignal.com/2015/05/15/federal-judge-refuses-to-reschedule-marijuana-under-controlled-substances-act/

Again from 1993 to 1997 there was a rise in the Harm Reduction movement that advocated that the criminal justice system created most of the harm from illegal drug use. And again there was a cultural shift (well-funded) focused on the promotion of medical marijuana.

In **Australia**, following decriminalisation, rates of drug use increased:

- SA and ACT – use initially went from negligible to almost double NSW and Victoria before settling back to the levels of these states with their already entrenched cannabis problems
- NSW Dept of Criminology 2001 study found that criminalisation of cannabis deters 29% of young people from trying[12]

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[10] UN World Drug Report 2010

[11] ONDCP, Drug Decriminalisation in Portugal – Challenges and Limitations (2009)

[12] NSW Dept of Criminology Report, 2001

This is supported by the National Drug Survey (NDS) Monograph 31 – demonstrates that decriminalisation causes confusion about legal status:

"The 1995 NDS survey shows that a majority, 54 per cent believed that it was legal to possess small amounts of marijuana in the ACT, while 41 per cent believed that a similar situation existed in South Australia. In the remaining states and the Northern Territory, the vast majority correctly answered that possession was illegal, with the proportions varying from 76 per cent in the NT to 87 per cent in Queensland".

Harm Reduction (Drug Legalisation) stance # 4 – "*Illicit Drug law reform (meaning legalisation/decriminalisation/regulation) should be incremental and evidence-based* – SOCIAL ENGINEERING

DFA Evidence to the contrary is:

There is a current push in Australia to be content with legalising (or regulating) just two of the illicit drugs and to have them distributed through 'health' outlets, such as pharmacies. They are cannabis and ecstasy. This is a 'front' for a bigger picture outcome – that of complete legalisation across the board, of all currently illicit drugs. An example of 'incrementalism' is where decriminalisation of marijuana was legislated in both South Australia and the ACT, followed by de facto decriminalisation in other states.

Harm Reduction (Drug Legalisation) stance # 5 - *"Portugal's drug policy is the best model to be emulated"* – FALSE

DFA Evidence to the contrary is:

The European Monitoring Centre for Drugs and Drug Addictions in 2011 'Surveys show a stable situation regarding cannabis use in Portugal but a possible increase in cocaine use among young adults. The country still has high levels of problem drug use and HIV infection and does not show specific developments in its drug situation that would clearly distinguish it from other European countries that have a different policy.

The Office of National Drug Control Policy in the United States has researched the current situation in Portugal and its findings are that the Cato Report is lacking. Go to:
http://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/portugal_fact_sheet_8-25-10.pdf

According to Dr Manuel Pinto Coelho, Director**,** Association for a Drug Free Portugal
– 'because of decriminalisation, there is a growing sense of fearlessness about the selling of small quantity of drugs, since most police officers don't think it's worthwhile' following up 'small dealers'.

Coelho quotes João Goulão former IDT President and SICAD Director: "*now we only care with kilos and tones, not with grams".*
Coelho observes: *"This can be noticed by anyone walking through the crowded streets of Lisbon's Cova da Moura ou Mouraria or through other areas in the city: they are likely to be approached by individuals with hashish, cocaine and other drugs to sell, even in broad daylight. This situation was nonexistent five years ago in such places".*

A further critique of the Portuguese decriminalisation model has been produced by the Dalgarno Institute, Melbourne. This supports the report from the ONDCP[13]**.**

Harm Reduction (Drug Legalisation) stance # 6 - "*Given that they are the most used illicit drugs, Marijuana and Ecstasy should be the starting point for drug law reform (legalisation, decriminalisation or regulation) -* SOCIAL ENGINEERING

DFA Evidence to the contrary is:

The deterrent of marijuana remaining criminalised is an important factor in 'permissibility of use'. Decades of study into the harms of marijuana have established a wide variety of unacceptable harms,

[13] Varcoe, SW, Franc, D. 'Evidence Based Data and the Failed Portuguese Experiment', November 2010

including the harms it causes to mental health and the developing brain. We need more education about the harms of both these drugs. Drug Law Reform needs to be a balanced policy with primary prevention, law enforcement, recovery-based treatment and research. (Note that recently, the UK has re-classified Marijuana and it is now in the bracket of a far more dangerous drug that they previously had classified)

In Australia (or elsewhere) if Ecstasy (MDMA) is regulated and distributed via pharmacies (the rationale being that because in its current form it is dangerous for users), that would be a **'green light'** about safety to users and potential users, as happened with cannabis in the UK and in South Australia, following decriminalisation.

We are already experiencing a concerning growth in the abuse of pharmaceutical drugs, which are 'controlled, regulated and legal'.[14]

Drug Law Reform - the way forward

National Drug Policy needs the following critical success factors:

- Drug literacy in our communities focuses on the real harms of drug consumption and how this can be prevented.
- We prevent deaths, disease, crime and corruption - not just 'minimise' them
- Our treatment and rehabilitation is 'recovery-based' so that people actually heal from their addiction.
- Interventions are available to ALL who use drugs (not just those who are 'concerned about their drug use').

We cannot be a 'lone voice' in what is essentially, a global problem. The UN Drug Conventions were adopted because of the recognition by the international community that drugs are an enormous social and health problem and that the trade adversely affects the global economy.

In 2012, UN Controls are working as deterrent. They have helped keep use rates low, with only 5% of people globally (between the ages of 15 and 64) using illicit drugs. International cooperation is imperative if we are to continue to succeed.

We need to:

- Move away from the misleading position put by the so-called 'Global Commission on Drug Policy' report, which was promoted in late 2011, towards more workable improvements in Australia's drug policy. We must not repeat the mistakes of the past – from lenient/permissive drug policy in other countries.

- Move in the direction of Sweden and give priority to Harm Prevention and children's rights.

- Re-focus Australia's drug policy on the UN Convention on the Rights of the Child, where Article 33 states that:

  Member States "*shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances*".[15]

- Reverse the emerging trend of increases in child abuse and neglect, both to the unborn child, and those who are growing up in families where illicit drugs are used regularly. Specifically, there are too many examples of increased rates of births of drug-addicted babies across the board, in Australia. Here is one such example: http://au.news.yahoo.com/thewest/a/-/breaking/8808278/drug-addict-baby-numbers-rise/

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[14] http://www.abc.net.au/news/2011-08-15/prescription-drug-overdoses-on-the-rise/2839544 and http://www.drugabuse.gov/drugs-abuse/prescription-medications

[15] UN Convention on the Rights of the Child, http://www.unicef.org/crc/

Links to child abuse and neglect are increasingly associated with intergenerational drug use. For instance, in 2008, research compiled by the Australian Institute of Family Studies (AIFS) found that a substantial number of Australian children are living in households where adults routinely misuse alcohol and other drugs. The AIFS research further shows that in cases of substantiated child abuse or neglect, 64% of parents experienced significant problems with substance and alcohol abuse.

And disturbingly, it is estimated that **30% of abused or neglected children go on to maltreat children in some way when they are adults**.
It also warns that existing data underestimates the impact of drug and alcohol abuse on children, because current national surveys do not collect information on parental status or child care responsibilities. [16]

- Join together with more countries against a more permissive drug policy, and in so doing, hold our commitment to the United Nations Drug Conventions.
- Communicate with political counterparts in other leading countries and, rather than further liberalising our drug laws, take a stronger stance against this global oppression.

See the May 2012 signing of the ***Joint Statement for a Humane and Balanced Drug Policy*** - by Drug Policy Directors/Ministers from Sweden, UK, Italy, United States and Russia at www.wfad.se [17]

Conclusion

A balanced, humane drug policy where law enforcement, combined with well-resourced education and public health practice, together with international cooperation, will help us reap the benefits of effective prevention and demand reduction initiatives.

Appeasement to the seductive chorus of calls for decriminalisation will only lead to greater uptake of illicit drug use. Those who offer this panacea of legalisation coupled with regulation have yet to demonstrate any practical means of regulation and should be held to account.

[16] *Australian Institute of Family Studies Research Report*, 2008

[17] Joint Statement for a Humane and Balanced Drug Policy; UK, Sweden, USA, Russia and Italy.