The Parliament of the Commonwealth of Australia

DEPARTMENT OF THE SENATE
PAPER No. 3311
DATE
PRESENTED
25 MAY 1989

DRUGS, CRIME AND SOCIETY

Report by the Parliamentary Joint Committee
on the National Crime Authority

Australian Government Publishing Service
Canberra

DRUGS, CRIME & Society

Report by the
Parliamentary Joint Committee
on the National Crime Authority

The Parliament of the Commonwealth of Australia

DEPARTMENT OF THE SENATE
PAPER No. 3211
DATE
PRESENTED
25 MAY 1989

DRUGS, CRIME AND SOCIETY

Report by the Parliamentary Joint Committee
on the National Crime Authority

Australian Government Publishing Service
Canberra

© Commonwealth of Australia 1989
ISBN 0 644 09707 8

Printed in Australia by R. D. RUBIE, Commonwealth Government Printer, Canberra

MEMBERSHIP OF THE COMMITTEE

Mr P.R. Cleeland, M.P. (Chairman)
Senator R.K.R. Alston (Deputy Chairman)
Senator B. Cooney*
Mr S.C. Dubois, M.P.
Senator R. Hill
Senator G.N. Jones
Mr P.J. McGauran, M.P.
The Hon. M.J.R. MacKellar, M.P.
Senator M.J. Macklin
Senator J. Morris+
Mr N.P. O'Keefe, M.P.

* Appointed 1 December 1988
\+ Discharged 1 December 1988

Secretary: Giles Short
Parliament House
Canberra

CONTENTS

Chapter		Paragraph	Page
	Summary		vii
	List of Recommendations		xv
	Preface		xvii
1.	Introduction		
	Terms of Reference	1.1	1
	Illegal drugs in perspective	1.6	3
	Conduct of the inquiry	1.16	9
2.	Drug Use: Facts and Myths		
	Introduction	2.1	13
	Cannabis	2.2	13
	Heroin	2.7	16
	Cocaine	2.15	20
	Amphetamines	2.20	22
	Addiction	2.23	24
	Drug, set and setting	2.29	27
	Conclusion	2.33	29
3.	The Scope and Nature of the Drug Trade		
	Introduction	3.1	33
	Cannabis	3.5	34
	Heroin	3.13	40
	Cocaine	3.25	48
	Amphetamines	3.29	51
	Conclusion	3.32	52
4.	Efficacy of Law Enforcement Strategies		
	Introduction	4.1	57
	Strategies - Crop eradication and substitution	4.3	58
	Interception of importations and destruction of plantations	4.6	59
	Targetting major traffickers	4.11	62
	Targetting lower level dealers	4.15	64
	Indicators of success	4.20	66
	Conclusion	4.25	70
5.	The Social Costs of Prohibition		
	Introduction	5.1	75
	Direct costs	5.2	75
	Raising prices	5.5	77
	Drug-related crime	5.7	78
	The criminal milieu	5.12	81

Chapter		Paragraph	Page
	Corruption	5.15	82
	Health costs	5.18	84
	Adulteration	5.20	85
	Stigmatising users	5.21	85
	Civil liberties	5.23	86
	Hypocrisy	5.25	87
	Benefits foregone	5.26	88
6.	Options		
	Introduction	6.1	91
	The present policy of prohibition	6.2	91
	Harsher penalties	6.5	93
	De facto decriminalisation	6.13	97
	Decriminalisation	6.17	99
	Prescription	6.21	102
	Licensing	6.30	108
	Regulation	6.31	109
	Conclusion	6.41	115
7.	Where Do We Go From Here?		121
	Dissent by Committee Members		127
	Appendix 1 - Individuals and Organisations Who Made Written Submissions to the Committee		129
	Appendix 2 - Individuals and Organisations Who Appeared as Witnesses Before the Committee at Public Hearings		131
	Appendix 3 - Individuals and Organisations Who Appeared as Witnesses Before the Committee at In Camera Hearings		136

SUMMARY

Introduction

The trafficking of illegal drugs is a major focus of the National Crime Authority's activities and this priority is reflected in other areas of Federal law enforcement. Despite the priority given to such matters, however, the law enforcement agencies have not succeeded in preventing the supply of illegal drugs to Australian markets. The Committee therefore decided to examine:

(i) the scope and nature of the trade in illegal drugs in Australia;

(ii) the efficacy of present law enforcement strategies in suppressing the trade in illegal drugs in Australia;

(iii) the social costs of the present policy of prohibition of the production, possession, use, supply, importation and exportation of illegal drugs; and

(iv) whether the present policy of prohibition is the most effective means to deal with the problem of drug abuse in our society.

The past year has seen a growing debate on the question of the alternatives to the present policy of prohibition in respect of the illegal drugs. In Britain the Economist has advocated a relaxation of the present policy to 'get the gangsters out of drugs'. In the United States hearings have been held in Congress on the issue and in this country a former Deputy Commissioner of Police in the State of Victoria, Mr Paul Delianis, has suggested that it is time to consider whether there is a case for making the presently illegal drugs available under strict government controls.

This report is going to prove a disappointment to anyone who expected the Committee to recommend sweeping changes to the present law. The Committee believes that there is ample evidence that the present policy of prohibition is failing to achieve its objective: namely to reduce the use of those drugs which are presently illegal by preventing supplies of such drugs reaching those in Australia who may wish to use them. The illegal drugs are available throughout Australia to anyone who wants them, although at prices artificially inflated by their illegality.

There is no consensus, however, on whether prohibition should be replaced and, if so, on what policy should replace it. Nor is the

community ready for any sudden change to the law. The present policy has costs, but so do the alternatives. There is no easy solution. The Committee hopes in bringing down this report to enable a more informed debate to take place within the community on the options available to government in this area of drug policy.

The Committee emphasises that the present policy of prohibition results in an absence of government control over the chemistry of the drugs being sold, the outlets where the drugs are sold and who the drugs may be sold to. The Committee recommends that the Federal and State Governments and the community at large give earnest consideration to the options by which governments might impose more controls on the sale and marketing of the presently illegal drugs.

Besides calling for more accurate statistical data and greater attempts to evaluate existing law enforcement strategies the Committee proposes that the Commonwealth Government set targets as indicators of the success of its latest initiatives in curbing the drug trade. Should these latest initiatives fail to make any significant inroads on the market then it would be appropriate to consider some relaxation of the present prohibitions as an alternative policy.

In the meanwhile the Committee proposes a ban on all advertising of alcohol and tobacco products. (Senators Alston and Hill, Mr MacKellar and Mr McGauran dissent from this recommendation: see dissent at page 127.) The Committee believes that the continued promotion of alcohol, tobacco and certain pharmaceutical drugs undermines the attempt through the National Campaign Against Drug Abuse to persuade young people that drug taking is unacceptable. Young people are acutely aware of the hypocrisy which marks our attitudes to drugs whereby we label the use of the illegal drugs as a crime but actively promote the use of the legal drugs despite the health and social problems which these drugs cause.

<u>Myths surrounding drug use</u>

The Committee found a great number of myths about addiction to the illegal drugs and heroin in particular. Young people are most likely to try the illegal drugs first in the company of friends. Heroin use spreads through friendship networks rather than through the agency of 'pushers'. Addiction is not inevitable: repeated use is necessary to establish dependence.

Heroin addicts can and do voluntarily cease to use the drug, and they may pass through a number of periods of abstinence in the course of their using careers. They are not necessarily addicted for life: in general they either give up after relatively brief periods of addiction or 'mature out' between the ages of 35 and 45 after longer using careers.

The description of addiction as a compulsion or a need for the drug which overpowers the individual's better judgment is therefore misleading. It is better defined as a behavioural pattern characterised by an overwhelming preoccupation with the use of the drug and the securing of its supply. Using this definition it is clear that the majority of users of the illegal drugs, heroin included, do not become addicted at all. The typical drug user is not the stereotype of the 'junkie' in the gutters of Kings Cross.

Extent of the trade

Using surveys carried out by Roy Morgan Research for the purpose of the evaluation of the anti-heroin campaign conducted as part of the National Campaign Against Drug Abuse, the Committee has made estimates of the numbers of users of cannabis, heroin and cocaine, the numbers of frequent or regular users, the amounts they consume and the overall turnover in the trade. These estimates are set out below but they should be treated with caution.

Drug	Cannabis	Heroin	Cocaine
Used in last 12 months	780,000	33,600	84,500
Frequent, regular users	226,000	3,360	6,640
Estimated annual consumption	120,000kg	350kg	65kg
Estimated annual turnover	$1,905m.	$699m.	$13m.

It should be stressed that the estimate of frequent users of heroin represents only persons who are <u>currently</u> such users. At any one time perhaps 1,000 persons who would otherwise fall in this category are in prison, another 6,000 are receiving methadone, perhaps a further 1,000 are in therapeutic communities and an indeterminate number are abstaining from the drug for periods of six months or even longer. In other words there may be over 12,000 people in the revolving door of heroin addiction but only a quarter of these may be treated as frequent users at any one time.

Success of law enforcement agencies

As already stated, these estimates should be treated with caution: the Committee notes the need for better data and

recommends that regular surveys be undertaken of larger population samples in an attempt to gather more accurate data on the extent of use of the illegal drugs. However it seems clear that the law enforcement agencies have been more successful than they have been given credit for in making seizures of drugs. On these figures over half of the total consumption of domestic cannabis may be being destroyed and seizures of importations of heroin and cocaine may be running at 23 per cent and 17 per cent of consumption respectively.

The fact that law enforcement agencies have been more successful in making seizures than they have been given credit for does not, however, mean that they are succeeding in preventing supplies of illegal drugs from reaching the market. The best indicators of success in this regard are the price, purity and availability of the drugs on the streets. Unfortunately these indicators are not measured systematically and the Committee recommends that this be done. On the basis of the data available it appears that the destruction of domestic cannabis plantations has indeed forced the price of this drug up. The price of heroin, on the other hand, appears to have fallen in real terms in the last 10 years, although there may have been some decrease in the purity of the drug at street level, and the prices of cocaine and the amphetamines have also fallen in the last year or so.

The Committee suggests that even if there were to be a significant increase in seizures this would have little impact. Because most of the value is added to drugs like heroin and cocaine after they enter the country, the seizure of a kilogram of heroin does not represent a loss to the importer of the 'street' value of the drug but rather its price in Asia - $12,000 to $15,000 - plus the costs of the importation.

The Williams Royal Commission recommended the targetting of major traffickers but this will only be of benefit if there are not other criminals ready to take their places. Paradoxically, the more successful the law enforcement agencies are in cutting off supplies and so raising the price of the illegal drugs, the greater the incentives are for others to enter the trade. Targetting user-dealers or known areas where dealing takes place may temporarily disrupt the markets but is unlikely to have any long term effect. The Committee recommends, however, that law enforcement strategies be reviewed to ensure they are directed to a greater degree at trafficking as distinct from the mere possession of illegal drugs.

<u>Social costs of prohibition</u>

The Committee acknowledges that, by raising the price of the illegal drugs and by making access at least risky and difficult, the present policy of prohibition deters new users who might be attracted to the illegal drugs if they were as readily available as alcohol and tobacco. The present policy also encourages heavy users to consider treatment and abstinence because of the cost

and 'hassles' of maintaining a habit. However it achieves these effects at a considerable cost to the users themselves and to the community at large.

The Committee estimates the direct annual cost of drug law enforcement at $123 million. This is not just a dead cost: it represents police diverted away from other duties and money diverted away from other calls on the public purse. It also represents delays in the courts and overcrowding in the gaols. The high price of heroin in particular means that users resort to dealing in the drug, to prostitution, and to fraud, property offences and armed robbery in order to support their habits. The community bears the cost of drug-related crime through increased insurance premiums, through the need for increased security measures around homes and businesses, and through the costs imposed on banks, other financial institutions and businesses which are passed on to consumers.

Users seeking to buy drugs are brought into contact with a criminal subculture and may progress from using cannabis and pills including the amphetamines to the use of heroin. The drug trade is violent: the profits to be made have attracted professional criminals who are not afraid to kill each other and to beat up or kill people who owe them money, people whom they suspect of having cheated them and people whom they believe to be informants. The profits to be made in the trade also promote corruption in law enforcement agencies.

The high cost of the illegal drugs promotes intravenous injection as the preferred mode of use because it ensures that users obtain the greatest effect from a given quantity of a drug. However intravenous injection, especially in insanitary conditions, carries obvious health risks. These are compounded by the sharing of needles which facilitates the spread of hepatitis-B and AIDS. While rates of HIV infection among intravenous drug users in Australia are low at present, the overseas experience suggests that the infection may spread very rapidly. There is a very real threat that AIDS may spread from the intravenous drug using population through heterosexual transmission to the community at large. Prohibition also means that the illegal drugs are 'cut' or adulterated with a variety of substances including talc, glucose, strychnine and arsenic, posing further dangers to users' health.

Prohibition, it is said, makes criminals out of persons who would not otherwise break the law and stigmatises them for life with criminal records if they get caught. Prohibition has also been responsible for an erosion of generally accepted civil liberties. Persons may be liable to intrusive searches upon suspicion and persons' reputations may be damaged not because of any crime that has been proved against them but because they are suspected of having some involvement in the trade. Prosecutions depend upon informers and the law bears most heavily on those drug users, primarily the young and the poor, who use drugs in public places.

An obvious double standard prevails in respect of recreational drug use when we give manufacturers of alcohol and tobacco products social recognition but put growers of cannabis in gaol for lengthy periods. At the same time the illegal drugs are not available for therapeutic applications. Cannabis has promise as an anti-emetic for cancer patients undergoing chemotherapy and in relieving intra-oscular pressure in sufferers from glaucoma and heroin has long been used in Britain to relieve the pain of terminally ill cancer patients.

Options:

Harsher penalties

What are the alternatives to the present policy? The Committee does not believe that increased penalties are a solution. The last two decades have seen a steady increase in the maximum sentences for drug trafficking offences in this country with negligible effects. Those countries in Asia which have imposed the death penalty for drug trafficking have also experienced an alarming increase in heroin addiction. The imposition of mandatory penalties and saturation law enforcement are only likely to lead to increased congestion in the courts and greater overcrowding in the gaols.

Decriminalisation

The Committee has examined the system of de facto decriminalisation of the possession and use of drugs applying in the Netherlands but it believes that such a policy might pose problems in Australia because of the discretion it places in the hands of those responsible for enforcing the law, both police and prosecutors. Decriminalisation of cannabis (implying a system of 'on-the-spot' fines for possession for personal use only as in South Australia) would probably not lead to any significant increase in use if the experience in the United States is any guide but it really only regularises the present situation where entirely predictable fines are imposed for cannabis offences.

Partial prohibition (the legalisation of possession and use and the cultivation and distribution of illegal drugs for personal use provided no profit is made) was the alternative advocated by the Sackville Royal Commission in South Australia in respect of cannabis and is probably only feasible in respect of that drug. However there would be no quality control on the product under this alternative, no monitoring of the amounts used by individuals or use by persons aged under 18 and no benefit to government in terms of taxation revenue.

Prescription

The impracticality of decriminalisation in respect of the so-called 'hard' drugs has led to proposals that all such drugs, or heroin at least, should be made available on prescription from

doctors or through special clinics. The Committee has examined the British experience with the prescribing of heroin prior to 1968 and its use as a maintenance drug (much as methadone is used in this country) after 1968. The Committee believes that it is vain to hope that making the illegal drugs available on prescription or through clinics will cause the black market in these drugs to disappear. Indeed in its pre-1968 form the British approach actually stimulated the growth of a black market in pharmaceutical heroin. Maintenance schemes do provide addicts with the opportunity to stabilise their lives if they wish to do so and they can provide significant benefits by reducing drug-related crime. However methadone has significant practical advantages over heroin as a maintenance drug and the Committee is not convinced that making available injectable drugs such as heroin, cocaine and the amphetamines through clinics will have a marked effect on needle sharing among intravenous drug users and hence on the spread of HIV infection.

Licensing

Another alternative which would substantially increase the Government's control over the trade in illegal drugs is a licensing system under which users would be required to be licensed in much the same way as persons wishing to purchase firearms under current laws. Levels of use could be monitored and under age persons could be prevented from purchasing drugs. There are privacy problems with such a scheme, however, particularly as regards the monitoring of use, and to the extent that it approximates to a policy of free availability it would very likely lead to a dramatic increase in the use of the presently illegal drugs.

Regulation

It is argued that regulation - making the presently illegal drugs available under strict government controls with a ban on commercial sale and advertising - would eliminate many of the costs associated with the present policy. The black market, it is said, would die away. There would be savings in law enforcement costs and taxes could be used to fund drug education and rehabilitation programmes. Drug-related crime would disappear as would the violence and corruption associated with the illegal trade. Some health problems - for example those resulting from adulteration - would be eliminated and users would be ready to come forward for treatment and would be available for education on issues such as needle sharing and AIDS.

On the other hand there would be a very substantial increase in the use of the illegal drugs - how great it is difficult to predict - and a consequent increase in health problems associated with this. If regulation were implemented only in respect of one drug - heroin, for example - a black market would remain in the other illegal drugs. Crime and corruption would remain as would the health problems of users who choose to follow a 'junkie'

lifestyle, particularly if they continued to practise intravenous injection in insanitary conditions.

Conclusion

Over the past two decades in Australia we have devoted increased resources to drug law enforcement, we have increased the penalties for drug trafficking and we have accepted increasing inroads on our civil liberties as part of the battle to curb the drug trade. All the evidence shows, however, not only that our law enforcement agencies have not succeeded in preventing the supply of illegal drugs to Australian markets but that it is unrealistic to expect them to do so. If the present policy of prohibition is not working then it is time to give serious consideration to the alternatives, however radical they may seem.

As stated at the outset, there is no easy solution. Each option involves trade-offs between costs and benefits. The present policy of prohibition raises prices and restricts access, thus making it more difficult for both new and existing users to obtain drugs. It deters new users and may push existing users into treatment and rehabilitation programmes. At the same time it imposes an enormous cost on the users themselves - through damage to their health and now the threat of the spread of AIDS through sharing needles - and on society at large through drug-related street crime, corruption and the direct costs of law enforcement.

At the other end of the spectrum making the presently illegal drugs available subject to government regulation would eliminate many of the social costs while not necessarily diminishing the health problems of addicts or improving their employment prospects. At the same time, however, it could lead to a dramatic increase in the use of the drugs and almost certainly to an increase in addiction.

The Committee hopes that its report will result in an informed debate within the community on these options so that policy development in this area is not left to international organisations and bureaucrats and so that the policies that are chosen can be clearly demonstrated to be effective in attaining the goals which the community wishes to achieve.

LIST OF RECOMMENDATIONS

Recommendation: The Committee recommends that the Commonwealth Government should undertake regular surveys of the general population and of illicit drug users along the lines of those commissioned from Roy Morgan Research for the evaluation of the NCADA anti-heroin campaign (but preferably using larger samples) in order to develop a body of data concerning the extent of the use of the illegal drugs, frequency of use, amounts consumed and trends in use over time. (Paragraph 3.34).

Recommendation: The Committee recommends that funds be made available through the NCADA Research Programme to compare the effectiveness of the differing law enforcement strategies adopted in Australia with a view to recommending those courses of action which constitute the best ways to attack the traffic in illicit drugs as distinct from their mere possession. (Paragraph 4.19).

Recommendation: The Committee recommends that the Commonwealth Government urgently initiate action through the Ministerial Council on Drug Strategy to ensure that data on the price, purity and availability of drugs <u>at street level</u> are collected on a uniform basis throughout Australia. (Paragraph 4.26).

Recommendation: The Committee reinforces the views of the Williams Royal Commission and recommends to the Commonwealth Government that it set targets as indicators of the success of its latest initiatives in curbing the drug trade. (Paragraph 7.5).

Recommendation: The Committee recommends that the Federal and State Governments and the community at large give earnest consideration to the options by which governments might impose more controls on the sale and marketing of the presently illegal drugs. (Paragraph 7.7).

Recommendation: The Committee recommends that the Commonwealth Government ban all advertising of alcohol and tobacco products on radio, television, in cinemas and in print, so far as it is within its constitutional power to do so. (Paragraph 7.11). (Senators Alston and Hill, Mr MacKellar and Mr McGauran dissent from this recommendation: see dissent at page 127.)

PREFACE

Australia's drug policy has developed in a somewhat haphazard fashion. All drugs were freely available in the nineteenth century and the opiates were widely used as cures for all sorts of ills. Their use for their euphoric effects was, however, frowned on. Concern about the use of arsenic in poisonings, murders and suicides led to the imposition of the first controls on the sale of drugs, restricting their sale to registered pharmacists. In 1905 the Commonwealth banned the importation of opium prepared for smoking, a move which may have been inspired by racist sentiments against the Chinese community (although in fairness it must be said that most of the Chinese community were also opposed to the custom of opium smoking). From that time on, however, Australian legislation concerning drugs has been determined by moves at the international level.[1]

Thus, following the First World War and the entry into force of the Hague Convention, the use of opium, morphine, heroin and cocaine was limited to medical purposes. The Geneva Convention of 1925 added cannabis to the list. Heroin remained freely available for medicinal purposes until 1953, when the World Health Organisation recommended that its use in medicine be banned. Most countries, including Australia, implemented this ban, although heroin remains in use in the United Kingdom as a pain killer and Canada recently permitted its use for the same purpose. The various conventions were consolidated in the Single Convention on Narcotic Drugs in 1961. Controls on the amphetamines, hallucinogens, barbiturates and certain tranquillisers were

implemented by the Convention on Psychotropic Substances in 1971 and a new Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances was signed in Vienna in February this year. This last convention requires countries to take co-operative measures against the drug trade, including the confiscation of assets and mutual arrangements for extraditions and access to financial records.[2]

When the Single Convention was signed in 1961 no country apart from the United States of America had a significant drug problem. The international regime on drugs seemed to be a striking example of effective international co-operation. As late as 1966 the international bureaucracy was able to reach the smug conclusion that:

> 'By now the problems have been clearly defined and some of them have been solved, or the instruments of their solution have been created: non-medical consumption of opium, coca leaf, cannabis and of the drugs manufactured from them is outlawed in principle and is bound to disappear after transitional periods of adaptation.'[3]

The paradox is that the Single Convention, designed to stamp out the drug trade once and for all, in fact ushered in an era in which the consumption of those drugs which it was supposed to control has increased beyond the most alarmist predictions.[4] It is in this context that this Committee has undertaken its present re-examination of the effectiveness of the present policy of prohibition as a means of controlling the abuse of the illegal drugs.

1. For a more detailed examination of the history, see Davies, S., Shooting Up (Hale & Iremonger, Sydney, 1986); Lonie, J., A Social History of Drug Control in Australia (South Australia, Royal Commission into the Non-Medical Use of Drugs, Research Paper 8, Adelaide 1979); Manderson, D., Proscription and Prescription - Commonwealth Government Opiate Policy 1905-1937 (Department of Community Services and Health, NCADA Monograph Series No.2, A.G.P.S., Canberra, 1987); and Carney, T., 'The History of Australian Drug Laws: Commercialism to Confusion?', in Monash University Law Review, vol.7 (June 1981), pp.165-204.
2. Evidence, Commonwealth Attorney-General's Department and Department of Community Services and Health, pp.535, 537-40. For more detail on the history of the international regime see Lowes, P.D., The Genesis of International Narcotics Control (Libraire Droz, Geneva, 1966), and Bruun, K., Pan, L., and Rexed, I., The Gentlemen's Club - International Control of Drugs and Alcohol (U. Chicago Press, 1975).
3. 'Twenty Years of Narcotics Control Under the United Nations-Review of the Work of the Commission on Narcotic Drugs', in Bulletin on Narcotics (1966), quoted in Bruun, Pan and Rexed, op.cit., p.33.
4. Henman, A., 'Cocaine Futures', in Henman, A., Lewis, R., and Malyon, T., Big Deal - The Politics of the Illicit Drugs Business (Pluto, London, 1985), pp.118-189 at pp.157-8.

CHAPTER ONE

INTRODUCTION

Terms of Reference

1.1 The Parliamentary Joint Committee on the National Crime Authority has the duty, under paragraph 55(1)(d) of the National Crime Authority Act 1984, 'to examine trends and changes in criminal activities, practices and methods and report to both Houses of the Parliament any change which the Committee thinks desirable to the functions, structure, powers and procedures of the Authority'. It may also, pursuant to paragraph 55(1)(b), 'report to both Houses of the Parliament, with such comments as it thinks fit, upon any matter appertaining to the Authority or connected with the performance of its functions to which, in the opinion of the Committee, the attention of the Parliament should be directed'.

1.2 The trafficking of illegal drugs has been a major focus of the National Crime Authority's activities. Of the eight references it has been given to date, three have directly concerned drug trafficking, two have had drug related elements and a further two have involved allegations of drug trafficking. At any one time over half the Authority's resources have been devoted to the investigation of drug trafficking matters. The priority accorded to such matters in the Authority's investigations is reflected in other areas of Federal law enforcement. Thus the Charter of Objectives and Priorities issued to the Australian Federal Police on 15 August 1985 calls on that agency to increase the effectiveness and scope of its investigations into drug trafficking as its first priority. The increased priority accorded to drug trafficking by law

enforcement agencies is also reflected in the increase in the size of the State and Territory police drug squads. Whereas in 1978 there were 140 police officers (approximately 0.5 per cent of the total State and Territory police strength in Australia) engaged in specific drug law enforcement duties, by 1989 there were about 726 police officers so engaged (or 2.0 per cent of total police strength).

1.3 Despite the increased priority given to drug trafficking matters, however, it seems clear that the law enforcement agencies have not succeeded in preventing the supply of illegal drugs to Australian markets. The Committee therefore decided on 24 May 1988 to undertake an inquiry into the issue of drugs, crime and society. The Committee decided that it would examine:

(i) the scope and nature of the trade in illegal drugs in Australia;

(ii) the efficacy of present law enforcement strategies in suppressing the trade in illegal drugs in Australia;

(iii) the social costs of the present policy of prohibition of the production, possession, use, supply, importation and exportation of illegal drugs; and

(iv) whether the present policy of prohibition is the most effective means to deal with the problem of drug abuse in our society.

1.4 The Committee has concentrated its attention on four illegal drugs in particular: cannabis, heroin, cocaine and the amphetamines. Cannabis is the most widely used illegal drug in Australia while heroin seems to have given rise to the greatest public concern. Cocaine does not yet constitute a major problem in this country but the experience in the United States has caused some people to suggest that it may become one. During the course of its inquiry the Committee heard evidence of an increase in the use of the amphetamines and it was suggested that they could be being offered as an alternative to marihuana, given the high retail prices for that drug.

1.5 By contrast, hallucinogens like LSD (lysergic acid diethylamide) seem to have lost their popularity, while drug analogues such as MDMA (3,4-methylenedioxymethamphetamine) or 'ecstasy' come and go like other fashions or fads. The diversion of pharmaceutical drugs such as barbiturates and tranquillisers into the illegal market is virtually inevitable so long as these drugs remain widely available for legitimate medical purposes, but the problems associated with these drugs, in particular the prevalence of accidental overdoses of barbiturates, seem to be diminishing. The existence of these other illegal drugs must be borne in mind, however, when considering the consistency of the law across the field of all drugs which are presently subject to total or partial prohibition.

Illegal drugs in perspective

1.6 Given the law enforcement bias in the Committee's statutory duties, it is perhaps unnecessary to explain the concentration of its inquiry on illegal drugs. However it should be emphasised that the Committee recognises that the illegal drugs are only a small part of the total picture of drug use in Australia. Legal drugs - alcohol, tobacco, caffeine and pharmaceutical drugs - are for obvious reasons the most widely used. Over eighty per cent of the adult population drink alcohol and around thirty per cent smoke tobacco products. By contrast a recent nationwide survey found that only 6.2 per cent of the population over the age of 14 had used cannabis in the last 12 months. The figures for heroin, cocaine and 'pills' (including not only amphetamines but also 'uppers' and 'downers') were too low to have any statistical significance.[1]

1.7 The Senate Standing Committee on Social Welfare in its report, 'Drug Problems in Australia - an Intoxicated Society?', stated that:

> 'We live in a drug-taking society. Drugs relieve symptoms, expand minds and satisfy a myriad of personal needs. The media exhort us to try chemical solutions for headaches, sleeplessness and obesity, and to make life more pleasurable by drinking alcohol or smoking tobacco. The use of prescription drugs continues to grow as the range of useful drugs increases and as patients more and more expect to have drugs prescribed for their ills.'[2]

The Social Welfare Committee reported on alcohol, tobacco, analgesics and cannabis in that report, tabled in October 1977, and on therapeutic drugs in its report, 'Another Side to the Drug Debate...a medicated society?', tabled in May 1981. The Senate also appointed a Select Committee to examine the abuse of volatile substances - the sniffing of petrol, glue and aerosol sprays - and that Committee reported in December 1985.

1.8 In terms of the problems they cause for public health, the legal drugs clearly outweigh the illegal drugs, chiefly because many more people make use of them. Tobacco caused 17,070 deaths in 1986, alcohol 3,465 deaths (including 1,494 car accidents in which alcohol was a factor), and the opiates (including legal drugs such as methadone, propoxyphene and dextromoramide) 249 deaths.[3] The association of cigarette smoking with lung cancer, chronic respiratory diseases such as chronic bronchitis and emphysema, arteriosclerosis (hardening of the arteries), coronary heart disease, stroke and impaired circulation (leading to gangrene) is well known. Smoking leads to an increased incidence of still-births, significantly reduces the birth weight of children born to women who smoke during pregnancy and increases the likelihood of the sudden death of infants.[4] Heavy alcohol use is associated with psychiatric and neurological disorders, malnutrition and vitamin deficiencies, cirrhosis of the liver, alcoholic hepatitis, inflammation of the lining of the stomach, increased risk of heart disease and cancers of the mouth, pharynx, larynx, oesophagus, liver and lung, and, in men, impotence, sterility and gynaecomastia (growth of breasts). Consumption of alcohol during pregnancy is linked to a pattern of

birth defects known as the foetal alcohol syndrome which results in mental retardation, growth deficiency and a characteristic pattern of facial abnormalities. The Senate Standing Committee on Social Welfare was told that at least 10 per cent of Australia's health costs were related to alcohol.[5]

1.9 Because of alcohol's effects on the brain and central nervous system, alcoholics suffer an increased risk of death from accidents, poisoning with other drugs, suicide and homicide. The association of alcohol with road fatalities is well known. In 1986, 40 per cent of drivers and motor cycle riders killed on the roads in Australia had a blood alcohol level over 0.05g/100mL.[6] The Canadian Commission of Inquiry into the Non-Medical Use of Drugs stated that:

> 'Of all drugs used medically or non-medically, alcohol has the strongest and most consistent relationship to crime.'[7]

The Le Dain Commission noted a 1956 study of homicides in Philadelphia which found that over a five year period alcohol was present in either the offender or the victim in 64 per cent of homicides. In 70 per cent of the alcohol related cases both the offender and the victim had been drinking and in the same percentage of cases the murders were committed by stabbing, kicking or beating by fists or with a blunt instrument, suggesting that the crimes were essentially unpremeditated physical assaults.[8] A 1986 study by the New South Wales Bureau of Crime Statistics and Research found alcohol to be present in 42.3 per cent of homicides, while in 46 per cent of spouse killings alcohol had been consumed by one or other of the parties prior to the offence. The Australian Institute of Criminology, reporting this finding, observed that studies were remarkably consistent in indicating that alcohol was present in approximately 50 per cent of homicides.[9]

1.10 The Senate Standing Committee on Social Welfare noted that in a Victorian study of 644 violent assaults of a non-sexual and non-acquisitive nature 'where aggression was perpetrated for its own sake' it was found that 73 per cent of the offenders and 26 per cent of the victims had been drinking prior to the offence. For occurrences between 10 p.m. and midnight, 98 per cent of the offenders had been drinking. Also, 24 per cent of the assaults had occurred in or immediately outside a public place where liquor was sold. A 1988 study by the New South Wales Bureau of Crime Statistics and Research similarly found that serious assaults were particularly common between 10 p.m. and 2 a.m., hours that correlated with hotel and club closing times. Of the assaults studied, 19 per cent occurred in a venue serving alcohol and 27 per cent in the street, with many assaults spilling over from the drinking venues.

1.11 The Le Dain Commission observed that a strong connection between alcohol use and sex crimes such as rape and incest had been demonstrated in many studies. A 1972 Victorian study found that 67 per cent of convicted rapists in that State reported that they had been drinking moderately prior to committing the offence, 10 per cent said they had been drinking heavily and 10 per cent said they had been drunk. The Western Australian Task Force on Domestic Violence found that 42 per cent of domestic violence incidents involved alcohol and the Senate Standing Committee on Social Welfare reported a study conducted at the Royal Children's Hospital in Melbourne which found that one in five maltreated children had at least one parent suffering from alcoholism.[10]

1.12 The Senate Select Committee on Volatile Substance Fumes found that 61 deaths had been reported in Australia between 1974 and October 1985 which could be attributed to the sniffing of aerosols, glue and other solvents. The prevalence of abuse among children aged between 12 and 15 was a major reason for concern as was the risk of death and the danger of long term damage to the

health of users including liver and kidney damage, brain damage and damage to peripheral nerves. The Committee also found that petrol sniffing was widespread among Aboriginal communities, the majority of sniffers being aged between 10 and 18. Sniffers suffered from low weight and stunted growth, loss of memory and poor attention span. They might suffer permanent damage to the nervous system leading to tremor, slurred speech and a lack of co-ordination. The lead in petrol affected liver and kidney function, caused brain damage and damaged peripheral nerves. Disinhibition caused by petrol sniffing resulted in increased promiscuity with a consequent risk of the spread of sexually transmitted diseases. Petrol sniffing during pregnancy could also cause congenital birth defects and size abnormalities. Petrol sniffing caused an indeterminate number of deaths, most frequently as a result of accidents through misadventure or the circumstances of abuse.[11]

1.13 In its report 'Another Side to the Drug Debate...a medicated society?', the Senate Standing Committee on Social Welfare noted that besides being concerned about the use of alcohol and tobacco and the illegal drugs, the Australian community should also be concerned about its high usage of prescription and over-the-counter therapeutic drugs.[12] The 1983 Australian Health Survey found that two-thirds of its sample of 15,167 people had taken some medication in the two weeks prior to interview. Almost one-third had taken a common pain reliever and 9 per cent had taken cough medicines. Almost a quarter of the females aged 18-50 had taken birth control pills, 10 per cent of the sample had taken medication for heart or high blood pressure problems, 3.7 per cent had taken tranquillisers or sedatives and 3.6 per cent had taken sleeping pills.[13]

1.14 Data on patients presenting to hospital accident and emergency units as a result of poisoning by drugs, collected under the National Drug Poisonings Case Reporting System, indicates that the benzodiazepines (a group which includes the

most commonly prescribed minor tranquillisers such as Valium, Librium, Serepax, Mogadon and Rohypnol) alone accounted for 36.3 per cent of cases in 1985 and 37.4 per cent of cases in 1986. Together with sleeping pills, other tranquillisers or sedatives and anti-depressants they accounted for almost 60 per cent of poisonings in each year. Common pain killers (aspirin and paracetamol) accounted for 14.3 per cent of cases in 1985 and 13.5 per cent in 1986 while alcohol accounted for 17.3 per cent of cases in 1985 and 18.6 per cent in 1986. Petrol accounted for 3.3 per cent of cases in 1985 and 2.5 per cent in 1986 while the opiates (including legal opiates other than dextropropoxyphene) accounted for 3.2 per cent of cases in 1985 and 3.7 per cent in 1986. Cannabis accounted for 0.4 per cent of cases in both years and cocaine accounted for 0.06 per cent of cases in 1985 and 0.11 per cent of cases in 1986.[14] Clearly in terms of the implications for public health, the abuse of the therapeutic drugs causes far more problems than the abuse of the illegal drugs.

1.15 Since young people have been the focus of concern and campaigns against drug abuse it should also be noted that the relative dimensions of the public health problems posed by drugs do not change when one turns to their drug use. Over 30 per cent of teenagers drink and almost the same percentage smoke tobacco products. The nationwide survey referred to above found that only 5 per cent of those in the 14-18 year old age group had used cannabis in the last 12 months. The figures for heroin, cocaine and 'pills' were too low to have any meaning when broken down by age group but surveys of schoolchildren have consistently shown that use of these drugs is negligible in this age group. In the 15-24 year old age group (the break down used by the Australian Bureau of Statistics for causes of death) car accidents are the major cause of death, accounting for roughly 43 per cent of deaths in that age group in 1986 and alcohol is estimated to be a factor in roughly 40 per cent of all car accidents. As with adults, the benzodiazepines, other tranquillisers and sedatives, anti-depressants and sleeping pills account for over half of all

drug poisoning cases in the 15-24 year old age group. Common pain killers accounted for 18.2 per cent of poisonings in 1985 and 17.3 per cent in 1986 in the 15-24 year old age group and alcohol accounted for 16.8 per cent of poisonings in 1985 and 18.6 per cent in 1986. The opiates (including legal opiates) accounted for 5 per cent of poisonings in this age group in 1985 and 1986 and cannabis, cocaine and the amphetamines for 1.6 per cent of poisonings in 1985 and 1.3 per cent in 1986. Nevertheless, the illicit drugs are the focus of the bulk of our law enforcement efforts and they are therefore the focus of this inquiry.[15]

Conduct of the inquiry

1.16 Advertisements were placed in the national press on 18 June 1988 calling for submissions and the Chairman also wrote to persons and organisations within the field, including persons and organisations involved in the treatment and rehabilitation of drug dependent persons, seeking their views. In addition, the Chairman wrote to the State Premiers and the Chief Minister of the Northern Territory and the Commonwealth Ministers for Justice, Community Services and Health and Science, Customs and Small Business seeking their co-operation in the inquiry. In the event the States of Victoria and Tasmania declined to make submissions.

1.17 The Committee received 97 submissions and held public hearings in Melbourne, Brisbane, Perth, Adelaide, Canberra and Sydney. It also conducted an inspection of Customs procedures at the Sydney International Airport and Port Botany. The Committee expresses its thanks to all persons and organisations who made submissions and presented evidence to the inquiry. It particularly wishes to thank those experts in the field who gave freely of their time so that the Committee might be better informed in this complex area. The Committee owes a special debt of gratitude to Margaret Moore, Reina Hill, Margaret Yates, Diane Hawke, Robin Cammack and Maryann Henwood of the Parliamentary

Library who performed prodigies in getting together from all over Australia the books and articles on which the research which provides the basis of this report is founded. Lastly the Committee wishes to acknowledge the assistance of its own staff, the Secretary, Giles Short, the two Research Officers in the course of the inquiry, John Carter and Rosa Ferranda, and its indefatigable Steno-Secretary, Chris Migus.

1. Plant, A., Macaskill, P., Lo, S.K., and Pierce, J., Report of the Evaluation of the Anti-Heroin Campaign (NCADA, Canberra, 1988), p.11.
2. Senate Standing Committee on Social Welfare, Drug Problems in Australia - an Intoxicated Society? (Parliamentary Paper No.228/1977, A.G.P.S., Canberra, 1977), p.15.
3. Commonwealth Department of Community Services and Health, Statistics on Drug Abuse in Australia 1988 (A.G.P.S., Canberra, 1988), p.34.
4. Senate Standing Committee on Social Welfare, op.cit., pp.86-7, 95; Jaffe, J.H., 'Drug Addiction and Drug Abuse', in Goodman, A.G., Goodman, L.S., and Gilman, A., eds., The Pharmacological Basis of Therapeutics (6th ed., Macmillan, New York, 1980), pp.535-84 at pp.558-9.
5. Senate Standing Committee on Social Welfare, op.cit., pp. 49-51; Canada, Commission of Inquiry into the Non-Medical Use of Drugs (Chairman: G. Le Dain), Final Report (Information Canada, Ottawa, 1973), pp.396-400; Ritchie, J.M., 'The Aliphatic Alcohols', in Goodman and Gilman, op.cit., pp.376-90 at pp.380-1.
6. Commonwealth Department of Community Services and Health, op.cit., p.41.
7. Le Dain, op.cit., p.402.
8. Ibid., p.403.
9. Mason, G., and Wilson, P.R., 'Alcohol and Crime', Trends and Issues (Australian Institute of Criminology), no.18 (April 1989).
10. Senate Standing Committee on Social Welfare, op.cit., p.52; Mason and Wilson, loc.cit.; Le Dain, op.cit., p.403.
11. Senate Select Committee on Volatile Substance Fumes, Report (Parliamentary Paper No.497/1985, A.G.P.S., Canberra, 1985), pp.13, 37, 65, 148, 157, 184-9.
12. Senate Standing Committee on Social Welfare, Another Side to the Drug Debate...a medicated society? (Parliamentary Paper No.98/1981, A.G.P.S., Canberra, 1981), p.3.
13. Australian Bureau of Statistics, Australian Health Survey 1983, (Catalogue No.4311.0, A.G.P.S., Canberra, 1986).
14. Commonwealth Department of Community Services and Health, op.cit., pp.42-3.
15. Commonwealth Department of Community Services and Health, op.cit., pp.1-10, 43; Plant, et al., op.cit., pp.11, 15-16; Australian Bureau of Statistics, Causes of Death - Australia, 1986 (Catalogue No.3303.0, A.G.P.S., Canberra, 1988).

CHAPTER TWO

DRUG USE: FACTS AND MYTHS

Introduction

2.1 This chapter aims to survey very briefly the characteristics of the four main illegal drugs identified in the previous chapter - cannabis, heroin, cocaine and the amphetamines - and to dispel certain myths which surround the use of illegal drugs.

Cannabis

2.2 The indian hemp plant, Cannabis sativa, has been known for thousands of years for its psychoactive effects. These come from the resin found in the plant's flowering tops and leaves which contains as its principal active ingredient THC (delta-9-tetrahydrocannabinol). In this report 'cannabis' will be used as a generic term for all the products of the plant but it should be noted that these contain different quantities of THC. Marihuana, the dried leaves and flowering tops, typically contains 1 per cent THC. Hashish, the resin scraped from the plant and compressed into brown or black blocks, contains up to 10 per cent THC, while hashish oil, an extract prepared by the use of organic solvents, may contain as much as 60 per cent THC.[1]

2.3 Cannabis is usually smoked but may also be eaten. The main effects of the drug are mild euphoria, changes in perception (for example, heightened appreciation of sounds and colours) and an apparent slowing of the passage of time. Studies have demonstrated that cannabis impairs short-term memory and learning. Its use by school-age children is therefore a major

cause for concern. It also affects perception and psychomotor co-ordination, meaning that cannabis, like alcohol, should not be used before driving or operating machinery. Depending on the dose and the underlying psychological condition of the user, cannabis may cause panic reactions characterised by hallucinations, delusions and paranoia. Because the incidence of such reactions is higher in the younger age groups and among female users, some theorists have suggested that the phenomenon may be associated with inexperience of the effects of the drug. Panic reactions are usually limited to the acute stages of the action of the drug and medical intervention is normally unnecessary. However on some occasions the symptoms persist beyond the period of intoxication. These disturbances are referred to as cannabis psychoses. Anxiety reaching panic proportions replaces euphoria, often as a result of a feeling that the drug-induced state will never end. Thinking becomes confused and disorganised. Depersonalisation - a sense of strangeness and unreality about the self - and altered time sense are accentuated. Case reports suggest that cannabis may exacerbate pre-existing mental illnesses, in particular schizophrenia, and cannabis use by schizophrenia patients is correlated with a higher incidence of delusional activity and hallucinatory symptoms. Tolerance to the drug's effects develops readily, but this apparently does not lead to the use of ever increasing dosages of the drug. Mild physical withdrawal symptoms may be experienced but physical dependence does not appear to play any part in the persistent use of the drug.[2]

2.4 The acute toxicity of cannabis is low and a lethal overdose of cannabis has never been documented in humans. Concern has been expressed, however, about the long term effects of cannabis use. The preferred method of ingestion in this country is smoking, a technique which involves deep inhalation and the exposure of the lungs to the smoke. Prolonged heavy use of the drug causes chronic bronchitis and symptoms of airway obstruction similar to the changes produced by tobacco smoke. The tar produced by the burning of cannabis has been proved to be more carcinogenic in

animals than that produced by tobacco. Thus, although the average smoker of cannabis does not smoke as many cigarettes as the average smoker of tobacco, each lungful of cannabis smoke may be more damaging than a lungful of tobacco smoke. Epidemiological studies similar to those linking tobacco smoking to lung cancer have yet to be carried out, but it is probable that prolonged heavy smoking of cannabis will lead to cancer of the lungs and impairment of the pulmonary function.[3]

2.5 Cannabis produces increases in heart rate which pose risks for persons suffering cardiac problems. Animal studies suggest that long term use may cause brain damage and heavy use has also been linked to a condition known as the 'amotivational syndrome' characterised by a state of withdrawal, apathetic indifference, general mental and physical deterioration and social stagnation. Studies do not establish whether the use of the drug is a cause or a result of this condition: heavy use of cannabis in adolescence appears to be linked to a lack of personal and social competence and individuals predisposed to such use are also likely to be heavy users of alcohol and of other illegal drugs including analgesics, stimulants and tranquillisers. Cannabis may affect the body's immune response system, but the small degrees of impairment that are suggested by animal experiments mean that large scale epidemiological studies would be necessary to determine the significance of the effect.[4]

2.6 Cannabis affects sperm production in men to a small degree and animal studies have shown effects on male reproductive hormones and female ovulation. Cannabis readily crosses the placental barrier and one study has linked the use of the drug during pregnancy to growth retardation, low birth weight and features compatible with the foetal alcohol syndrome (i.e. mental retardation, growth deficiency and characteristic facial abnormalities). Maternal use of marihuana is usually accompanied by other risk behaviours such as the smoking of tobacco and the use of alcohol, but this study suggests that marihuana rather

than alcohol may be a causative factor in some babies suffering from the foetal alcohol syndrome. On the plus side, cannabis has proved to have some therapeutic potential as an anti-emetic for cancer patients undergoing chemotherapy and in relieving intra-oscular pressure in sufferers from glaucoma.[5]

Heroin

2.7 Heroin comes from the opium poppy, Papaver somniferum. Opium has been used medicinally to relieve pain and induce sleep since as early as 4000BC. It is obtained by incising the unripe seed capsule of the plant and allowing the milky juice to dry into a brown gummy mass which is scraped off by hand. 'Prepared' opium, used for smoking, is the produce of boiling down raw opium to leave a thick, sticky paste. The most potent alkaloid in opium, morphine, was isolated in 1803. It is widely used medicinally for the relief of severe pain. Heroin (diacetylmorphine), a semisynthetic opiate, was first isolated in England in 1874. However it was the Bayer pharmaceutical company, the inventor of aspirin, which realised that the addition of an acetyl molecule would make morphine more palatable and which in 1898 first marketed the compound as a cough suppressant under the trade name heroin.[6]

2.8 Heroin injected intravenously is converted into morphine in the bloodstream but heroin is roughly two and a half times more powerful than morphine on a per weight basis because it crosses the blood-brain barrier more readily. Whereas perhaps one two-thousandth of any morphine in the bloodstream reaches the brain, a fraction of heroin injected intravenously gets to the brain before it is converted into morphine, thus accounting for heroin's greater power. Careful double-blind studies have shown, however, that in equivalent dosages morphine and heroin are equally effective in relieving pain and improving mood.[7]

2.9 Heroin is the only opiate which is not allowed to be used medicinally in Australia. Another alkaloid in opium, codeine, is a common ingredient in non-prescription pain-killers and cough medicines, while synthetic opiates such as dextropropoxyphene (marketed in combination with paracetamol as Di-Gesic), pethidine (also called meperidine or Demerol), detramoramide (Palfium) and pentazocine (Fortral or Talvin) are all commonly used as analgesics in medical practice. Both here and overseas pethidine has replaced morphine as the most common drug of abuse among medical professionals. The synthetic opiate methadone (also called physeptone), originally used for its analgesic properties, is now employed as a substitute for heroin in facilitating opiate withdrawal and in the long term medical management of opiate dependence.

2.10 Heroin may be mixed with tobacco and smoked or it may be placed on a sheet of foil and heated by a flame, the resultant fumes being inhaled through a paper tube (a method of use known as 'chasing the dragon'). However the high cost of the drug (a consequence of its illegality) means that heavy users prefer to inject the drug intravenously, thus ensuring that they get the most effect from a limited quantity of the drug. Injecting heroin causes an immediate euphoric effect, the 'rush', caused by heroin bathing the brain before it has time to be diffused through the bloodstream and converted to morphine. After the rush comes the high, a warm, drowsy state lasting anything from 6 to 10 hours. Nausea is common, and vomiting may also occur. The opiates depress the respiratory centre, the part of the brain that controls breathing, so that respiration becomes shallow and higher doses cause increasing respiratory depression, unconsciousness and death. As with other opiates, users build up a tolerance to the effects of the drug and require increasing dosages to experience a high: whereas a dose of as little as 5mg injected intravenously may produce psychoactive effects in an individual who has not developed tolerance, a habitual user may require 100mg or more to achieve the same effects. Cessation of

use results in the user experiencing physical symptoms of withdrawal beginning with yawning, tears, a runny nose, cold sweats, dilation of the pupils, gooseflesh, restlessness, irritability and tremor. The symptoms reach their peak after 48 to 72 hours with the subject experiencing violent yawning and sneezing, nausea and vomiting, diarrhoea, abdominal cramps and muscle spasms and waves of gooseflesh which are popularly supposed to have given the experience the name of 'cold turkey'.[8]

2.11 An accidental overdose of heroin can cause death and one might expect such overdoses to be common, given that street heroin is always 'cut' or mixed with other substances and that the user therefore cannot tell the precise strength of the drug he or she is injecting. However, tolerance to heroin's toxic effects develops concurrently with tolerance to its other effects (unlike barbiturates, where tolerance to sedation develops far more rapidly than tolerance to toxicity, a fact which led in the past to many fatal overdoses). Given the strength of street heroin in this country - around 20 per cent pure heroin - accidental overdoses are therefore relatively unlikely except where special considerations apply: for example, where a heavy user has just been released from gaol and has not had a chance to establish his or her previous level of tolerance.

2.12 The precise cause of the majority of fatal reactions to heroin is thus not clear. Studies in North America have noted fatalities where it was possible to examine a sample of the substance injected and where no evidence was found of an unusual concentration of pure heroin. There have also been cases where the fatal reaction has been so sudden that the needle used has been found still in the user's arm or hand. This contrasts with the classic overdose where the subject lapses into a coma and death from respiratory failure follows only after several hours (and may be avoided if an opiate antagonist such as naloxone is administered). The anomalous cases have led to suggestions that the acute fatal reaction is due either to a contaminant in the

heroin or to the act of injection itself. However the contaminant identified as responsible in cases in New York, quinine, is not used to 'cut' heroin in Canada or Australia where similar acute fatal reactions have been observed and the intravenous injection of other drugs - for example amphetamines - has not given rise to similar acute fatal reactions. Attention has also been drawn to the fact that in the late 1960s British addicts, who had heroin of known strength prescribed for them by doctors, had a mortality rate equal to that of addicts in the United States. Other drugs were typically involved in the British fatalities and this aspect of the problem may be worth pursuing since habitual heroin users frequently use other drugs such as alcohol and barbiturates in combination with heroin.[9]

2.13 Although heroin users are traditionally characterised as 'nodding off' once they have taken their dose, the Committee has been informed that neither heroin nor methadone has more than a minimal effect on skills performance, including driving skills. The experience with heroin maintenance in England and methadone maintenance throughout the world has proved that good health and productive work are not incompatible with regular opiate use. It appears that long term heavy use of heroin causes little direct permanent physiological damage and no permanent changes in cognitive or intellectual functioning. There is no indication of psychosis or other major psychiatric complications arising from heroin use.

2.14 Heroin causes suppression of testosterone secretion and a reduction or cessation of menstruation and it may cause endocrinal damage. Use of heroin by pregnant women may result in obstetrical complications and babies born to mothers who are dependent on heroin may themselves be physically dependent. Such babies may also have low birth weights but it is unclear whether this is due to the heroin or to factors such as poor nutrition, inadequate hygiene and the use of other drugs, in particular tobacco, during pregnancy. Intravenous injection, the preferred

method of administration of heroin in this country, poses risks of damaged or collapsed veins, vein thromboses, embolisms (obstructions of the arteries), abscesses and permanent scarring ('track marks'). Addicts commonly suffer from endocarditis, an inflammation of the lining of the heart, septicaemia (blood poisoning), and hepatitis. Disorders such as these, tetanus and AIDS (acquired immune deficiency syndrome) are attributable to the sharing of needles and an inability to sterilise needles properly.[10]

Cocaine

2.15 The leaves of the coca bush, Erythroxylon coca, have been chewed for centuries by the Indians of the Andes to ward off fatigue and to reduce hunger. The principal active alkaloid in the leaves, cocaine, was isolated in 1858 and Sigmund Freud popularised its use in the treatment of morphine and alcohol dependence in the 1880s. It was also widely used at that time as a local anaesthetic and it remains in medical use today for that purpose in ear, nose and throat and eye operations. The leaves of the coca bush contain only 0.5-1.0 per cent cocaine and in order to extract the drug they are first treated with solvents to produce coca base, which may itself be smoked in a mixture with tobacco. Further chemical processing turns the base into cocaine hydrochloride, a fine white powder, in which form the drug may easily be smuggled. This is then 'cut' to 10-30 per cent purity for sale.

2.16 Cocaine is most commonly sniffed ('snorted') into the nose. It is rapidly absorbed through the nasal membranes, producing immediate effects. It may also be injected, either on its own or in combination with heroin, a practice known as 'speedballing'. Cocaine hydrochloride may also be reprocessed into pure cocaine and the resulting 'freebase' smoked through a small glass water pipe, a butane lighter being used to apply heat to the pipe's bowl, thus vaporising the freebase. The form of cocaine known as

'crack' which was the subject of some sensationalism in the media in 1986 is in fact simply a commercial form of freebase cocaine made by boiling down a mixture of cocaine hydrochloride, baking soda and water to create a paste that contains about 75 per cent cocaine. The paste hardens and is cut into chips referred to as 'rocks' which are smoked in glass pipes.

2.17 As with heroin, intravenous injection ensures that the user obtains the most effect from a given quantity of the drug but 'freebasing' may release 50-75 per cent of the drug's active content which is then absorbed by inhalation. Both methods of administration are more likely to give rise to habitual use than 'snorting' the drug because one of the important variables in determining the persistence of conditioned behaviour is the shortness of the time between the behaviour and its reward. In the case of both intravenous injection into the arm and inhalation of the fumes of the drug the time between injection or absorption of the drug into the lungs and the delivery of the drug to the brain by the bloodstream is about 7 seconds. When the drug is 'snorted' the same reaction takes several minutes.

2.18 Cocaine, unlike cannabis and heroin, is a stimulant. It produces a 'rush' or 'flash' of euphoria followed by a 'high' which may last 20 minutes to one hour. Users experience increased wakefulness and energy and become extremely self-confident in their physical and mental capabilities. The brief period of intense euphoria is followed by an equally intense 'crash' or 'down' phase as the effects of the drug wear off and feelings of depression, lethargy and misery induce a craving for readministration of the drug. Users may therefore consume a number of doses in a single session. Cocaine causes profound psychological dependence, most clearly demonstrated in animal studies. Given a choice between cocaine and food over a period of 8 days, monkeys consistently choose cocaine. There is no scientific agreement on the development of tolerance to the drug's effects. Cessation of use does not produce any physical

withdrawal symptoms akin to those experienced in withdrawal from heroin but it appears that the depression and insomnia experienced by cocaine users on ceasing use may have a biochemical and physiological basis.

2.19 Deaths attributable to cocaine are rare but because it increases heart rate and blood pressure it may cause cardiac arrest or a stroke. Long term heavy use may result in a toxic psychosis characterised by agitation, paranoia and delusions. A user may, for example, feel that small insects or worms ('coke bugs') are burrowing under his or her skin and may scratch the skin raw trying to eliminate them. Because cocaine constricts the blood vessels in the nose, long term 'snorting' of the drug carries the risk of perforation of the nasal septum. Intravenous injection is accompanied by the same dangers as those described above in relation to heroin. Cocaine may cause foetal abnormalities and babies born to cocaine dependent mothers suffer from the depression and insomnia associated with withdrawal as well as other complications.[11]

Amphetamines

2.20 The amphetamines are synthetic stimulants which are in some ways similar to the body's own adrenalin. Their pharmacological effects are remarkably similar to cocaine. First synthesised in the latter part of the nineteenth century, they were introduced into medicine in the 1930s and were widely used during the Second World War to combat fatigue. In the post-war period they continued to be used by students and truck-drivers who wished to remain awake over long periods of time and they were used in medicine in the treatment of depression and obesity. At present their use in medicine is confined to the treatment of narcolepsy (uncontrolled fits of sleep) and certain kinds of over activity in children. The main members of the group are amphetamine (Benzedrine), dexamphetamine (Dexedrine) and methamphetamine (Methedrine). Chemical variations of the amphetamine molecule

have resulted in drug analogues which mimic the action of the naturally occurring hallucinogen mescaline while retaining the strong stimulant properties of the amphetamines. The most prominent of these analogues are MDA (3,4-methylenedioxy-amphetamine) and MDMA (3,4-methylenedioxymethamphetamine), the latter being marketed at present in Australia under the name 'Ecstasy'.

2.21 Amphetamines are usually taken orally in pill form, but there have been occasional epidemics of intravenous use. Injection is said to produce an intense 'flash' of exhilaration while a single oral dose of amphetamine may stimulate the body for at least four hours. Users experience euphoria, a sense of markedly enhanced physical strength and mental capacity and feel little need for either sleep or food. As the drug wears off, unpleasant feelings of fatigue and depression replace this euphoria, inducing a craving for readministration. As with cocaine, use of the amphetamines, particularly by intravenous injection, is characterised by 'runs' during which a user may inject at intervals of 2-3 hours over a period of 12-18 hours. After such a 'run', deep sleep follows and upon awakening users are lethargic and depressed. The lethargy may persist until a new cycle of drug use is initiated.

2.22 Because tolerance develops rapidly, acute intoxication (which may result in death) is only found in novice users. The syndrome includes dizziness, tremor, hallucinations, chest pain, sweating and cardiac arrhythmia. Similar effects have been observed with 'ecstasy' in this country and it is possible in any case that methamphetamine is being passed off as MDMA. High doses of the amphetamines, particularly if injected intravenously, lead to violent paranoia, hallucinations and bizarre stereotyped behaviour such as disassembling and reassembling the same object time after time. As with cocaine, hallucinations include itching and creeping sensations under the skin thought to be caused by imaginary insects or parasites. Scratching or digging at these

'crank bugs' may become so intense as to produce bleeding sores and permanent scars. Intravenous users or 'speed freaks' are notorious for developing feelings of suspicion and hostility, even towards friends. They suffer from malnutrition and disorders associated with intravenous injection in unhygienic conditions (as do heroin addicts). Dependence is psychological rather than physical, and the long term physical effects of amphetamine use appear to relate more to the chaotic lifestyle of users than to the properties of the drug itself.[12]

Addiction

2.23 Despite the common suggestion that a novice user will be induced to try an illicit drug by a stranger or 'pusher', a user's first experience is likely to be in the company of friends. Whereas we are typically initiated in the use of alcohol by our parents, other drugs, beginning with tobacco, are usually first experienced with our peers. Cannabis, cocaine and the amphetamines are likely to be shared first in a social context. Heroin is likely to be tried first in the company of a relative or friend who is already a user. Heroin spreads in this way through a friendship network rather than through the agency of a 'pusher'. This is not to deny that many heroin addicts in particular support their habits through dealing in the drug but Dobinson and Poletti's study of user-dealers in Sydney suggests that they are reluctant to sell to people who are not known to them or introduced by people who are known to them.[13]

2.24 One of the most durable of the many myths associated with drug use is the idea that, having once tried an illegal drug, whether it be cannabis, heroin, cocaine or the amphetamines, 'addiction' is inevitable. In fact repeated use is necessary to establish dependence. In the case of heroin, for example, daily use over a period of two weeks is usually necessary before physical withdrawal symptoms will be experienced on the cessation of use. Moreover many people cease to use a drug after trying it

only a few times. As with people's first experience of smoking tobacco, initial impressions of illegal drugs may not be favourable. Beginner cannabis users often do not experience a 'high' on the first few occasions and many heroin users report that their initial use of the drug was actually unpleasant. Rather than being 'hooked' by a 'pusher', therefore, the novice user may have to overcome significant deterrents to persist with use.[14]

2.25 Part of the problem with the traditional picture of an inevitable downward slide into addiction lies in the term 'addiction' itself. It usually carries with it the notion of compulsion: the addict is said to experience an overpowering need for the drug even though he or she may also express a desire to stop using it. However, even where abstinence may bring about painful physical symptoms of withdrawal, as is the case with heroin, it is clear that many addicts can and do voluntarily cease to use the drug. Dobinson and Ward's study of persons seeking treatment for drug dependence in New South Wales, for example, showed that 60 per cent of those studied had abstained from heroin use for periods greater than one month in the course of their using careers. The most common reason given was that they were fed up with the lifestyle. Withdrawal may be accomplished without medical help or users may enrol in detoxification or methadone programmes, claiming an intention to give up the drug permanently.[15]

2.26 If addiction is not a continuous state, neither is it permanent. While staying off drugs is undoubtedly difficult, particularly if the underlying factors which caused the individual to use drugs remain unchanged, there is growing evidence that many heroin addicts, for example, either give up heroin at an early age after a relatively brief period of addiction or 'mature out' of their addiction between the ages of 35 and 45 after longer using careers. The description of addiction in terms of a compulsion or a need for the drug which

overpowers the individual's better judgment is thus perhaps misleading. It may be better to follow Krivanek who defines addiction as 'a behavioural pattern characterised by an ongoing and overwhelming preoccupation with the use of the drug and the securing of its supply'. It is suggested that this definition accurately identifies the self-destructive pattern of behaviour which has given rise to social concern about drug addiction.[16]

2.27 Looked at in these terms it is clear that the majority of users of illegal drugs do not become addicted at all. This is particularly true of cannabis, cocaine and the amphetamines where the incidence of those for whom the drug becomes a preoccupation at the expense of other aspects of their lives appears to be extremely small. However, even in the case of heroin - so firmly associated in the public mind with the image of the hopeless junkie - studies point to a large population of occasional or social users. One study of a cross-section of males in the United States, for example, showed that of those who had ever used heroin only one-third had used the drug daily for any period.[17]

2.28 A number of explanations have been put forward to explain why the image of the typical heroin user has been that of the addict. First, most studies of heroin use until recently drew their samples from the gaols and treatment centres and those samples were therefore biased towards addicts. Secondly, addicts are the most visible users of heroin whereas occasional users go to some lengths to conceal their use of the drug, particularly if they are employed and they consider that their employer or their fellow workers would not accept their heroin use. Thirdly, as heroin use has grown, so the population of heroin users has come more closely to resemble the general population. Thus, when heroin use was first emerging as a social problem users were likely to be drawn from already established deviant subcultures and addiction was inherently more likely. As the use of the drug spread, so the percentage of occasional or social users was likely to grow. Finally, it can be argued that as the use of a

drug becomes better established in a society, rules for controlled use develop. Such rules already exist in respect of alcohol use, for example, and they operate to promote moderation. Thus it is a general rule not to drink alone and not to drink in the mornings. Similar informal rules are said to have been developed by controlled users of heroin.[18]

<u>Drug, set and setting</u>

2.29 There are two further notions which have exercised a baleful influence in deliberations on drug use. For over a hundred years it has been common to personify drugs as independent agents of demonic possession, enslaving the users' minds and bodies. It is common today to speak of a drug plague or a drug epidemic as if drugs were agents of disease and one could catch addiction like the common cold. In fact one has to take drugs and - apart from exceptional cases such as those where addiction to opiates has arisen out of medical treatment - users are aware of what they are taking, of the potential for addiction and of some of the other dangers involved. Not only are they not deterred by these dangers but in some circles the dangers involved may actually add to the status acquired by taking the drug.

2.30 The desire to provide a scientific basis for the treatment of addicts as victims rather than as criminals deserving punishment led to the development of the notion of the addictive personality. Certain individuals, it was argued, were, through their genetic make-up, upbringing or other personality factors, predisposed to become addicted to drugs. However exhaustive studies of users have failed to show any correlation between factors such as broken homes and exposure to abuse as a child and addiction. Moreover it would be difficult to explain the upsurge in heroin addiction in the developed countries in terms of an upsurge in the incidence of addictive personalities.

2.31 Experts today are generally agreed that drug use can only be explained in terms of the interaction of the drug (the pharmacological action of the substance itself), 'set' (the attitude of the person at the time of use, including his or her personality), and 'setting' (the influence of the physical and social setting in which the use occurs). Thus the effect of a drug is not a pharmacological constant: a drug injected in a hospital may have different effects from a drug injected in the streets because of the user's expectations and the setting of use. By way of example Kaplan instances an early study of the euphoric properties of marihuana which was based on experiments performed in the cadaver room of a hospital. Not unnaturally the effects were nothing like those experienced by users in more amenable surroundings.[19]

2.32 The classic example of the effect of setting is the spread of heroin addiction among United States soldiers in Vietnam. Current estimates suggest that at least 35 per cent tried heroin in Vietnam and 54 per cent of those who did became addicted. In-country treatment programmes were unsuccessful: recidivism rates as high as 90 per cent were reported. On return to the United States, however, only 7 per cent continued to use heroin and only about 2 per cent remained addicted. One factor in the prevalence of heroin use in Vietnam was clearly the ready availability of the drug: Robins found that 85 per cent of the veterans had been offered heroin and that it was relatively inexpensive. Smoking was an economical and effective method of use. By contrast, back in the United States the drug was difficult to obtain and expensive and therefore smoking was impractical as a method of use. Zinberg argues, however, that ready availability alone will not explain the prevalence of addiction and that this must be attributed to the interaction of factors personal to the soldiers with the 'abhorrent social setting' of Vietnam.[20]

<u>Conclusion</u>

2.33 The Committee has not attempted to develop some general theory to explain the prevalence of the use of the illict drugs in our society. However it should be observed that it is helpful if we think of the use of these drugs in the same terms as we think of those drugs which we ourselves use, such as alcohol and tobacco, rather than as something entirely foreign to our experience. The reasons given by the occasional or 'controlled' heroin users in Zinberg's study for their drug use - to enjoy the 'high', to socialise, for recreation and for relaxation - are not dissimilar to the reasons most of us would give for social drinking.[21] Habitual users of heroin speak of having to inject just to feel normal, an experience that will be familiar to those of us who do not feel normal until we have had our first cigarette for the day.[22] This is not to belittle the vast differences in effect between these drugs but rather to attempt to make the phenomenon of drug use intelligible. We are a drug using society and the use of the illegal drugs is merely a part of this behaviour.

1. Royal Commission of Inquiry Into Drugs (Commissioner: The Hon. Mr Justice E.S. Williams), Report (A.G.P.S., Canberra, 1980), p.A63; Polich, J.M., Ellickson, P.L., Reuter, P., and Kahan, J.P., Strategies for Controlling Adolescent Drug Use (Rand Corporation, Santa Monica, 1984), p.14.
2. Ibid., p.15; Relman, A.S., 'Marijuana and Health', in The New England Journal of Medicine, vol.306, no.10 (11 March 1982), pp.603-4; Submission from Dr G.B. Chesher, Appendix, pp.1-2; Nahas, G.G., 'Cannabis: toxicological properties and epidemiological aspects', in The Medical Journal of Australia, vol.145 (21 July 1986), pp.82-7 at pp.82-3; Jaffe, J.H., 'Drug Addiction and Drug Abuse', in Goodman, A.G., Goodman, L.S., and Gilman, A., eds., The Pharmacological Basis of Therapeutics (6th ed., Macmillan, New York, 1980), pp.535-84 at p.561.
3. Relman, loc.cit., p.604; Nahas, loc.cit., pp.82-3; Submission from Dr. G.B. Chesher, Appendix, p.4; Evidence, Dr. S.K. Mugford, p.752; Tashkin, D.P., 'Marijuana '87: Summary of the Session on Pulmonary Effects', in Chesher, G., Consroe, P., and Musty, R., Marijuana : An International Research Report (Proceedings of the Melbourne Symposium on Cannabis, 2-4 September 1987, Commonwealth Department of Community Services and Health, NCADA Monograph Series No.7, A.G.P.S., Canberra, 1988), pp.49-52.
4. Polich et al., op.cit., p.16; Relman, loc.cit., p.604; Nahas, loc.cit., pp.83-4; Johnson, V., 'A Longtitudinal Assessment of Predominant Patterns of Drug Use Among Adolescents and Young Adults', in Chesher, Consroe and Musty, op.cit., pp.173-82; Pandina, R.J., Labouvie, E.W., Johnson, V., and White, H.R., 'The Impact of Prolonged Marijuana Use on Personal and Social Competence in Adolescence' in Chesher, Consroe and Musty, op.cit., pp.183-200; Musty, R.E., 'Summary of the Session on Behavioural and Mental Effects', in Chesher, Consroe and Musty, op.cit., pp.237-41; Submission from Dr. G.B. Chesher, Appendix, pp.3-5. For the function of cannabis as a *'gateway' drug, see paragraph* 5.14 below.
5. Polich et al., op.cit., p.16; Relman, loc.cit., p.604; Nahas, loc.cit., pp.83-4; Submission from Dr. G.B. Chesher, Appendix, pp.3-4; Jaffe, loc.cit., p.563.
6. Davies, S., Shooting Up (Hale & Iremonger, Sydney, 1986), pp.31-2; Musto, D.F., 'The History of Legislative Control Over Opium, Cocaine and Their Derivatives', in Hamowy, R., Dealing With Drugs - Consequences of Government Control (Lexington Books, Lexington, 1987), pp.37-71 at p.59.
7. Jaffe, J.H., loc.cit., p.545; Kaplan, J., The Hardest Drug - *Heroin and Public Policy* (U. Chicago Press, 1983), p.6.
8. Jaffe, J.H., and Martin, W.R., 'Opioid Analgesics and Antagonists', in Goodman and Gilman, op.cit., pp.494-534 at pp.499, 505; Jaffe, loc.cit., pp.545-8; Polich et al., pp.10-11; Kaplan, op.cit., pp. 10, 19, 22-3; Bucknell, P., and Ghodse, H., Misuse of Drugs (Waterlow, London, 1986), pp.32-4.
9. Kaplan, op.cit., p. 130; Canada, Commission of Inquiry into the Non-Medical Use of Drugs (Chairman: G. Le Dain), Final Report (Information Canada, Ottawa, 1973), pp.313-5; Submission from Dr G.B. Chesher, p.3; Submission from Dr D.A. Pocock, p.3.

10. Jaffe, loc.cit., pp.545-6; Evidence, Dr G.B. Chesher, p.1371; Submission from Dr G.B. Chesher, p.4; Kaplan, op.cit., pp.127-9; Le Dain, op.cit., pp.308-10; Klenka, H.M., 'Babies born in a district general hospital to mothers taking heroin', in British Medical Journal, vol.293 (20 September 1986), pp.745-6; Stimson, G.V., and Oppenheimer, E., Heroin Addiction - Treatment and Control in Britain (Tavistock, London, 1982), p.4; Submission from the Rev. Dr. J.K. Williams, pp.10-11.
11. Polich et al., op.cit., pp.11-13; Williams, op.cit., pp.A45-6; Le Dain, op.cit., pp.348-53; Bucknell and Ghodse, op.cit., pp.38-9; Jaffe, loc.cit., pp.555-7; Collins, E., Hardwick, R.J., and Jeffrey, H., 'Perinatal cocaine intoxication', in The Medical Journal of Australia, vol.150 (20 March 1989), pp.331-4; Submission from the Commonwealth Attorney-General's Department and the Department of Community Services and Health, p.12; Evidence, New South Wales Department of Health, pp.914-8, 927-8.
12. Le Dain, op.cit., pp.334-47; Jaffe, loc.cit., pp.553-7; Polich et al., op.cit., pp.20-21; Weil, A., and Rosen, W., Chocolate to Morphine: Understanding Mind-Active Drugs (Houghton-Mifflin, Boston, 1983), pp.47, 107-8; Evidence, New South Wales Department of Health, pp.940-1.
13. Kaplan, op.cit., pp.27-8; Pearson, G., Gilman, M., and McIver, S., Young People and Heroin (Gower, Aldershot, 1987), p.38; Zinberg, N., Drug, Set and Setting (Yale U.P., New Haven, 1984), pp.9-10, 16-17; Dobinson, I., and Poletti, P., Buying and Selling Heroin (New South Wales Bureau of Crime Statistics and Research, Sydney, 1989), pp.69-72, 101-2.
14. Jaffe, loc.cit., p.539; Kaplan, op.cit., pp.27-9; Pearson et al., op.cit., pp.35-7.
15. Kaplan, op.cit., p.34-5; Dobinson, I., and Ward, P., Drugs and Crime - Phase II (N.S.W. Bureau of Crime Statistics and Research, Sydney, 1987), pp.41-2; Evidence, South Australian Government, pp.392-4; Dr. S.K. Mugford, p.750.
16. Kaplan, op.cit., pp.36-8; Robins, L.N., Helzer, J.E., and Davis, D.H., 'Narcotic Use in Southeast Asia and Afterward', in Archives of General Psychiatry, vol.32 (August, 1975), pp.955-961; Waldorf, D., 'Natural Recovery from Opiate Addiction: Some Social-Psychological Processes of Untreated Recovery', in Journal of Drug Issues, Spring 1983, pp.237-77; Stimson and Oppenheimer, op.cit., pp.155-6, 161-7; Krivanek, J.A., Drug Problems, People Problems (Allen & Unwin, Sydney 1982), pp.83-5, 87.
17. Kaplan, op.cit., pp.33-4; Zinberg, op.cit., passim; Evidence, Fitzroy Legal Service, pp.90-91; South Australian Government, pp.384-5; Dr S.K. Mugford, pp.744, 760; Mr I. Dobinson, p.1164.
18. Zinberg, op.cit., pp.5-10, 80, 153-5.
19. Pearson et al., op.cit., pp.9, 38, 59; Krivanek, op.cit., p.90; Bakalar, J.B., and Grinspoon, L., Drug Control in a Free Society (Cambridge U.P., 1984), p.43; Zinberg, op.cit., p.5; Kaplan, op.cit., pp.11-12; Submission from the Royal Australian and New Zealand College of Psychiatrists, pp.3-4.
20. Zinberg, op.cit., pp.12-13; Submission from Dr G.B. Chesher, p.8; Evidence, Dr A. Wodak, pp.1040-1; Robins, L.N., Davis, D.H. and Goodwin, D.W., 'Drug Use By U.S. Army Enlisted Men in Vietnam: A Follow-Up On Their Return Home', in American Journal of Epidemiology, vol.99, no.4 (April 1974), pp.235-49.
21. Zinberg, op.cit., pp.76-7.

22. Stewart, T., 'The battle to be normal', in New Statesman, vol.114 (2 October 1987), pp.20-21.

CHAPTER THREE

THE SCOPE AND NATURE OF THE DRUG TRADE

Introduction

3.1 Eighteen years ago, in May 1971, the Senate Select Committee on Drug Trafficking and Drug Abuse recommended:

> 'that urgent action should be taken by the Commonwealth Department of Health with the co-operation of State Departments of Health, to organise, survey and assemble statistics on all forms of drug abuse on a uniform basis throughout Australia and that such information be made available freely to research and other interested organisations.'[1]

3.2 In December 1979 the Australian Royal Commission of Inquiry into Drugs again drew attention to the lack of reliable statistical information on drug-related matters and stated that the decisions of policy making agencies in the field had suffered because of this. The Commonwealth Department of Health in its initial submission to the Royal Commission commented that the extent of illegal drug use in Australia was difficult to gauge due to the lack of comprehensive and uniform statistics and that:

> 'it is difficult to compare study findings and reach any conclusions other than those of a general nature, i.e. drug use is increasing and illicit drug use is commencing at a younger age.'[2]

3.3 The Royal Commission recommended the establishment of a network of Drug Information Centres charged with collecting, collating and disseminating all drug-related information with the exception of criminal intelligence. The only immediate result, however, was that publication of a statistical survey, 'Drug

Abuse in Australia', compiled by the Commonwealth Police and subsequently by the Australian Federal Police, was discontinued because the Royal Commission had found the Drug Intelligence Reports submitted by State police which formed the basis of the survey to be both incomplete and unreliable.

3.4 The National Campaign Against Drug Abuse (NCADA) initiated by the April 1985 'Drug Summit' Conference placed new impetus behind the Royal Commission's proposals. A National Drug Abuse Data System is being developed by the National Drug Abuse Information Centre located in the Commonwealth Department of Community Services and Health and an Australian Drug Data Base (Law Enforcement Component) is to be developed under the control of the Australian Bureau of Criminal Intelligence. It is expected that the latter system will be fully operational in January 1990. Once these systems are up and running it should be possible to obtain a clearer picture of the size of the drug trade. In the meanwhile the Committee has attempted to make some estimates of its own on the basis of the available data.

Cannabis

3.5 In the United States, estimates of the numbers of users of cannabis, cocaine and stimulants (including the amphetamines) are arrived at on the basis of national household surveys of drug use commissioned by the National Institute on Drug Abuse. (The number of heroin users is too small to yield a reliable estimate on the basis of national surveys). Combining these estimates with data on frequency of use and the quantity consumed per session enables one to make very rough estimates of total annual consumption. In Australia NCADA has commissioned two national surveys, in 1985 and 1988. The first of these, carried out by Reark Research, asked only whether persons had 'ever tried' particular drugs. Such a survey does not enable one to identify current users or to make estimates of frequency of use. The second, carried out by Australian Market Research, also asked

questions on use within the last 12 months and frequency of use. Of a sample of 1826 persons over the age of 14 (weighted sample 1830), 11.9 per cent said that they had used 'marihuana/hash' within the last 12 months.[3] Although the percentages for frequency of use obtained by this survey and the Roy Morgan Research Community Prevalence Survey, dealt with below, are similar, the total percentage of those who had used within the last 12 months obtained by Australian Market Research is almost double that obtained in the Roy Morgan Research survey (11.9 per cent as against 6.2 per cent). Because of the larger sample size of the Roy Morgan Research survey (3,594 persons as against 1,826) the Committee has used it in preference to the Australian Market Research survey.

3.6 Two surveys were conducted by Roy Morgan Research for the purpose of the evaluation of NCADA's anti-heroin campaign. The first of these is referred to as the Community Prevalence Survey. A total of 3,594 persons over the age of 14 were interviewed about drug use in the last 12 months. As noted above, 6.2 per cent of the sample reported that they had 'smoked marihuana, grass, hash, pot' during the last 12 months. This suggests a population of roughly 780,000 users. The second survey, referred to as the Illicit Drug Users Survey, was undertaken to establish baseline data about people considered to be most at risk of using heroin. The survey interviewed only persons aged 15-30 years who admitted using one or more of the illegal drugs during the last 12 months. The survey covered 841 persons, 98.5 per cent of whom had used marihuana at some time. Most of the sample were able to recall the last two occasions on which they had used marihuana and, of those, roughly 29 per cent used the drug more than once a week, 12 per cent once a week, 10 per cent once a fortnight, 25 per cent once in three months, 12 per cent once in six months and 12 per cent once in nine months.[4]

3.7 The level of use reported in this survey is very similar to the estimate of roughly 400,000 Australians using cannabis at

least once a month adopted by the Senate Standing Committee on Social Welfare in 1977. The frequency of use reported is, however, somewhat higher than that recorded in the Sackville Royal Commission's survey, 'Drug Use in Adelaide 1978', where only 39 per cent of cannabis users aged between 13 and 34 reported using the drug in the past month as against roughly half the users in the current survey.[5] For the purpose of hazarding a guess at the total annual consumption of cannabis it is the 226,000 persons who use the drug more than once a week who matter. Assuming that they use on average 10 grams of cannabis a week one arrives at an annual consumption of cannabis of around 120,000 kilograms. At street prices of $450 an ounce this would mean an annual turnover of $1,905 million.

3.8 It should be noted that neither the Community Prevalence Survey nor the Illicit Drug Users Survey asked questions about cannabis use as such, asking instead whether persons had smoked 'marihuana, grass, hash, pot', so that it is unclear whether the figures obtained include cannabis resin (hashish) or cannabis oil. As these products are more potent than marihuana their inclusion would most likely reduce the overall estimate of the size of the trade by weight, but ideally the three products should probably be considered as separate drugs, each with their own market. Likewise no distinction was made between local and imported products, the latter therefore comprising an indeterminate part of the total arrived at. However, given the proportions of plantations destroyed to seizures of imported products and the obvious effect of the destruction of plantations on the supply and price of cannabis in the marketplace it would not seem unreasonable to attribute 90 per cent of the total - that is, 108,000 kilograms - to domestic production.

3.9 With all its imperfections the estimate suggests that law enforcement agencies have in fact been far more successful in making seizures of cannabis than they have been given credit for. A total of 122,929 cannabis plants were destroyed in 1987,[6] which

- adopting the Woodward Royal Commission's estimate that each plant produces about half a kilogram of marihuana - would amount to seizures of over 60,000 kilograms of cannabis. Seizures by Federal agencies, which mainly relate to importations, may also be exceeding the 10 per cent rule of thumb for seizures used by the Williams Royal Commission. What this suggests is that the market is quite tight and that the destruction of big cannabis plantations such as the 73,000 plants destroyed by the New South Wales Police in Operations Banana and Banana Split in the Coffs Harbour and Kempsey areas in November-December 1987 and January 1988 or the 127,000 plants destroyed by the New South Wales Police in Operation Dutchman in the Mudgee area in February 1989 really may be capable of creating temporary cannabis droughts as has been claimed by users' groups. It should be emphasised, however, that the estimate is one of overall consumption, not production, and that major producers presumably allow for the possibility of seizures in attempting to meet the demands of the market.

3.10 If there is little reliable statistical material on the size of the trade at the present time, there is still less showing trends over time. The most obvious measure would be general population surveys of drug use, but there have been few of these and they have not always asked the same questions. Table 1 below summarises the results of the available general population surveys in respect of cannabis use. Because experimentation with cannabis is concentrated in the population under the age of 30, there has been a steady increase in the numbers of those who have ever used cannabis as more and more young Australians have had the opportunity to try the drug. Table 2 breaks down the figures by age groups. Although there are problems of comparability, the results in the two NCADA surveys suggest that experimentation with cannabis is occurring at an earlier age than it was ten years ago. However the underlying rate of current use would appear to have remained broadly the same, a conclusion borne out by the New South Wales surveys of

TABLE 1 - CANNABIS USE				Percentage
Date	Author	Sample Population	Ever Used	Used in Past Year
1971	George	639 persons, 14-65, Manly, N.S.W.	8.9	4.0
1973	George	1011 persons, 14-65, Western suburbs of Sydney	5.5	2.4
1974	Carrington-Smith	500 women, 18-60, Hobart	4.0	2.6
1977	Roy Morgan	2207 persons, 14 and over	12.0	8.0
1978	Sackville R.C.	2928 persons, 13-60, Adelaide	15.0	9.0
1978	The Age	1702 persons, 18 and over, Melbourne	17.0	5.0
1985	NCADA	2796 persons, 14 and over	28.0	-
1988	NCADA	1830 persons, 14 and over	28.0	11.9
1988	Roy Morgan	3594 persons, 14 and over	-	6.2

TABLE 2 - CANNABIS USE BY AGE GROUP

Date	Author	Percentage Use by Age Group - Ever Used			
		(14-19)		(20-29)	(30 +)
1977	Roy Morgan	19		29	9
		(13-17)	(18-24)	(25-34)	(35-60)
1978	Sackville R.C.	13	36	18	4
		(14-19)		(20-39)	(40 +)
1985	NCADA	30		48	8
1988	NCADA	29		49	9

Date	Author	Percentage Use by Age Group - Used in Past Year			
		(13-17)	(18-24)	(25-34)	(35-60)
1978	Sackville R.C.	11	25	9	2
		(14-29)		(30 +)	
1988	Roy Morgan	12.6		3.1	

TABLE 3 - WEEKLY USE OF CANNABIS, YEAR 10 STUDENTS, N.S.W.

Year	1971	1973	1977	1980	1983	1986
Sample Size	3,300	3,369	492	395	755	1,216
Percentage	2	4	8	6	12	9

weekly drug use by Year 10 students (aged 15-16 years), set out in Table 3.[7]

3.11 No detailed studies appear to have been made of the nature of the trade in cannabis. The size and sophistication of the plantations which have been destroyed in the past year or so suggest that the bulk of Australian production is in the hands of a small number of relatively well capitalised growers. Elaborate irrigation and security systems are being employed although the most technically sophisticated plantation which has come to light in recent years was actually a small 15 square metre plot discovered by South Australian police in 1985 which was concealed underground beneath a concrete tennis court. Smaller plantations and home-grown marihuana continue to co-exist with these larger operations and will continue to do so, particularly given the vulnerability of the latter to police action.

3.12 While there continue to be numerous instances of importation of hashish and hashish oil by passengers on commercial flights, either couriers or free agents, concealing the substance in their luggage or on or in their persons, there appear to be increasing numbers of importations of a tonne or more of marihuana or hashish using small ocean-going yachts. Like the more sophisticated plantations, such importations require considerable capital and a greater degree of organisation to move the product once landed without attracting undue attention. Both Australian grown marihuana and imported cannabis products are distributed through networks of dealers in a somewhat similar fashion to fruit and vegetable produce, value being added at each level as the product is broken down into smaller units for resale until it reaches the end user. There is no suggestion that these distribution networks are organised in the sense that an importer or grower controls the network right down to point of sale. Large growers and importers must, however, control the initial distribution, usually in a capital city, of their products. Small

growers and freelance importers may sell directly to friends or persons introduced to them by friends.[8]

Heroin

3.13 National surveys are of no use in identifying the number of heroin users because such users constitute a very small percentage of the population at large. In the United States the National Narcotics Intelligence Consumers Committee relies on estimates of 'active addicts' in major cities made by the National Institute on Drug Abuse in order to arrive at its estimates of annual heroin consumption. In Australia various attempts have been made to estimate numbers of addicts but the number of occasional or social users remains obscure. The Illicit Drug Users Survey may, however, provide some assistance. For these purposes it can essentially be regarded as a survey of heroin use among marihuana users aged 15-30 years. Of the sample of 841 persons, 4.5 per cent had used heroin in the last 12 months. Using the figures for marihuana users derived from the Community Prevalence Survey this would suggest a population of 23,200 heroin users between 15 and 30 or approximately 33,600 heroin users in the population overall. Of those who had ever tried heroin who reported the timing of the last two occasions on which they used the drug, less than 10 per cent had used the drug more than once a month.[9]

3.14 The authors of the study suggest that this almost certainly underestimates the number of frequent users of heroin: because of the nature of frequent use and the need to finance their habits such persons are less likely to be at home and available for surveys of this nature.[10] Nevertheless, the very low figure of frequent users which would result from this analysis - in the order of 3,360 Australia-wide - should not be rejected simply because it does not match our expectations. Those expectations are based for the most part on 'guesstimates' like the figure of 10,000 regular heroin users in New South Wales which attained

some currency in that State in the late 1970s. The Williams Royal Commission stated that:

> 'Using seizure data together with other evidence which included data on mean dosage rates and purity, the Commission estimated that in 1978 there may have been between 14,200 and 20,300 hard core heroin addicts in Australia.'[11]

3.15 It appears that this figure was derived from the Commission's estimate of annual heroin importations as 900-1300 kilograms at 80 per cent purity taken together with a New South Wales Police estimate that addicts on average used 1 gram of street heroin (at 20 per cent purity) a day and a statement by the United States Drug Enforcement Administration that addicts on average consumed heroin for only 70 per cent of the year. Nowhere, however, did the Commission indicate how it arrived at the figure of 900-1300 kilograms. It certainly was not derived from the application of the Commission's rule of thumb that law enforcement agencies detected only 10-15 per cent of importations since heroin seizures in 1978 amounted to only 18 kilograms.[12]

3.16 In March 1988 the National Drug Abuse Information Centre (NDAIC) published a statistical update stating that it could be conservatively estimated that Australia had some 30,000 to 50,000 'frequent, regular dependent heroin users' and at least 60,000 'irregular, "recreational", non-dependent heroin users'.[13] This astonishing estimate was distilled from five other estimates using differing methodologies:

(1) The estimate of 14,200-20,300 'hard core heroin addicts' made by the Williams Royal Commission and referred to above.

(2) The estimate of 10,000 dependent heroin users in New South Wales, also referred to above, which is apparently still being used by the health authorities

in that State and which NDAIC suggested indicated a national total of 30,000.

(3) The fact that Australia had 249 opiate related deaths in 1986 which, multiplied by 100 or 200, would give an estimate of 25,000 to 50,000 regular heroin users. This so-called 'overdose multiplier' method was originally advanced by Dr M. Baden, the Deputy Medical Examiner of New York City. It is based on an untested assumption that the number of opiate related deaths bears some direct relationship to the number of regular users. In a report for the NSW Drug and Alcohol Authority on 'Methods of Estimating the Number of Heroin Users in New South Wales', Dr R.L. Sandland, a Consultant Statistician with Siromath Pty Ltd, stated that 'bluntly, it is difficult to take this method seriously'.[14] At best drug-related deaths may provide some indication of broad trends in drug use.

(4) A national household survey conducted by the Department of Health and the National Advisory Council on AIDS in 1986-87 in which 1.8 per cent of the sample of 1511 people aged between 16 and 60 years stated that they had injected themselves with illegal drugs in the past 12 months. According to NDAIC, this would represent 172,000 people, generalised to the population as a whole. However such national surveys, because of their small sample size, are only accurate to plus or minus 2 per cent and a finding of 1.8 per cent is therefore not statistically significant. Moreover even if the figure could be used as the basis of a valid national estimate it would not be an indicator of regular heroin users but of all heroin users plus the majority of amphetamine users and the one-third of cocaine users whom NDAIC estimates inject their drugs.[15]

(5) The fact that at 31 December 1987 there were 5,735 people being treated with methadone for opiate (mostly heroin) dependence. NDAIC argues: 'If they are two-thirds of the people being treated for heroin dependence, and for each of them there are six to ten who are not in treatment (as UK data would suggest), the national regular user population would be in the vicinity of 50,000 to 80,000.' Like the 'rule of thumb' assumption that law enforcement agencies only ever seize 10-15 per cent of illegal drug importations, the assumption that only 15 per cent of heroin addicts are ever in treatment at one time is inherently absurd. The National Campaign Against Drug Abuse as a deliberate act of policy has expanded methadone treatment from a base of 2,203 persons in February 1985 to 6120 persons in June 1988. To suggest that this has been accompanied by a parallel increase in the number of regular heroin users is nonsensical. If anything such an expansion would be expected to be accompanied by a corresponding decrease in the number of heroin users. Moreover there is no reason to believe that the ratio of users in treatment to those not in treatment found in a UK survey will hold good in Australia. The only sensible course would be to replicate the UK study in this country.

3.17 Having arrived at a figure of 30,000 regular users, the NDAIC document goes on to state that 'overseas data suggest that there are typically two or three occasional, irregular heroin users for each regular user' and so arrives at its figure of 60,000-90,000 irregular or intermittent users of heroin in Australia. Once again there is no reason to believe that the ratios which apply overseas necessarily apply in this country. It is somewhat disturbing that estimates arrived at by such doubtful

methods should have been issued by the National Drug Abuse Information Centre.

3.18 The problem with such large estimates is that they neglect the question of how so many heroin addicts might be expected to finance their habits. Accepting that a significant number of users finance themselves by dealing in the drug, the fact remains that at the bottom of the heroin distribution pyramid there must be sufficient users paying cash for their supplies to support the whole edifice. Someone using a gram a day needs to come up with a minimum of $1400 a week. Legal sources such as savings, social security and support from relatives and friends may provide part of this but they cannot do so consistently for any length of time. Illegal sources must therefore provide the bulk of the funds. Taking the Williams Royal Commission's figure of 20,300 addicts using a gram a day for 70 per cent of the year, a total of $1,034 *million would have to be found largely from illegal* sources. This is patently absurd. Dobinson and Ward found in their study of property offenders that the average number of armed robberies committed annually by each member of the heroin using group of offenders in support of their $2,000 a week habits was 8 and that the average number of burglaries was 143. Even if one attributes all property crimes reported in Australia to heroin users - which is a false assumption since Dobinson and Ward found that only 35 per cent of incarcerated property offenders were regular users of heroin prior to arrest - one comes up with only a small proportion of the total of $1,034 million required.[16]

3.19 The estimate of 3,360 frequent users is at least realistic given the rather limited avenues which heroin users have to finance their habits. It should be stressed that the figure represents persons who are currently frequent users. At any one time perhaps 1,000 persons who would otherwise fall in this category are in prison, another 6,120 are receiving methadone, perhaps a further 1,000 are in therapeutic communities and an

indeterminate number are abstaining from the drug for periods of six months or more. Many of these persons will return to frequent heroin use in the future but at the same time some of the current group of frequent users may be imprisoned, seek treatment or abstain from drug use. In other words there may be over 12,000 people in the revolving door of heroin addiction but only a quarter of these may be counted as frequent users at any one time.[17] The corollary of this is that, whereas individual users may not maintain a consistent pattern of use throughout the year, it is possible to estimate total annual consumption on the basis of a constant population of 3,360 frequent users.

3.20 As with marihuana it is the frequent users who matter for the purpose of estimating total annual consumption: the occasional or social users, although important for other reasons - for example in assessing the consequences if AIDS spreads *through the population of intravenous drug users - have little* impact on overall levels of consumption. Using figures derived from Dobinson and Ward's two studies it is estimated that one third of the frequent users consume on average between 9 and 12 grams of street heroin at 20-22.5 per cent purity per week, one third consume on average 5-8 grams per week and one third consume on average 1-4 grams per week.[18] This gives an estimated annual consumption of between 884 and 1404 kilograms of heroin at 20-22.5 per cent purity or between 177 and 316 kilograms of pure heroin. As imported heroin averages between 80 and 90 per cent purity, for the purpose of comparison with seizures this figure should be corrected to a total annual consumption of 200-400 kilograms of heroin at that level of purity. The Committee's preference is for a figure of around 350 kilograms at 80 per cent purity or 1398 kilograms when 'cut' to an average street purity of 20 per cent. At street prices of around $500 a gram this would mean an annual turnover of $699 million.[19]

3.21 These estimates are included to give some indication of the magnitude of the trade. They should be treated with caution,

however, not least because the survey from which they are derived was not intended to sample heroin users as such. Because the number of frequent users is, on any estimate, very small, an error in the estimate or in the assumed levels of use may have a large effect on the overall figure for total annual consumption. It should also be emphasised, as with marihuana, that the estimate is one of consumption, not of the total amount being imported into the country. Major importers must make allowances for seizures and therefore it is almost certain that more heroin is being imported than is necessary to meet the existing demand. Nevertheless, once again it appears that law enforcement agencies are in fact having more success than they are being given credit for. In 1987 Federal agencies seized 60 kilograms of heroin[20] and in 1988 two operations yielded seizures of 31.5 kilograms and 45 kilograms respectively.

3.22 It seems likely that the majority of heroin importations are made using couriers travelling on commercial air flights who carry amounts of one or more kilograms concealed on their persons or in their luggage. Importations have also been made by commercial shipping using a member or members of the ship's crew and the recent Australian Federal Police/Royal Hong Kong Police joint operation dealt with an intended importation using an ocean-going yacht. According to Dobinson's latest study, once landed the heroin is distributed by a pyramid-shaped network, the importers selling in kilograms to a number of wholesalers who 'cut' the heroin to about half its original purity and in turn sell in 'ounces' to 'ounce dealers'. Such dealers cut the heroin again to its street level of purity and package it in 10 and 5 gram bags and smaller gram amounts which they sell to numerous 'user-dealers'. Dobinson found two categories of such dealers: those who purchased heroin exclusively from ounce dealers and those - designated as small-time user-dealers - who mainly bought from other user-dealers. Dealers sell to users in grams, half grams and 'street deals' or 'tastes' which contain 0.1-0.2 of a gram. At this level weights are notional. The pyramid-shaped

network is not an organised affair in the sense that the importer or wholesaler controls the distribution of heroin down to the lowest level but in some cases the first three echelons in the network (down to the ounce dealers) may form part of an organised criminal group or syndicate. It should also be noted that the importation of small amounts of heroin for personal use or the use of friends by mail or by users themselves travelling on commercial flights is not uncommon.[21]

3.23 Because general population surveys are of no use in identifying the number of heroin users in Australia, owing to the very small numbers involved, it is very difficult to provide any indication of trends in heroin use over time. In the United States, data such as deaths due to drug use and drug-related emergencies are used as indicators of trends in the use of heroin and a National Drug Poisonings Case Reporting System is being developed in this country but the figures available are as yet insufficient to indicate any trends. The figures on deaths due to drug use are more comprehensive, and can be used to indicate trends over time, as illustrated in Figure 1.

3.24 Two cautions are necessary. Prior to 1979, some deaths due to opiate use were attributed to 'other drugs' with the result that the total figure for deaths due to drug dependence may actually provide a better indicator for opiate use during this period than the figure for deaths due to drug dependence of the opiate type. It will be noted that these two graphs show a much better fit after 1979. Secondly, the deaths due to opiate use include deaths attributable to licit opiates such as propoxyphene, dextromoramide and methadone. This is probably of less importance when using the figures to indicate broad trends than when attempting to use them as the base for an estimate of the number of heroin users in Australia. The data presented in Figure 1 would suggest that heroin use grew steadily until 1978, when it dropped dramatically before rising again to its previous

level in the mid-1980s. It is too early to tell whether the slight drop recorded in 1986 will continue.[22]

Cocaine

3.25 In the United States it is possible to estimate the total number of users of cocaine on the basis of national household surveys but in Australia the number of users is too low to permit this to be done with any accuracy. Of the sample of 841 persons in the Illicit Drug Users Survey, however, 11.3 per cent had used cocaine in the last 12 months. Using the figures for marihuana users derived *from* the Community Prevalence Survey and regarding the Illicit Drug Users Survey as a sample of marihuana users aged 15-30, as with the estimate of the number of heroin users, this would suggest a population of 58,254 cocaine users between 15 and 30 or approximately 84,500 cocaine users in the population overall. Of those who had ever tried cocaine who reported the timing of the last two occasions on which they used the drug, only 7.86 per cent, or roughly 6,640 persons, had used the drug more than once a month.[23]

3.26 There do not appear to have been any *detailed studies of* patterns of cocaine use in Australia which would suggest quantities used on each occasion of use. Utilising figures derived from United States studies, however, it is estimated that one third of the frequent users consume on average four administrations of 50mg at 45 per cent purity or 90mg on each occasion of use and that the remainder of users consume on average *three* administrations of 50mg at 30 per cent purity or 45mg on each occasion of use.[24] Taking the figures on frequency of use derived from the Illicit Drug Users Survey this gives an estimate of annual cocaine consumption of about 65 kilograms. At street prices of around $200 a gram this would amount to an annual turnover of $13 million.

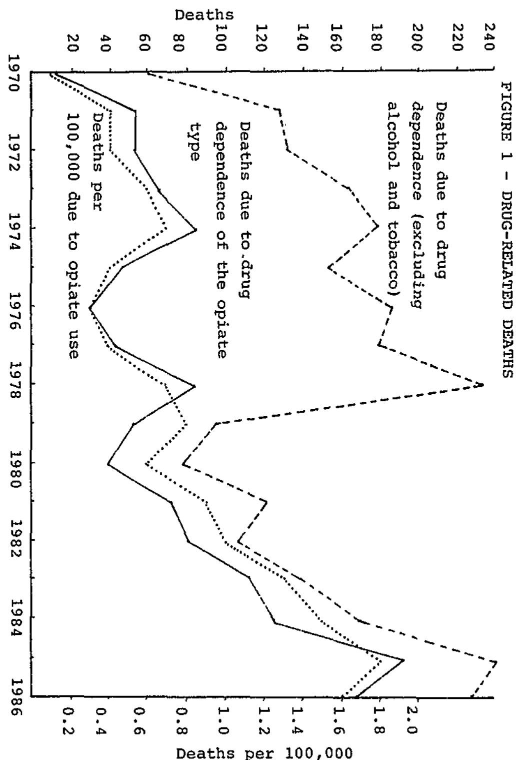

FIGURE 1 - DRUG-RELATED DEATHS

3.27 Two points should be made about this estimate. First, it is always dangerous to extrapolate from the experience of another country. If, as has been suggested, cocaine in Australia averages 15 per cent purity at point of sale, then the estimate could be reduced to around 55 kilograms (assuming, as in the United States estimates, that the most frequent users manage to obtain their supplies at higher purity than the less frequent and casual users). Secondly, the United States studies are based on users 'snorting' cocaine and consumption patterns may differ if the drug is injected intravenously or smoked. Despite these uncertainties, however, the overall estimate suggests, once again, that law enforcement agencies are having greater success than they have been credited with. Federal law enforcement agencies seized over 21 kilograms of cocaine in 1986 and 10 kilograms in 1987.[25]

3.28 So far as Australia is concerned, the trade in cocaine does not appear to be organised to the same extent as the heroin trade. The largest importation seized to date consisted of 6 kilograms impregnated in the cardboard panels of a trunk. Quantities of a kilogram or more have been concealed in the frame of a hang-glider, in divers' air tanks, in hollowed out pieces of wood used in packing cases and by impregnating clothing with cocaine in solution. The bulk of the trade appears, however, to consist of smaller quantities imported by mail or by persons travelling on commercial flights acting on their own behalf or on behalf of friends. Studies indicate that the association of cocaine with glamour and high income-earners is misleading in the Australian context so that although commercial distributors and dealers exist it is likely that the majority of transactions take place in more informal distribution networks and on a friendship basis.[26] There are insufficient data available to enable the Committee to make any statements about trends in the use of cocaine in Australia.

Amphetamines

3.29 Both the Community Prevalence Survey and the Illicit Drug Users Survey asked respondents only whether they had 'taken pills, such as amphetamines, speed, uppers, downers'.[27] No distinction was therefore drawn between stimulants, such as the amphetamines, and depressants, such as the common prescription tranquillisers and barbiturates. Similarly, no distinction was drawn between legally obtained pills and those illegally obtained (whether on the black market, by forging doctors' prescriptions or by robbing pharmacies). While amphetamines appear to be purchased exclusively on the black market, the five heroin users whom Simon Davies studied obtained sedatives by imposing on doctors.[28] Finally, it is by no means clear whether respondents would have identified a question which referred to 'taking pills' with intravenous use of the amphetamines, although data from the A.C.T. Drug Indicators Project suggests that over half amphetamine users may inject the drug.[29]

3.30 Surveys of young street drug users in Sydney and Adelaide indicate that amphetamine use is widespread in this subculture but only relatively small percentages (1.9 per cent of the 15-18 year olds in the Sydney survey and 3.2 per cent of the 12-25 year olds in the Adelaide survey) reported using the drug four or more times a week.[30] The NCADA surveys found that only 8 per cent of respondents in 1985 and 5 per cent in 1988 reported having 'ever tried' amphetamines. Of the sample in the 1988 survey, only 2.1 per cent had used amphetamines in the last 12 months, which, given the sample size, is too low a percentage to place any reliance on.[31] The Committee considers that the available data does not enable an estimate to be made of the current size of the trade in amphetamines or trends in the use of this drug.

3.31 Amphetamines are typically manufactured in illicit laboratories in Australia and this process does not apparently require an advanced knowledge of chemistry. The trade has

generally been associated with the 'bikie' subculture and the State police forces have succeeded in closing down a number of illicit laboratories with links to such groups. The Committee was told that Western Australia, South Australia and New South Wales have seen increases in seizures of amphetamines in the last year and importations of MDMA have also been seized, but no information is available which would indicate whether the structure of the trade is changing in any way.[32]

Conclusion

3.32 The Committee's estimates suggest that there are roughly 780,000 cannabis users in Australia, 33,600 heroin users and 84,500 users of cocaine although there is undoubtedly a considerable degree of overlap between these groups. The turnover in the illegal drug trade would amount to $2,617 million annually on these estimates. Over 50 per cent of the total consumption of domestic cannabis may be being destroyed and seizures of importations of cocaine and heroin may be running at 23 per cent and 17 per cent of consumption respectively. Information regarding trends is unreliable, but it seems that the use of cannabis is static and the use of heroin may be declining. Arguably the massive expansion of methadone programmes under the auspices of the National Campaign Against Drug Abuse has had a very significant effect on the number of regular heroin users. The vast majority of users of all four illegal drugs - cannabis, heroin, cocaine and the amphetamines - are occasional or social users.

3.33 Despite the recommendations of the Senate Select Committee on Drug Trafficking and the Williams Royal Commission there is still very little hard data available on the number of users of the illegal drugs in Australia, the amounts they consume or trends in use. This is despite the obvious importance of these figures for the development of policy in this area. The law enforcement agencies, for example, cannot remain satisfied with

the claim that they seize only 10-15 per cent of all importations into this country irrespective of the tactics they employ or the resources invested in the effort. Clearly they need to know what effect their activities are having on patterns of use. So, for similar reasons, do policy makers and politicians. If, for example, the destruction of cannabis plantations and the consequent rise in the price of that drug is simply leading to an increased use of amphetamines or other pills, then the cost-effectiveness of that strategy may need to be reconsidered. Similarly, far more accurate figures on the extent of intravenous drug use than those provided by the single survey which has so far been undertaken need to be obtained if we are to make a realistic assessment of the threat posed by the spread of AIDS through this population. The supposed inaccuracy of self-reported data on drug use (because of its illegality) should not be used as an excuse for the failure to gather better statistics. While researchers overseas have found that addicts in particular tend to overstate the size of their habits, they have found them accurate when asked to report their daily pattern of use over a period and they have certainly not found that either addicts or occasional users are unwilling to be interviewed provided that their confidentiality can be assured. In this respect it is suggested that drug users do not differ greatly from the rest of the population.[33]

3.34 Recommendation: The Committee recommends that the Commonwealth Government should undertake regular surveys of the general population and of illicit drug users along the lines of those commissioned from Roy Morgan Research for the evaluation of the NCADA anti-heroin campaign (but preferably using larger samples) in order to develop a body of data concerning the extent of the use of the illegal drugs, frequency of use, amounts consumed and trends in use over time.

1. Senate Select Committee on Drug Trafficking and Drug Abuse, Report (Parliamentary Paper No.204/1971, A.G.P.S., Canberra, 1971), p.22.
2. Royal Commission of Inquiry into Drugs (Commissioner: The Hon. Mr Justice E.S. Williams), Report (A.G.P.S., Canberra, 1980), pp.D59-61.
3. Australian Market Research Pty. Ltd., A Study To Evaluate Australia's National Campaign Against Drug Abuse 1985 To 1988 (May 1988), included as Part 9 of vol.2, NCADA Taskforce on Evaluation, Report (unpublished, August 1988), pp.136-41.
4. Plant, A., Macaskill, P., Lo, S.K., and Pierce, J., Report of the Evaluation of the Anti-Heroin Campaign (NCADA, Canberra, 1988), pp.9-11, 22-4, 27, 31.
5. Senate Standing Committee on Social Welfare, Drug Problems in Australia - An Intoxicated Society? (Parliamentary Paper No.228/1977, A.G.P.S., Canberra, 1977), pp.134-5; South Australia, Royal Commission into the Non-Medical Use of Drugs (Chairman: Professor R. Sackville), Final Report (S.A. Government, Adelaide, 1979), p.101.
6. Australian Federal Police, Illicit Drugs in Australia - Situation Report 1988 (Canberra, September 1988), p.29.
7. New South Wales, Royal Commission into Drug Trafficking (Commissioner: The Hon. Mr Justice P.M. Woodward), Report (N.S.W. Government Printer, Sydney, 1979), pp.77-81; Sackville, op.cit., pp.101-2; Commonwealth Department of Community Services and Health, Statistics on Drug Abuse in Australia 1988 (A.G.P.S., Canberra, 1988), pp.3, 28-31; Plant et al., op.cit., p.11.
8. Australian Federal Police, op.cit., pp.29, 36; Illicit Drugs in Australia - Situation Report 1987, pp.25, 34-5, 38; Illicit Drugs in Australia - Situation Report 1986, pp.22, 30-31, 35; Submission from the Australian Federal Police, pp.6-8.
9. Plant et al., op.cit., pp.26, 30, 34.
10. Ibid., p.52.
11. Williams, op.cit., p.A294.
12. Ibid., p.A234; for criticism of the Williams Royal Commission's estimate, see Elliott, I.D., 'Heroin: Mythologies for Law Enforcers', in (1982)6 Crim.L.J., pp.6-43.
13. National Drug Abuse Data System, Statistical Update, No.5 (March 1988).
14. Sandland, R.L., Methods of Estimating the Number of Heroin Users in New South Wales (N.S.W. Drug and Alcohol Authority, Sydney, 1984), p.4.
15. Spooner, L., 'The Prevalence of Intravenous Drug Use in Australia', unpublished paper presented at the Third National AIDS Conference, Hobart, August 1988, pp.5-7.
16. Dobinson, I., and Ward, P., Drugs and Crime - A Survey of N.S.W. Prison Property Offenders, 1984 (N.S.W. Bureau of Crime Statistics and Research, Sydney, 1985), pp.32, 43-5, 66. The Committee's line of argument here is not new: see Singer, M., 'The vitality of mythical numbers', in The Public Interest, no.23 (1971), pp.3-9; Reuter, P., 'The (continued) vitality of mythical numbers', in The Public Interest, no.75 (1984), pp.135-47; Elliott, I.D., loc.cit.; Elliott, I.D., 'Heroin Myths Revisited: The Stewart Report', in (1983)7 Crim.L.J., pp.333-45; Elliott, I.D., 'Mythical Numbers - An Australian Perspective', unpublished paper delivered at an Australian Institute of Criminology Seminar on 'Corruption and Illegal Markets', 22-23 March 1984.

17. For a precursor of this 'revolving door' concept see Johnson, B.D., 'Once an addict, seldom an addict', in Contemporary Drug Problems, vol.7 (Spring 1978), pp.35-53 at p.49.
18. Dobinson and Ward, op.cit., pp.33-4; Dobinson, I., and Ward, P., Drugs and Crime - Phase II (New South Wales Bureau of Crime Statistics and Research, Sydney, 1987), pp.23-7, 49.
19. The figure of $500 a gram reflects not the street price for a gram - around $200 - but the price when the gram is broken down for sale to end users in 'street deals ' of $50 or $100.
20. Australian Federal Police, Illicit Drugs (1988), p.34.
21. Ibid., pp.35, 37; Australian Federal Police, Illicit Drugs (1987), pp.22-3, 32-3, 36-7; Dobinson, I., and Poletti, P., Buying and Selling Heroin (N.S.W. Bureau of Crime Statistics and Research, Sydney, 1989), pp.86-98.
22. Sources: Commonwealth Department of Community Services and Health, op.cit., pp.34-5; Drew, L.R.H., 'Death and Drug Use in Australia', in Technical Information Bulletin, no.69 (October 1982), pp.1-44; Personal Communication, Mr M. Gibson, National Drug Abuse Information Centre.
23. Plant et al., op.cit., pp.26, 30, 33.
24. Wisotsky, S., Breaking the Impasse in the War on Drugs (Greenwood Press, Westport, 1986), p.15.
25. Australian Federal Police, Illicit Drugs (1988), p.34.
26. Ibid., pp.36,38; Illicit Drugs (1987), pp.24, 33-4; Illicit Drugs (1985), pp.22, 26; Evidence, Dr. S.K. Mugford, p.759; Submission from Dr. S.K. Mugford, Appendix 2, pp.21-2.
27. Plant et al., op.cit., p.22.
28. Davies, S., Shooting Up (Hale & Iremonger, Sydney, 1986), pp.108, 115, 118.
29. Spooner, op.cit., p.6.
30. Reilly, C., and Homel, P., 1986 Survey of Recreational Drug Use and Attitudes of 15 To 18 Year Olds in Sydney (N.S.W. Drug and Alcohol Authority, Sydney, 1987), p.8; Bungey, J., Faulkner, C., Gitsham, B., McNeil, E., Madden, P., and Sweeney, R., Youth : Alcohol and Drug Use in Inner City Adelaide (S.A. Government, Adelaide, 1989), p.35.
31. Commonwealth Department of Community Services and Health, op.cit., pp.28-9; Australian Market Research, loc.cit., pp.136-41.
32. Perkal, M., Liddy, M.J., and Haydock-Wilson, O., 'Illicit Amphetamines in Australia in the 1980s - A Preliminary Outline to May 1986', in Australian Federal Police, Illicit Drugs (1986), pp.48-59; Australian Federal Police, Illicit Drugs (1987), pp.33, 37; Illicit Drugs (1988), pp.28, 36, 38; Submission from Western Australian Police, p.2; Evidence, South Australian Government, p.386; New South Wales Police, pp.993-4.
33. Krivanek, J.A., Heroin: Myths and Reality (Allen & Unwin, Sydney, 1988), pp.121, 152-6; Johnson, B.D., Goldstein, P.J., Preble, E., Schmeidler, J., Lipton, D.S., Spunt, B., and Miller, T., Taking Care Of Business - The Economics of Crime By Heroin Abusers (Lexington Books, Lexington, 1985), pp.22, 33.

CHAPTER FOUR

EFFICACY OF LAW ENFORCEMENT STRATEGIES

Introduction

4.1 The previous chapter suggests that Australian law enforcement agencies have been more successful in making seizures of drugs than they have previously been given credit for. That in itself does not imply, however, that they have been successful in stamping out drug trafficking. Seizures are a way of stopping drugs reaching the market but it is universally accepted that law enforcement agencies cannot hope to stop all drugs reaching the market. So long as there is demand, even at what may seem to be irrationally high prices, someone will attempt to supply it. The law enforcement agencies themselves accept this and perhaps the most striking proof of this is that, even with the most stringent security measures, it is not possible to keep drugs out of our gaols. While it seems clear that the extent of drug use in gaols has been greatly exaggerated, nonetheless demand has created a supply, however small.[1]

4.2 The criminal justice system aims at deterring people from committing crimes by raising the likelihood that, if they do so, they will be detected and convicted and will therefore face heavy penalties including imprisonment and the confiscation of assets derived from their wrongdoings. By deterring people from becoming involved in drug trafficking, law enforcement hopes that the supply to the market will be reduced, that the price of drugs will rise, that existing users will find it more difficult to obtain supplies of their drugs and that new users will not be able to enter the market through an inability to obtain drugs. The remainder of this chapter examines the strategies used by law

enforcement agencies in this country in pursuit of this objective of deterrence and possible indicators of their success or failure.

Strategies - Crop eradication and substitution

4.3 The United States has concentrated a substantial part of its law enforcement resources on an attempt to reduce production of cannabis, opium and coca through crop eradication and substitution programmes. Australia is involved in these efforts through United Nations agencies and since United States programmes have touched on the Golden Triangle, which supplies the bulk of Australia's heroin, and Bolivia and Peru, which supply such cocaine as reaches Australia, it is worth mentioning these programmes briefly. The philosophy underpinning such programmes is that the best way to stamp out drug trafficking is to attack the trade at its source. However they have been singularly unsuccessful for a number of reasons including the economic importance of the crops for their growers, the lack of skills or resources for growing substitute crops, the existence of legal uses for the crops in their countries of origin, the fact that the governments of the producing countries are only able to exercise weak control over the producing areas and the abundance of potential supply countries.

4.4 Thus marihuana can be grown virtually anywhere and United States attempts to control its production have been limited to Mexico where they have been hampered by corruption on the part of the government officials supposedly responsible for overseeing the eradication programmes. Turkish opium production was stamped out following the conclusion of a treaty with the United States under which it agreed to compensate former growers but the shortfall in production was picked up by Mexico. Iran and Afghanistan have both become major suppliers of heroin to Europe in recent years following political disturbances which weakened the control of central governments in those countries and the

control exercised by the neighbouring governments of Thailand, Laos and Burma over the area known as the Golden Triangle is notoriously weak.

4.5 Opium is a traditional crop in many of these areas and it has not proved possible to come up with substitutes which offer growers the same profits. Similarly, coca is a traditional crop in the Andes and the chewing of the leaves of the plant is still legal in Peru above certain altitudes. The greatest objection to eradication as a strategy, however, is the relatively small area of production needed to supply the world demand for illegal drugs. The United States' consumption of heroin, for example, has been estimated at 5 tonnes. World production of opium fluctuates but is estimated at over 2,000 tonnes, capable of producing over 200 tonnes of heroin. Even if all production of opium could be stamped out, a forlorn hope, the synthetic opiates such as fentanyl (a chemical compound about 250 times stronger than heroin) would remain.[2]

Interception of importations and destruction of plantations

4.6 Law enforcement strategies in this country focus on three levels of the trade: the interception of importations at point of entry and, in the case of marihuana, the destruction of plantations, the targetting of major importers and distributors, and the harassment of low-level dealers and users. Interception 'at the barrier' relies on officers' intuition, drug detector dogs and intelligence. An officer may, for example, feel that a suitcase is too heavy and on examination it may prove to have a false bottom concealing drugs. The Australian Customs Service has 43 drug detector dog teams and these are used to search incoming mail, passengers' baggage and cargo. The Service also has a major intelligence function in co-operation with other law enforcement agencies and in recent years greater use appears to have been made of 'controlled deliveries' whereby importations are allowed to proceed by Customs officers in the hope that this will assist

other agencies in identifying and arresting those persons responsible for organising the importation. While the greatest number of seizures of heroin and cocaine by the Customs Service relate to importations through the mail, over 90 per cent of the seizures by weight are importations by passengers on commercial aircraft. As noted in the previous chapter, where marihuana is concerned, importations by ocean-going vessels also form a significant component of seizures.

4.7 In the absence of intelligence identifying a proposed importation, random interception poses a seemingly daunting task. Some 3.8 million passengers enter Australia each year, mainly by air, and it is estimated that only 10-20 per cent of incoming air passengers have their baggage subjected to any form of search. Drug detector dogs no doubt assist in identifying baggage which should be subjected to search, but heroin, cocaine and hashish oil can all be concealed on or in the person or in hand luggage and drug detector dogs do not appear to be used to search persons or their hand luggage in the absence of intelligence indicating that an importation may be expected on a particular flight. Where shipping is concerned, Customs figures indicate that 10,622 arriving or departing vessels were boarded in 1987-88 but only 1,024 were searched.[3]

4.8 Despite repeated suggestions that shipping containers are being used for drug importations, random searches of containers have proved unproductive. Similarly, despite rumours that the northern coastline of Australia is rife with unidentified aircraft and ships, all no doubt involved in the drug trade, the House of Representatives Expenditure Committee reported in its review of coastal surveillance in 1986 that, although the patrols produced an enormous number of sightings, few prosecutions resulted and none of these related to the importation of drugs.[4] The idea that Australia is especially vulnerable because of the length of its coastline and the volume of its incoming passenger traffic and container cargo is something of a myth. The Customs

Service relies on intelligence to identify potential avenues for trafficking rather than on random searches. The Committee was told, for example, that better than 50 per cent of successful searches are the result of selections by Customs officers, a good indicator of the strength of the intelligence profiles which the Customs Service has developed, while the balance are the result of hard intelligence pointing to specific passengers or consignments. Similarly the Customs Service and the Australian Federal Police rely on intelligence to identify vessels and aircraft which may be attempting to import drugs and they have had considerable success in this area in recent years.[5]

4.9 The economics of the drug trade mean that the interception of importations at point of entry is unlikely to have any significant effect unless the organisers of the importation can be identified and successfully prosecuted. The reason for this is that most of the value is added to the drugs after they enter the country. According to Dobinson's latest study a kilogram of heroin, for example, costs $12,000-15,000 in Asia and can be sold for $200,000-250,000 in Australia. Thus the seizure of 2 kilograms of heroin in the luggage of a courier represents a loss to the importer of $30,000 plus the cost of the air ticket, an insignificant amount when compared to the profit to be made from a successful importation. Even seizures such as the recent ones by the National Crime Authority and the Australian Federal Police of 31.5 and 45 kilograms respectively would not result in losses which could not be recouped in a single successful importation, although they may lead the importers to avoid large importations in favour of units of 2-5 kilograms in future.[6]

4.10 Similar considerations apply with respect to the destruction of cannabis plantations. Although such plantations, particularly the larger, more technically sophisticated ones seen in recent years, represent substantial capital investments, their destruction does not represent a loss to the grower of the 'street value' of the crop destroyed which is often quoted in

newspaper coverage of such operations. At most it represents a loss of any capital invested in the land, improvements such as irrigation equipment, seed and labour costs. The United States experience suggests that large plantations can readily be identified from the air but growers have responded by concealing smaller plantations in forest areas and similar developments have been noted here. Once again intelligence is required to identify such plantations and it is debatable whether any great value attaches to the arrest of the labourers who may have been hired to tend and guard the crops. Certainly the destruction of plantations at the height of the growing season appears to have significant effects on the supply of cannabis in the marketplace, but unless the investors behind the plantations are identified this effort is likely to continue year after year with no discernible diminution in the amounts of cannabis being grown. Indeed, if the returns to growers are increasing, as has been suggested, the destruction of plantations may even stimulate new parties to enter the trade.

Targetting major traffickers

4.11 There are good reasons for supposing that the drug trade is more vulnerable to intelligence gathering operations than many other forms of criminal activity. Dealers at the base of the trade often carry out transactions in the street and they must be prepared to deal with customers who are not known to them, thus leaving themselves open to approaches by informants and undercover agents. Dealers in heroin at this level are invariably users themselves and all dealers are vulnerable to charges of supplying drugs, resulting in heavy prison sentences. As a result they are more likely to co-operate with police in identifying their suppliers in return for leniency or non-prosecution. Distribution networks in turn are vulnerable to surveillance and the use of telephonic interception and listening devices. Moreover dealers at this level do not appear to make much of an effort to conceal their wealth, often driving readily

identifiable vehicles and spending large sums in gambling. Importers in turn are particularly vulnerable to the use of telephonic interception and listening devices as they make arrangements with their confederates overseas. This is not to suggest that action by law enforcement agencies at all levels is not both time-consuming and expensive but it does argue that the length of Australia's coastline, the number of incoming visitors and vessels each year and the size of those parts of the country suitable for the growing of marihuana are not in themselves insurmountable obstacles to effective drug law enforcement.

4.12 The targetting of major traffickers was recommended to law enforcement agencies by the Williams Royal Commission which was critical of what it perceived as the agencies' concentration on statistics of numbers of arrests and convictions. The Commission argued that this led to a preoccupation with users and dealers at street level rather than any attempt to move up the trafficking hierarchy.[7] Law enforcement agencies responded to this criticism by creating specialised drug squads with a mandate to identify and prosecute major traffickers. Governments also created special task forces such as the Commonwealth-New South Wales Joint Task Force on Drug Trafficking and new agencies like the State Drug Crime Commission of New South Wales. Despite this investment of resources, however, Dobinson suggests that very few major importers have been arrested.[8] There are reasons to think this has been changing in the last few years but what is not clear is the likely effect of the arrest of major traffickers.

4.13 Reuter and Wardlaw have argued that in order for the strategy of targetting major traffickers to have any significant long term impact on the market a number of assumptions must hold true. At any one time there must be relatively few high level traffickers and they must require substantial experience in the trade to reach this level. The organisations assembled by high level traffickers must take significant time to assemble, must be durable and must adapt slowly and/or expensively to changes in

law enforcement strategies and tactics. If these assumptions do not hold good, they suggest, the market will adjust relatively rapidly to the removal of even major traffickers and only short term, localised disruption will result.[9]

4.14 Such information as is available suggests that one does not in fact need substantial experience in the drug trade to become a major trafficker. At least where the heroin trade is concerned distribution networks appear to be dominated by people who already have criminal records, often for crimes of violence. Such persons have the reputation and the contacts to ensure that they will not be 'ripped off' in drug transactions. It is also worth noting that for such persons a further prison term may not be a significant deterrent. It appears to be relatively easy for dealers to accumulate capital and to move up the hierarchy. According to Dobinson's study, the 'ounce dealers', who form the lowest level in the hierarchy above the user-dealers, stand to make $7,000-8,500 gross profit on each ounce sold while incurring minimal overheads.[10] Thus if wholesalers are imprisoned or leave the trade for other reasons there would be a number of lower level dealers ready to take their places. Importers may be more difficult to replace depending on whether confederates in their organisations remain at large, ready to continue their operations, or whether they are ready to pass on their contacts overseas to someone else in exchange for a share in the continuing profits.

Targetting lower level dealers

4.15 This analysis suggests, paradoxically, that it may be more rewarding to concentrate on the lower levels of the dealing hierarchy. Importers and wholesalers cannot risk associating directly with users (or, in the case of heroin, user-dealers) and may find their networks temporarily disrupted if a significant number of dealers at this base level can be removed. New users should find it more difficult to obtain supplies at all and

existing users may need to expend more time and money in seeking supplies. Users of heroin in particular may be prompted to seek treatment. Wardlaw reports that a recent study of targetted low-level heroin enforcement in a medium-sized city in the United States concluded that the removal of a small number of low level dealers had succeeded in eliminating an active street market. Burglaries in the area fell 41 per cent year-on-year and demand for heroin treatment increased by 90 per cent.[11]

4.16 Indeed for some purposes a strategy of targetting only major traffickers and neglecting lower level dealers may be positively detrimental. Pearson suggests on the basis of his study of heroin use in the north of England that the adoption of such a strategy may in fact make it easier for heroin to spread within a neighbourhood peer group. The reason for this is that as part of such a strategy law enforcement agencies must leave the lower level dealers relatively undisturbed in the hope of tracing their higher level suppliers and making a case against them. For a period at least, therefore, a neighbourhood may have relatively easy access to heroin. Pearson suggests that this may also lead to poor relations between police and the public since local community groups may question whether the police are taking their local heroin problems sufficiently seriously.[12]

4.17 Wardlaw's example is of a medium-sized city, however, and Pearson's study deals with towns in the north of England. It is questionable whether low-level enforcement would have the same effect in a city like Sydney, for example, where there are already large numbers of heroin users. A recent study by the Citizens Crime Commission of New York concerning drug law enforcement strategies in that city, for example, suggested that saturation enforcement in one area simply shifted drug dealing to other neighbourhoods.[13] An additional problem, which will be considered later in this report, is that the numbers arrested may prove too much for the courts and gaols to cope with. While, therefore, low-level enforcement may cause temporary disruption

to markets and may force some users into treatment because they are unable to obtain supplies, its long-term effect is more dubious.

4.18 It is difficult to tell whether law enforcement agencies in Australia have in fact reduced their pressure at lower levels to any degree in the hope of making cases against higher level traffickers. Recorded drug offence rates have shown a steady increase but it is not possible to say whether this is simply an artefact of increased enforcement or whether it reflects an increase in offending within the community overall. The vast majority of offences relate to possession rather than supply and it appears that in most States over 90 per cent of offences relate to cannabis. These statistics may be no more than a reflection of the relative proportions of cannabis users to heroin users in the general population and the obvious fact that users outnumber dealers. However, the differences between jurisdictions within Australia in relation to the percentage of supply charges suggest that this latter statistic may be the result of differing law enforcement strategies. If so, then it might be possible for those States where supply charges form less than 10 per cent of drug offences to lift that percentage.[14]

4.19 Recommendation: The Committee recommends that funds be made available through the NCADA Research Programme to compare the effectiveness of the differing law enforcement strategies adopted in Australia with a view to recommending those courses of action which constitute the best ways to attack the traffic in illicit drugs as distinct from their mere possession.

<u>Indicators of success</u>

4.20 The theory underpinning present law enforcement strategies posits a decrease in the supplies of the illegal drugs reaching the marketplace, either as a result of seizures or as a result of law enforcement action raising the risk of apprehension and

conviction and so deterring people from entering the market. The visible consequences of this reduction in supply should be a decrease in the availability of the product, an increase in adulteration and an increase in price. It should not be ignored, however, that law enforcement may also have a demand reduction effect, particularly where it aims at disrupting low level dealing, thus making it difficult for new users to obtain supplies. This will actually counter the three indicators of success in supply reduction identified above, since a diminishing supply of drugs may in fact be chasing a market which is diminishing at a greater rate. This is particularly important when one takes into account the effect of the rapid expansion in methadone maintenance programmes for heroin users, for example, which in three years may have taken almost 4,000 regular users out of the market for heroin. Nevertheless, the three indicators of price, purity and availability appear to be the best available.

4.21 Unfortunately none of these indicators is measured in any systematic fashion. Both cannabis and cocaine are 'cut' with other substances but there are no statistics available which would enable one to state with any certainty whether the purity of the product at street level is increasing or decreasing. The reported purity of heroin varies widely between cities and between samples and it is not always clear that the level of purity recorded for a seized sample is in fact the level of purity at which the drug would have been sold on the street. The Woodward Royal Commission in New South Wales found that the purity of street heroin in that State averaged 21.2 per cent in 1978 and Dobinson and Poletti's study suggests that 20-22.5 per cent is typical today indicating that there has been little variation over the years. On the other hand, 31.8 per cent of the user-dealers in their sample had 'cut' the heroin they received at the 20-22.5 per cent level, some by as much as half again, and Mr Dobinson suggested in evidence before the Committee that 10 per cent might be a more typical finding for street levels of

purity at present. Changes to the law in New South Wales apparently mean that drugs seized at the street level in New South Wales are no longer being analysed for court purposes so there is clearly room for considerable doubt in this area.[15] By contrast, the Western Australian Government estimates that the purity of heroin at street level in that State is now down to 6 per cent.[16]

4.22 Turning to availability, the picture is even more murky, since there is no statistical basis for this indicator at all, although one could be devised, based for example on the ease with which undercover police could make drug buys in given localities at given intervals of time. The Australian Federal Police publication, Illicit Drugs In Australia, indicates whether drugs are 'in short supply', 'available' or 'readily available' in various localities but the basis of these classifications is not clear and it appears that they depend to a considerable extent on the law enforcement activity of the State police forces. Thus cocaine, from being 'available' only in Sydney in 1987 suddenly became available in South Australia, New South Wales and Victoria in 1988 with a seizure being made in the Northern Territory. Over the past five years heroin has been 'available' to 'readily available' in all major cities with some intermittent shortages and indications that a market existed for lower grade South-West Asian heroin as well as for the preferred South-East Asian product. Demand for cannabis oil has been consistently low but imported cannabis resin and compressed leaf and tops have been 'available'. The availability of domestic cannabis leaf appears to be variable, dependent on the destruction of plantations, climatic factors and the seasons. Cocaine has been consistently available in Sydney but as indicated above its availability elsewhere in Australia has been variable. The amphetamines have been 'available' to 'readily available' with signs of increasing demand in 1987. In summary, there does not appear to be any consistent trend in availability although there is some

indication that seizures by law enforcement agencies do have an effect on the market.[17]

4.23 Prices are similarly subject to the vagaries of reporting by law enforcement agencies and, like the purity of the drugs, prices appear to vary widely between cities. Dobinson and Ward stated in 1985 that the price per gram of street heroin in Sydney had risen from $70 in 1976 to between $200 and $350 at that time and Dobinson and Poletti's study suggests a similar price today. If anything there has been a slight downturn in price in the last year or two. The Australian Federal Police, on the other hand, report the price per gram across Australia as varying between $180 and $800. The lower of these two figures is a reduction from $250 in the previous two years while the higher of the two has shown a consistent increase from $500 in 1984. One would need to know which cities these figures are derived from before one could discern any consistent trend. The Australian Federal Police figures do, however, confirm Dobinson and Ward's contention that there has been an increase in the price of street heroin from the $100-120 reported by the Woodward Royal Commission in New South Wales in 1978 and the $120-150 reported by the Williams Royal Commission in 1979 to present day minimum prices of at least $180-200. The increase is less than the rate of inflation and so represents a fall in the real price of the drug.[18]

4.24 Domestic cannabis leaf has undergone a marked increase in price, from $25-35 or $25-40 an 'ounce' according to the Woodward and Williams Royal Commissions in 1978 and 1979 to between $150 and $500 for the same quantity in 1987 according to the Australian Federal Police. This would represent an increase in real price not matched in respect of the imported products. The Woodward and Williams Royal Commissions found 'buddha sticks' selling for $15 in 1978 and 1979 and the Australian Federal Police quote $15-40 for such sticks in 1987. Cannabis resin, which according to the Woodward and Williams Royal Commissions underwent a marked rise in price between 1977 and 1979 from

$100-150 an ounce to $200-600, depending on quality, now sells for $350-800 an ounce. With regard to cocaine, the Royal Commissions did not cite prices but the Australian Federal Police figures suggest that, while the wholesale price per kilogram rose between 1986 and 1987, the retail price fell from $150-450 to $75-325 a gram. The amphetamines are quoted at $30-250 a gram, representing a slight fall in the upper price level between 1986 and 1987. The statistics on price are therefore inconclusive although they support the thesis that law enforcement action against domestic cannabis plantations has had some effect on the price and availability of that product.[19]

Conclusion

4.25 If better data were available in comparable series over time it would be possible to state with greater confidence what is happening as a result of the increased law enforcement effort against drugs over the last decade. As it is, it is only possible to state some tentative propositions. The destruction of domestic cannabis plantations does appear to have had a definite effect on the supply of domestic cannabis leaf and its price. The increased sophistication of the law enforcement effort directed against imported cannabis products does not appear to have had a comparable effect. The fall in the real price of heroin may indicate an increase in the overall supply of the drug or it may indicate that the same quantity of the drug is chasing fewer buyers as a result of other government initiatives in demand reduction. If the availability reports are correct it would appear that there is not generally an oversupply of the drug and that law enforcement action is capable of creating temporary shortages in some markets. The most recent data on purity may suggest that, while heroin is still being sold in deals carrying the same prices, there has been a reduction in the actual quantity of heroin being sold. This would reflect the experience in the United States which suggests that, because heroin is sold in fixed dollar amounts, purity is a better indicator of the

supply situation with regard to this drug than price.[20] The price and availability data on cocaine would seem to indicate an increase in supply in the past year, although there is no real trend apparent.

4.26 **Recommendation: The Committee recommends that the Commonwealth Government urgently initiate action through the Ministerial Council on Drug Strategy to ensure that data on the price, purity and availability of drugs <u>at street level</u> are collected on a uniform basis throughout Australia.**

4.27 Despite the substantial resources afforded to drug law enforcement and the success of agencies in making seizures of drugs in unprecedented quantities, it is questionable whether there has been any marked effect in terms of the reduction of the supply of drugs reaching the marketplace. The foregoing analysis suggests that importations which are intercepted can readily be replaced and that even if major traffickers are apprehended this will not have a dramatic effect on the drug trade. Given the profits to be made, others will be prepared to take their places and increasingly they will be drawn from the ranks of professional criminals who are not deterred by the prospect of going to gaol. The best that law enforcement can probably hope for, therefore, is to keep drug abuse in society within acceptable limits. Even that prospect has disappeared in the United States of America.

1. Submission from the Australian Federal Police, p.10; Evidence, Mr P. Delianis, p.25; Queensland Government, p.135; Western Australian Government, p.223; South Australian Government, p.389; Australian Customs Service, pp.623, 626; In Camera Evidence, New South Wales Department of Corrective Services, p.38.

2. Polich, J.M., Ellickson, P.L., Reuter, P., and Kahan, J.P., Strategies for Controlling Adolescent Drug Use (Rand Corporation, Santa Monica, 1984), pp.51-6; Kaplan, J., The Hardest Drug - Heroin and Public Policy (U. Chicago Press, 1983), pp.67-72; Reuter, P., 'Eternal hope: America's quest for narcotics control', in The Public Interest, no.79 (1985), pp.79-95.

3. Australian Customs Service, Annual Report 1987-88 (A.G.P.S., Canberra, 1988), pp.37, 40.

4. House of Representatives Standing Committee on Expenditure, Footprints in the Sand - Inquiry into Civil Coastal Surveillance Co-ordination (Parliamentary Paper No.116/1986, A.G.P.S., Canberra, 1986), pp.37-8.

5. Evidence, Australian Customs Service, pp.620, 639-40.

6. Dobinson, I., and Poletti, P., Buying and Selling Heroin (N.S.W. Bureau of Crime Statistics and Research, Sydney, 1989), p.93. For argument on the effectiveness of interdiction see Reuter, P., 'Can the borders be sealed?', in The Public Interest, no.92 (Summer 1988), pp.51-65.

7. Royal Commission of Inquiry into Drugs (Commissioner: The Hon. Mr Justice E.S. Williams), Report (A.G.P.S., Canberra, 1980), pp.B224-6.

8. Dobinson and Poletti, op.cit., p.93. By way of example, Mr Dobinson considered that David John Kelleher, who was sentenced to life imprisonment in September 1988 for conspiring to import 9.5 kilograms of heroin, would have been located around the ounce-dealer or wholesaler level in his analysis of the structure of the heroin distribution network: see Evidence, Mr I. Dobinson, p.1165.

9. Wardlaw, G., 'Organized Crime and Drug Enforcement' in Proceedings of the Institute of Criminology (The University of Sydney), No.67 (Proceedings of a Seminar on The Control of Organized Crime, 12 March 1986), pp.17-30 at pp.25-6; see also In Camera Evidence, A Judge of a State Supreme Court, p.13; Evidence, Mr P. Delianis, p.35.

10. Dobinson and Poletti, op.cit., p.94.

11. Wardlaw, loc.cit., p.27.

12. Pearson, G., Gilman, M., and McIver, S., Young People and Heroin (Gower, Aldershot, 1987), p.26.

13. 'Supply-side failures', in The Economist, 17 December 1988, p.36.

14. See Wardlaw, G., 'Uses and abuses of drug law enforcement statistics', Trends and issues (Australian Institute of Criminology), no.1 (July 1986).

15. New South Wales Royal Commission into Drug Trafficking (Commissioner: The Hon. Mr Justice P.M. Woodward), Report (N.S.W. Government Printer, Sydney, 1979), p.328; Cook, G.A., and Flaherty, B.J., 'The Analysis of Street Drugs - New South Wales, 1978', in Man, Drugs and Society - Current Perspectives (Proceedings of the First Pan-Pacific Conference on Drugs and Alcohol, AFADD, Canberra, 1981), pp.383-6; Dobinson and Poletti, op.cit., pp.94-5; Evidence, Mr I.R. Dobinson, p.1158; Personal Communication, Mr I.R. Dobinson.

16. Evidence, Western Australian Government, p.215.

17. Australian Federal Police, Illicit Drugs in Australia - Situation Report (1985), pp.17-18; (1986), pp.21-3, 26-7, 34-6; (1987), pp.22-5, 28-9, 36-8; (1988), pp.28-9, 37-9.

18. Dobinson, I., and Ward, P., Drugs and Crime - A Survey of N.S.W. Prison Property Offenders, 1984 (N.S.W. Bureau of Crime Statistics and Research, Sydney, 1985), p.64; Dobinson and Poletti, op.cit., p.89; Australian Federal Police, Illicit Drugs (1988), p.31; (1987), p.27; (1986), p.25; (1985), p.16; Woodward, op.cit., p.329; Williams, op.cit., p.A256.

19. Ibid., pp.A256-7; Woodward, op.cit., pp.85-6; Australian Federal Police, Illicit Drugs (1988), p.31; (1987), p.27.

20. Goldman, F., 'Drug Abuse, Crime and Economics: The Dismal Limits of Social Choice', in Inciardi, J.A., ed., The Drugs-Crime Connection (Sage, Beverly Hills, 1981), pp.155-181 at pp.164-5.

CHAPTER FIVE

THE SOCIAL COSTS OF PROHIBITION

Introduction

5.1 The Committee was criticised by the Commonwealth Attorney-General's Department and Department of Community Services and Health in their submission for apparently setting out to address the costs of the present policy of prohibition without addressing the associated demand reduction strategy put in place by the National Campaign Against Drug Abuse.[1] However the Committee notes that the measures directed at reducing the demand for drugs apply not only to the illegal drugs but also to those drugs in respect of which regulation, rather than prohibition, has been chosen as the appropriate policy. That is, there is no necessary association between the policy of prohibition on the one hand and the demand reduction strategy on the other. The Committee applauds the steps which have been taken to reduce the demand for drugs as part of the National Campaign. At the same time it feels it appropriate to address the question of the effectiveness of the present legal regime in relation to the illegal drugs. Having observed that it is universally conceded that the present policy of prohibition is ineffective, in that it cannot stop the illegal drugs being supplied to those Australians who seek them, the Committee has attempted an assessment of the costs which that policy imposes on the Australian community.

Direct costs

5.2 The most obvious costs imposed by the present policy of prohibition are of course the direct costs of law enforcement,

which include not only the operational costs of the law enforcement agencies but also the costs of the prosecution and defence lawyers, the costs of court time and staff involved in the hearing of cases relating to drug offences, and in the more serious cases the costs of imprisonment. It is difficult to put a figure on these items. Law enforcement agencies, for example, do not break down their budgets in such a way as to indicate how much they spend specifically on drug law enforcement. Moreover parts of these costs cannot necessarily be attributed to prohibition: the Australian Customs Service would still need to maintain barrier control and coastal surveillance for other reasons even if all drugs were legalised. Nevertheless the Committee has attempted a rough calculation which is set out below.

TABLE 4 - LAW ENFORCEMENT COSTS

	$ million
Australian Federal Police	18.1
National Crime Authority	9.8
Australian Customs Service	6.9
State police	25.7
Prisons	45.3
Courts	17.4
TOTAL	123.2

5.3 The figures for police and customs are based largely on statistics of numbers of staff engaged exclusively on drug law enforcement work provided to the Committee in the course of its hearings.[2] The figure for the National Crime Authority is simply 60 per cent of its budget. The figure for the New South Wales State Drug Crime Commission, included with State police, is that body's total budget. The figure for prisons is based on an average costing in respect of the 1,380 prisoners who were in

gaol for drug offences in 1986 (the latest figures available). The figure for the courts is based on the proportion of drug offences dealt with as against other matters and does not include the costs of legal representation. No attempt has been made to include the law enforcement costs in relation to offences committed by persons in order to finance their drug habits and capital costs have not been included.

5.4 The point was made in submissions to the Committee that this amount of $123 million is not just a dead cost. It also represents police diverted away from other duties or money diverted away from other calls on the public purse. The law enforcement effort in relation to drug offences results in additional calls on already scarce court time and additional pressures on already overcrowded gaols. Certain cases relating to drug offences, particularly where conspiracy charges have been laid against a number of defendants, may be particularly lengthy: the Committee was told of one case which took nine months to try.[3] The Committee's point is not that drug law enforcement is unique in placing these pressures on the criminal justice system but rather that most of these costs would disappear should the present policy of prohibition be replaced by one of regulation. Licensing cases, prosecutions for sale of alcohol to minors and prosecutions for evasion of State taxes on tobacco take up very little of the courts' time and rarely result in anyone going to gaol.

Raising prices

5.5 Prohibition means that the price of the illegal drugs is higher than it would otherwise be. An element of this is a simple premium for the costs involved and the risks run in trafficking in a prohibited substance but it does not appear that the traffickers respond to increased penalties by raising prices. An element of the higher price is also related to shortage of supply, as in any black market. The more successful law

enforcement is, the higher the price may be expected to rise. In this fashion, as a State Supreme Court Judge expressed it to the Committee, the criminal justice system becomes part of the pricing mechanism for the trade. The increase in prices prompted by effective law enforcement means that in turn there are greater profits to be made by those prepared to engage in the trade. In other words the effect of law enforcement may actually be to stimulate the trade, both by creating artificial shortages and by increasing the returns to those who are prepared to supply the resulting demand.

5.6 Raising the price of the illegal drugs also has two further costs. First, it means that the trade is most profitable in the refined forms of the naturally occurring drugs because a small quantity of such drugs offers a greater high for the same price and can be more easily smuggled. Thus heroin is traded in *preference to opium and cocaine in preference* to coca leaves. Secondly, it means that the drug user is forced to use the most efficient method of administration of the drug in order to gain the best value for his or her money. In the case of heroin, cocaine and the amphetamines, this means intravenous injection, with all its attendant hazards for health. This is not simply pure theory: in Hong Kong, when effective law enforcement raised the price of heroin, users switched from 'chasing the dragon' or inhaling the fumes of the drug to intravenous injection.[4]

Drug-related crime

5.7 Raising the prices of the illegal drugs also promotes the commission of profit-earning crimes by those who cannot afford the cost of the drugs in any other way. It is generally agreed that, the amphetamines and LSD apart, the illegal drugs are not criminogenic in themselves: that is, their pharmacological action does not cause people to commit crimes they would not otherwise have committed. In this respect they differ from alcohol, which clearly has this effect, as outlined in Chapter One. However, the

high price of heroin in particular means that regular users of the drug cannot support their habits by legitimate means and must resort to dealing in the drug, to prostitution, and to fraud, property offences and armed robbery.[5] The Committee was told that as much as 70 per cent of all crime and as much as 80 per cent of property crime in some States is believed to be drug-related.[6]

5.8 The relationship of drug use and crime has been the subject of much study. At first glance it seems self-evident that users, finding themselves unable to pay for the drug which they feel they desperately need, will turn to crime. However the picture is not so simple. Dobinson and Ward found that 78.1 per cent of the heroin users in their sample of New South Wales property offenders had first committed property crimes before their first use of heroin. These crimes tended to be less serious or juvenile crimes such as motor vehicle larceny or shoplifting. Regular crime tended to be committed after, or simultaneously with, the onset of regular heroin use. As the level of heroin used increased, so did the amount of money generated by property crime. By the same token, during periods of abstinence users tended to decrease or stop their criminal activities.

5.9 Dobinson and Ward's study of users seeking treatment produced similar results. The treatment group generally reported average use and expenditure levels half those of the heroin-using property offenders. Nearly half (48 per cent) had never been regularly involved in the commission of property crime. Four individuals, however, reported committing 715 break and enters in the six months prior to treatment, one individual 26 robberies (unarmed), two individuals 303 frauds and one individual 800 larcenies. These persons were found to be using above-average amounts of heroin and spending proportionately more than the majority of the sample.

5.10 The authors note that these findings are consistent with two explanations. Heroin users who are property offenders may

consume more heroin and therefore 'need' to generate more income and commit more crime. Alternatively, heroin users who are property offenders may commit more crimes and generate more income, thus enabling them to afford more heroin. In any case, it is clear that whether or not heroin-using property offenders already formed part of a delinquent subculture prior to their first use of heroin, their regular use of the drug coincided with periods during which they committed larger numbers of offences, and generated greater income, than non-using property offenders. What is not so clear is whether such heroin users would abandon crime altogether if they ceased to use the drug or were able to obtain it at vastly reduced cost.[7]

5.11 The costs imposed on the community at large by drug-related crime are substantial. There were 302,935 breaking and entering offences reported to police in Australia in 1986-87, and while the Committee does not believe it is possible to determine what precise percentage of such offences were committed by persons seeking to support their drug habits it believes that a significant proportion of such crimes can be attributed to users of heroin in particular. The New South Wales Police Department reported in its 1985-86 Annual Report that the average value as reported to them of property stolen in such burglaries was $1,100, so that even without adjusting this figure for inflation it can be stated that this type of crime is costing the community over $333 million a year.[8] Some householders will carry their own losses but the bulk of this amount will be passed on to the community at large through increased insurance premiums. Shoplifting is another avenue by which many heroin users seek to support their habits - one young woman in Dobinson and Poletti's study of user-dealers reported that she made nearly $300 a day through shoplifting[9] - and once again the cost is passed on to the community through the increased price of merchandise. Individuals are often forced to bear the cost of cheque and credit card fraud themselves but, once again, if the burden falls on financial institutions they will pass it on to their customers

through increased charges. Users with heavy habits may resort to armed robbery and besides the financial losses incurred by the banks, building societies and businesses which are robbed this may result in long term psychological trauma, injury or even death for staff who are threatened in the course of the commission of such crimes. Householders and businesses bear the cost of the increased security measures which they may feel forced to take or which their insurers may require of them in order to attempt to minimise the possibility of burglaries and armed robberies. Once again, where businesses are concerned, these costs must be passed on to the community at large.

The criminal milieu

5.12 Not only does prohibition create high prices, it also determines the other dominant characteristics of the illegal market. As Bakalar and Grinspoon put it:

> 'The institutionalised corruption, betrayal, chaos and terror promoted by drug law enforcement are not only unfortunate by-products of a nasty but necessary business, they are essential means of attaining the law's ends....By making the business as nasty and risky as possible, law enforcement is supposed to limit supplies and keep retail prices high. So those who support the system are in an uneasy position when they profess outrage at contemptuous, cruel and lawless behaviour by narcotics agents. It is certainly hypocritical to pretend to indignation and alarm about the murderousness of drug trafficking itself, since we have in effect deliberately tried to shape it in a way that makes it attractive to the most reckless and callous people and as nerve-racking as possible for everyone involved.'[10]

5.13 The super-profits to be made from illegal drugs, most particularly heroin, have attracted professional criminals who live by the law of the jungle. It is because the trade takes place outside the law that such criminals are able to enforce their own rough justice. They may kill each other in disputes

over 'territory', over drug shipments gone astray or over bad debts. They may beat up or kill people who owe them money, people whom they suspect of having cheated them or people whom they believe to be informants. They may 'rip off' customers by selling them under-weight and adulterated products or by taking their money and giving them nothing at all in return. Worse still, perhaps, some law enforcement officers may respond to these conditions by stealing drugs or money found in the possession of offenders and by planting drugs on suspects to secure convictions.[11]

5.14 The fact that the drug trade takes place in a criminal environment means that otherwise law-abiding citizens are brought into contact with a criminal subculture. Although it seems that heroin dealing is a discrete activity, the Committee was told on more than one occasion that amphetamines may be offered to buyers when marihuana is unavailable. There is also the risk that, having crossed the significant barrier represented by the taking of one illegal drug, the novice user may then be more ready to move to others, including heroin. The Committee is not advancing the hoary old chestnut that marihuana use leads inevitably to the use of heroin: clearly if, as the Committee has estimated, there are 780,000 cannabis users but only 33,600 heroin users, it does not. However there does seem to be evidence of a progression in the careers of drug users, beginning with the use of alcohol and tobacco in early adolescence and moving through the use of cannabis and pills including the amphetamines to the use of heroin.[12]

<u>Corruption</u>

5.15 The enormous profits to be made from the drug trade also promote corruption within law enforcement agencies. Their officers are human and the temptation to take very large sums of money for turning a blind eye or to participate actively in the trade making use of all the specialised skills and knowledge

available to law enforcement officers must at times be overwhelming. As one witness told the Committee:

> 'Our wonder in this society is not that we have got bent coppers, it is that we have got straight ones.'[13]

5.16 It is difficult to quantify the extent of corruption which can be directly attributed to the drug trade: there was corruption before the drug trade, associated with sly grog, illegal abortions, and SP bookmaking, and even if the drug trade were to disappear tomorrow there would no doubt continue to be corruption. Nevertheless there have been a number of notable instances in recent years of law enforcement officers who have been seduced by the super-profits offered by the drug trade. Chief Inspector Barry Moyes, the former chief of the South Australian Drug Squad, sentenced to 21 years imprisonment for his part in various drug dealings, is one example, as are the former Customs investigator Alan McLean, sentenced to 24 years' imprisonment in 1987 for the importation of 5 kilograms of heroin concealed in three soccer balls, the former Victoria Police Detective-Sergeant William Harris, sentenced to 14 years' imprisonment in 1987 for his part in the importation of 330 kilograms of cannabis from Lebanon, and the former New South Wales Police Detective-Sergeant Max Gudgeon, sentenced to 10 years' imprisonment in 1986 for his part in the cultivation of as many as 6,000 cannabis plants on a property near Byrock, 60 kilometres south of Bourke, in 1981-82.

5.17 In all these instances the officers concerned took an active part in the drug dealings concerned. There is little evidence of law enforcement officers taking money to turn a blind eye to importations or 'protecting' particular drug traffickers. The Committee has only been able to identify one case in recent years, that of former New South Wales Police Detective-Sergeant John Dougan, who pleaded guilty in 1986 to conspiring to import 20 kilograms of cannabis resin. Dougan was alleged to have

received $40,000 in return for arranging for the cannabis to be cleared through Customs as a 'controlled delivery'. In a number of other cases allegations have been made which have yet to be proven. There are, however, persistent rumours of drug-related corruption in law enforcement agencies.[14] The Committee believes that in the main these rumours lack foundation.

Health costs

5.18 The high cost of heroin is also responsible to some degree for the general ill-health of regular heroin users. Their preoccupation with getting the resources needed to obtain the drug leads them to suffer from malnutrition and general self-neglect. The illegality of drug use means that users may be reluctant to call medical assistance when one of their friends suffers an overdose and the inability to continue their drug use means that regular users are unwilling to be hospitalised, even if this is necessary for their health. The illegality of those drugs which are injected intravenously appears to promote the sharing of needles and the consequent danger of the spread of hepatitis-B and AIDS. Users lack the facilities to sterilise needles properly and do not place a high premium on hygiene.[15]

5.19 The possibility that AIDS may spread throughout the population of intravenous drug users in Australia and from them through heterosexual transmission into the wider community poses a serious public health problem. While rates of Human Immunodeficiency Virus (HIV) infection among intravenous drug users in Australia are low at present, the overseas experience suggests that the infection may spread very rapidly. In one group of 161 intravenous drug users in Edinburgh, HIV infection grew from nil in 1983 to 51 per cent in 1986. The number of HIV positive intravenous drug users in southern Italy increased from 6 per cent to 76 per cent between 1980 and 1985. Over 40 per cent of the estimated 40,000 intravenous drug users in Bangkok have become infected with HIV in the last 18 months. The threat that

AIDS may spread from intravenous drug users to the general population is not imaginary: in the United States, 75 per cent of those who have contracted the disease through heterosexual contact have been infected by intravenous drug users.[16]

Adulteration

5.20 Prohibition also means that the illegal drugs are adulterated, because of the need for each echelon in the trade to take out its profits by 'cutting' the pure drug with other substances. Contaminants as various as glucose, cornflour, talc, battery acid and strychnine (used to mask the sweet taste of other adulterants) have been found in heroin and a case was recently reported where arsenic had been used to 'cut' cocaine. Heroin users cannot judge the purity of the drug they are injecting and may suffer accidental overdoses as a result. The paradox of heroin-related deaths which do not appear to be classic overdoses has already been noted as has the fact that in the 1960s British addicts, who had heroin of known strength and purity prescribed for them by doctors, had a rate of mortality similar to that of heroin addicts in the United States. However, even if the adulterants in the illegal drugs are not responsible for as many addicts' deaths as has been suggested, it is clear that they are responsible for many health problems, for example the blockage of veins where the drug is injected and arsenical poisoning in the case noted above.[17]

Stigmatising users

5.21 Prohibition, it is said, makes criminals out of persons who would not otherwise break the law and stigmatises them for life with criminal records if they get caught. Criminal records may create difficulties for such persons in gaining employment and may bar them from entering certain professions. There is, of course, a general argument in favour of the expunging of all criminal records, at least in respect of minor offences, after a

certain period. However the criminalisation of users of the illegal drugs may fairly be regarded as a special case, particularly since, where convictions for possession and use are concerned, the users hurt no one but themselves. This argument is given added weight by the fact that initiation into use of the illegal drugs typically takes place between the ages of 14 and 24 and that drug offences at this time may fairly be regarded as youthful indiscretions.[18]

5.22 The Australian Law Reform Commission has recommended in its report on Spent Convictions (ALRC 37) that convictions should be regarded as spent after 10 conviction-free years in the case of adult offenders and 2 conviction-free years in the case of juveniles. Courts would be permitted to continue to have regard to spent convictions in sentencing but in the absence of express legislative provision former offenders would not be obliged to acknowledge spent convictions and it would be made unlawful to discriminate against former offenders on the basis of spent convictions. These recommendations have yet to be implemented.[19]

Civil liberties

5.23 Prohibition has also been responsible for an erosion of generally accepted civil liberties. This has been particularly marked in relation to police raids on rural areas where helicopters have disturbed innocent citizens, properties have been entered by heavily armed police in search of non-existent drugs and roadblocks have been set up for the random search of passing vehicles. Persons may be liable to intrusive searches upon suspicion and persons' reputations may be damaged not because of any crime that has been proved against them but because they are suspected of having had some involvement in the drug trade. The accusations made against the murdered yachtsman David Blenkinsop are a case in point[20] and the Committee has also been told of a case where an Australian citizen was refused entry to Indonesia because the Australian Federal Police refused to

certify that it had no reason to suspect him of any criminal activity even though he had never been charged with any offence.

5.24 The laws themselves have eroded traditional liberties, one typical feature being the reversal of the onus of proof in respect of offences of supplying illegal drugs whereby a person found in possession of a quantity of drugs above a statutory amount is deemed guilty of supply unless he or she can establish that the drugs were for personal use only and not for sale. It has also been observed that prosecutions in this area are peculiarly dependent upon informers and that the judiciary are placed in an invidious position when sentencing persons who have done deals with the prosecuting authorities in return for leniency on sentence. Finally it is argued that the law has been brought into disrepute because the private nature of much drug-taking behaviour means that it is only the young and poor drug offenders who take drugs in public places who are likely to be prosecuted. The rich who indulge their vice in private homes escape detection.[21]

Hypocrisy

5.25 The argument is also put that the present policy of prohibition in respect of certain drugs brings the law into disrepute because other drugs are not only legal but support valued industries in Australia. Why, as one submission put it, do we give social recognition to manufacturers of wine and tobacco products but put growers of cannabis in gaol for lengthy periods? As has already been mentioned tobacco caused 17,000 deaths in 1986 yet we do not regard the owner of the corner store as a drug 'pusher' even if we know that he sells children cigarettes in contravention of the law. A very obvious double standard prevails in respect of drug use in our society.[22]

Benefits foregone

5.26 Finally, any itemisation of the costs of prohibition must take into account the benefits foregone by prohibiting the possession and use of these drugs. Most obviously society has been denied any possible benefits which the illegal drugs may have in medicine. As noted in Chapter 2, cannabis has some promising applications as an anti-emetic for cancer patients undergoing chemotherapy and in relieving intra-oscular pressure in sufferers from glaucoma. Similarly there are arguments for making heroin available as an analgesic even though in careful double-blind studies its effects cannot be distinguished from those of morphine. It is also argued that in a number of cases, particularly perhaps in regard to regular users of the illegal drugs rather than occasional or social users, the use of the illegal drugs may be a form of self therapy. If the illegal drugs were made legal they could be taxed in the same way as alcohol and tobacco are now and the resulting revenue used for drug rehabilitation and education programmes. Finally the cannabis plant apparently has potential as a source of fibre for the manufacture of paper and could be used as a substitute for woodchips, thus saving scarce forest resources.[23]

1. Submission from the Commonwealth Attorney-General's Department and Department of Community Services and Health, p.33.
2. Evidence, Queensland Government (32 officers), p.143; Western Australian Government (41 officers), p.214; South Australian Government (28 officers), p.421; Australian Federal Police (350 officers), p.588; Australian Customs Service (200 officers), p.619; New South Wales Police (170 officers), p.970. Figures for Victoria (72 officers) and Tasmania (25 officers) were taken from Levett, C., 'Authorities concerned as cocaine traffic increases', Sydney Morning Herald, 19 July 1988, p.8.
3. In Camera Evidence, A Judge of a State Supreme Court, p.14; Evidence, New South Wales Bar Association, p.1203; Submissions from the Humanist Society of Western Australia, p.1; the Salvation Army, p.2; the National Organisation for Reform of Marijuana Laws, p.5; a Judge of a State Supreme Court, p.4.
4. Submissions from a Judge of a State Supreme Court, p.2; Drs J.A. Doeleman; the Rev. Dr. J.K. Williams, p.7; Dr. G.B. Chesher, pp.9, 13; Mr R. Walsh; Dr. S.K. Mugford; Evidence, Dr. S.K. Mugford, pp.749; Dr. L.R.H. Drew, p.895; Dr. A.D. Wodak, pp.1025, 1029.
5. Submissions from Mr R.F. Rogers; Mr P. Delianis, p.10; Messrs S. Pinn and M. Fitzgerald; The Prisoner Support Group (Queensland); Fitzroy Legal Service, pp.7-8; South Australian Government (Drug and Alcohol Services Council); Evidence, Mr I. Dobinson, p.1161.
6. Evidence, South Australian Government, p.383; New South Wales Police, pp.970-1.
7. Dobinson, I., and Ward, P., Drugs and Crime - A Survey of N.S.W. Prison Property Offenders, 1984 (N.S.W. Bureau of Crime Statistics and Research, Sydney, 1985), pp.42-51, 55-6; Dobinson, I., and Ward, P., Drugs and Crime - Phase II (N.S.W. Bureau of Crime Statistics and Research, Sydney, 1987), pp.30-40, 51-2.
8. Australian Bureau of Statistics, Pocket Year Book Australia 1988 (A.B.S. Catalogue No.1302.0, ABS, Canberra, 1988), p.35; New South Wales Police Department, Annual Report 1985-86 (N.S.W. Government Printer, Sydney, 1986), p. 31.
9. Dobinson, I., and Poletti, P., Buying and Selling Heroin (N.S.W. Bureau of Crime Statistics and Research, Sydney, 1989), p.78.
10. Bakalar, J.B., and Grinspoon, L., Drug Control in a Free Society (Cambridge U.P., 1984), pp.112-3.
11. Submissions from Mr P. Dykstra; Mr N. Ritchie; Mr R.H. McLeod, pp.1-3; Mr P. Delianis, pp.9-10; Dr. R. Marks, p.15; The National Organisation for Reform of Marijuana Laws, p.7.
12. Evidence, Mr I. Dobinson, p.1174; Dr. G.B. Chesher, p.1386; Professor D. Hawks, pp.331-2; South Australian Government, pp. 396-7; Dr. A.D. Wodak, p.1050.
13. In Camera Evidence, A Judge of a State Supreme Court, p.18.
14. See, for example, submissions from Mr A.J. Tweedie; Mr A.B. Newton; and Mr L.P. McLeay.
15. Submissions from Dr. L.R.H. Drew, pp.6-7; the Humanist Society of Victoria; Dr. S. McLean; Dr. C. Mathers; The Royal Australian and New Zealand College of Psychiatrists; the Centre for Education and Information on Drugs and Alcohol, p.4; Dr. G.B. Chesher, p.3.

16. Submissions from Dr L.R.H. Drew, Attachment 3, p.15; N.S.W. Bar Association, pp.7-8; Professor R. Penny, pp.1-2; Evidence, Dr. A.D. Wodak, pp.1028-9.
17. Submissions from Mr D. Reidpath; the Rev. Dr. J.K. Williams, pp.3-4; Mr R.H. McLeod, p.11; Dr. S. McLean; Mr A. Arthur; Dr. S.K. Mugford; Evidence, Dr. A.D. Wodak, p.1043; Dr. R. Marks, p.1115; Dr. G.B. Chesher, p.1366; 'Risk of arsenic in cocaine', Canberra Times, 31 March 1989, p.7; Bewley, T.H., Ben-Arie, O., and Pierce James, I., 'Morbidity and Mortality from Heroin Dependence', in British Medical Journal, 1968, vol.1, pp.725-6.
18. Submissions from Mr R.J. Swan; Mr K. Hansen; Mr A.B. Newton; Mr R. Walsh; the Salvation Army; Mr I. Campbell; the National Organisation for Reform of Marijuana Laws, pp.5, 17; Evidence, New South Wales Law Society, pp.1058-9.
19. Australian Law Reform Commission, Spent Convictions (ALRC 37, A.G.P.S., Canberra, 1987).
20. See Senate Hansard, 14 October 1988, p.1394.
21. Submissions from Mr D. Dowling; Mr K. Schwinning; Mr A.J. Tweedie; the South Australian Council for Civil Liberties; Mr J. Bourke, p.16; Dr. L.R.H. Drew, p.8; Mr M. Marx; Mr A. Ozols, pp.1, 4; the Law Council of Australia, pp.3-4; A Judge of a State Supreme Court; In Camera Evidence, A Judge of a State Supreme Court, pp.10-11; Evidence, N.S.W. Bar Association, p.1202; Dr. G.B. Chesher, p.1367; Mr M. Marx, pp.1453, 1461.
22. Submissions from Mr D. Dowling; Mr C. Warneminde; Dr. L.R.H. Drew, p.8; the Humanist Society of Victoria; Dr. S. McLean; Mr M. Fryszer; the Lions/ADFA Foundation; the Centre for Education and Information on Drugs and Alcohol; the Law Council of Australia, pp.8-9; the Alcohol and Drug Foundation, Australia; In Camera Evidence, A Judge of a State Supreme Court, p.26.
23. Submissions from the Rev. Dr. J.K. Williams, p.7; Dr. G.B. Chesher, Appendix, p.8; Dr. R. Marks, p.15; Mr A. Ozols, p.5; Ms J. Dallas; Evidence, South Australian Government, p.393; Dr. L.R.H. Drew, pp.898-9; Dr. G.B. Chesher, p.1366; Stimson, G.V., and Oppenheimer, E., Heroin Addiction - Treatment and Control in Britain (Tavistock, London, 1982), pp.74-5.

CHAPTER SIX

OPTIONS

Introduction

6.1 The question posed by the Committee in the fourth of its terms of reference is essentially whether the costs of the present policy of prohibition are worthwhile. The answer depends very much on what one believes the policy was designed to achieve. The stated aim of the National Campaign Against Drug Abuse is 'to minimise the harmful effects of drugs on Australian society' but it seems that harm minimisation means different things to different people. It is clear from the thrust of the campaign that at the official level harm minimisation means reducing the use of drugs, both by demand reduction (through education, treatment and rehabilitation) and by supply reduction (through law enforcement). An alternative interpretation, based on an acceptance of certain levels of drug use in Australian society, would emphasise the need to minimise the harm which users may do to themselves as a result of their drug use. Such an interpretation implies rather different policies to those being pursued at present.[1] It would suggest, for example, that the policy should put primary emphasis on safe use, rather than on deterring use, and that the supply of the illegal drugs should be regulated by the government in some way rather than being left outside the law in the hands of criminals. It would certainly imply that use and possession should not be criminal offences as they are at present.

The present policy of prohibition

6.2 The present policy of prohibition, which has been in place

in Australia for over half a century, rests on the view that there are some substances which are so harmful that people should not be allowed access to them. If the aim of the policy was to reduce the use of the prohibited substances, or even to minimise access to them, it has clearly failed. The last two decades have seen a dramatic increase in the use of the illegal drugs in the developed nations. Law enforcement agencies now concede that they cannot halt the traffic in such drugs. However it is contended that, by raising the price of the drugs and making access at least risky and difficult (both because of the possibility of arrest and the need to buy from criminal elements), the present policy deters new users who might be attracted to the drugs if they were as readily available as alcohol and tobacco.[2]

6.3 It is also suggested that the present policy encourages those who have become heavy users to consider treatment and abstinence. *Dobinson and Ward found that the most common* reason given by heroin users when asked why they stopped using for periods or sought treatment was that they were 'fed up' with the lifestyle of a regular heroin user, particularly the regular hassles of 'scoring' each day and getting enough money to do so and the problems caused by themselves, close friends or their usual suppliers being arrested.[3] Heavy users of marihuana and cocaine too are presumably forced to count the cost of their habits and the hassles of maintaining supplies. The present policy may also promote treatment in a more formal way through courts requiring offenders to enter rehabilitation programmes as a condition of bail or of a good behaviour bond.[4] However there are reasons to doubt whether such involuntary treatment achieves anything other than a saving to the state of the cost of imprisonment.[5]

6.4 In terms of minimising harm by reducing drug use the present policy therefore has a significant effect: it may deter new users from experimenting and existing users from continuing to use even though it may not be possible to prevent use

altogether. It does this at a cost to society and to the health and long term prospects of users outlined in the previous chapter. The widespread use of methadone maintenance has demonstrated that even persons who require daily doses of opiates to function normally can stabilise their lives although they may continue to abuse legal drugs, particularly alcohol and tobacco, and their employment prospects may remain poor. This supports the view that many of the aspects of heroin users' current lifestyles are determined solely by the illegality of the drug. The present policy also has some unintended consequences. It almost certainly adds to the glamour and attraction of the illegal drugs, particularly for persons who already identify themselves as deviant or delinquent and alienated from or rejecting the values of mainstream society.[6] The sensationalised coverage given to illegal drugs in the media, and particularly to new fashions in drug use, also contributes to their attractions. Legal drugs like *alcohol and tobacco are not reported in* the same way. Indeed it has been suggested that any manufacturer launching a new alcohol or tobacco product would be overjoyed to get the sort of coverage accorded to cocaine in the United States in the late 1970s and more recently to 'ecstasy'.

1. Harsher penalties

6.5 What then are the alternatives to the present policy? Is it possible to 'do it better'and thereby to cut off the supply of drugs to the market altogether? It has already been observed that the performance of the law enforcement agencies in reducing supplies reaching the market appears to have improved over the past decade. With better data it would be possible to evaluate law enforcement strategies more accurately and to place resources where they will be most effective. The Committee has already made recommendations to this effect above. However, for reasons given in Chapter 4, increased expenditure on law enforcement is unlikely to produce much reduction in drug use beyond present levels.

6.6 One alternative is to increase the penalties for trafficking in the hope that this will deter both those persons already in the trade and those who might be tempted to enter it. In fact penalties have been steadily increased over the course of the last two decades. In 1967, when the Commonwealth Customs Act was revised to take account of the Single Convention on Narcotic Drugs, a general penalty of $4,000 or ten years imprisonment was imposed for unlawful importation. In 1970, as a result of an agreement reached in the National Standing Control Commitee on Drugs of Dependence, a two tier system of penalties was introduced. Offences involving a trafficable quantity, defined in a Schedule to the Act, continued to carry the higher penalty, while offences involving a lesser quantity attracted only a fine of $2,000 or two years imprisonment.

6.7 In 1976 the penalty for offences involving trafficable quantities of drugs other than cannabis was raised to $100,000 or 25 years imprisonment or both. The maximum penalty in respect of trafficable quantities of cannabis remained $4,000 or ten years imprisonmenmt and offences involving lesser quantities continued to carry the penalty of $2,000 or 2 years imprisonment. In 1979 the concept of a commercial quantity was introduced - 100 kilograms in respect of cannabis, for example, and 1.5 kilograms in respect of heroin - and a new maximum penalty of life imprisonment without the option of a fine was introduced in respect of offences involving such quantities. Comprehensive data are not kept which would enable one to say whether this increase in the maximum penalties available to judges has been matched by a trend in the actual sentences imposed. However sentences of over 20 years imprisonment for major trafficking offences are now becoming commonplace.

6.8 Despite this increase in penalties there has been no diminution in the size of the drug trade. The experience of overseas countries which have imposed the death penalty for drug

trafficking is also not encouraging in this regard. In Singapore, which introduced the death penalty in 1975, the estimated number of addicts grew from 2,000 in 1975 to 13,000 in 1977. Malaysia, which likewise introduced the death penalty in 1975, identified 55,395 addicts between 1970 and 1980. By 1985 there were 101,000 registered addicts and the total addict population was estimated at half a million, in a country of only 15 million people. Pakistan, which had almost no problem with heroin abuse in 1979, now has an estimated 700,000 to 900,000 addicts.[7]

6.9 There are a number of logical reasons why increased penalties may be expected to make little impact on the overall trade in the illegal drugs. First, following the analysis in Chapter 4, the most likely response by the traffickers to any perceived increase of risk would be to raise the price of their product, thus increasing the incentive for others to enter the trade. Secondly, as was also argued above, even if a significant number of traffickers were to be captured and executed, others may still be tempted to enter the trade because of the very substantial rewards it offers. Thirdly, drug traffickers probably do not make a rational calculation of risks when entering the trade in any case, and, if they do, it is more likely to concern the probability of detection and conviction than the possible penalties which may be imposed. Unless, therefore, the risk of detection can be significantly raised, the increased penalties are unlikely to have any deterrent effect.[8] For similar reasons, forfeiture of assets legislation may not be the 'magic bullet' which it is often suggested to be. While the idea of seizing the ill-gotten gains of the drug traffickers is very attractive, it is still necessary to catch and convict them first and to identify their assets. The Committee is sceptical of the claims that were made to it by the Commonwealth Attorney-General's Department that those countries which make a speciality of banking secrecy are simply going to drop all their resistance to opening their books for all to see.[9]

6.10 It may be argued that there are reasons for the failure of law enforcement to make an impact on the drug trade in the Asian countries referred to above which would not apply in Australia. In this regard the experience of New York State in the United States of America is instructive. In 1973 New York State radically revised its law relating to illegal drug use. Mandatory minimum sentences of 15 years to life were set for dealers selling one ounce or more of heroin or possessing more than two ounces. These quantities were set by reference to the gross weight of the substance seized rather than the quantity of heroin it might contain. The new drug law was said to have two objectives. It was intended to deter drug dealers and thus to reduce illegal drug use and it was intended to reduce crimes associated with drug use, such as robbery, burglary and theft.

6.11 On both these counts the new law failed. A study by a Joint Committee of the Drug Abuse Council and the Association of the Bar of the City of New York in 1976 found that there was no evidence that heroin use had declined or that the availability of heroin in New York City had been affected. Police officials and drug treatment administrators agreed that the marketplace was as open in mid-1976 as at any time in their experience. Serious property crime of the sort associated with heroin users increased in New York State at the same rate as that found in neighbouring States and the number of crimes attributed to narcotics users in New York City itself remained constant. The main effect of the new law was on the courts. Between 1973 and 1976 the time taken to deal with cases relating to drug offences nearly doubled despite the appointment of 49 new judges. The demand for trials rose sharply: whereas under the old law only 6 per cent of drug indictments in New York City had been disposed of by trial, under the 1973 law trials rose to 16 per cent of dispositions.[10]

6.12 The principal conclusion of the Joint Committee on New York Drug Law Evaluation is pertinent in the Australian context:

> 'New York City suffered from heavy congestion of its court system prior to the enactment of the 1973 law. In any state or city suffering from similar court congestion, it would make little difference whether laws like New York's were passed or not. If enacted, such statutes would be likely to founder in the implementation process; the major result would probably be an increase in the amount of money spent.'[11]

The benefits of increased penalties are therefore doubtful in the Australian context. The Queensland Government told the Committee that, based on its intelligence, it believed that many big traffickers had left the State since the imposition of penalties of mandatory life imprisonment for trafficking under the Drugs Misuse Act in 1986. However the representatives of the Queensland Government conceded that they had no evidence that the quantity of drugs reaching the marketplace had actually declined or that there were fewer drug users in Queensland as a result of the change to the law.[12] This is the crux of the issue: the aim of the present policy of prohibition is not just to seize more drugs or to put more people in prison. It is to reduce the amount of drugs reaching the marketplace and thereby to reduce the number of drug users. Unless an option does this it cannot be judged a success.

2. <u>De facto decriminalisation</u>

6.13 The costs imposed on users by the present policy of prohibition of use and possession of the illegal drugs have prompted suggestions that these prohibitions should be relaxed while maintaining the prohibition on commercial cultivation, manufacture, import, export and commercial sale. Various methods have been proposed for achieving this including discretionary non-enforcement of the present laws ('the Dutch system'), decriminalisation (implying a system of 'on-the-spot' fines as in South Australia) and partial prohibition (the legalisation of possession and use and the cultivation and distribution of illegal drugs for personal use provided no profit is made). The

chief objection to these alternatives is that they would send a message to potential users that society does not regard drugs as harmful, thus leading to an increase in use. However society already sends mixed messages in relation to cannabis in particular where the penalties are so negligible as to make the law a 'Clayton's prohibition' - the prohibition you have when you're not having a real prohibition - as one submission terms it.[13]

6.14 In the Netherlands a policy which may be termed de facto decriminalisation has been adopted whereby the laws prohibiting possession of the illegal drugs including cannabis remain on the statute book but are not enforced. As a result of a review of drug policy in 1972, the Netherlands decided to make a conscious distinction between drug users and drug traffickers. Against the background of a legal system which affords considerable prosecutorial discretion the decision was made not to prosecute the users of cannabis products. As Dr. E.L. Engelsman, the Head of the Alcohol, Drugs and Tobacco Branch of the Dutch Ministry of Welfare, Health and Cultural Affairs expresses it:

> 'If criminal proceedings against cannabis users do not eliminate the drug problem but aggravate it, the law steps aside. The same principle accounts for the sale of limited quantities of hashish in youth centres and coffee shops. This aims at a separation of the markets in which hard drugs and soft drugs circulate.'[14]

6.15 With regard to the harder drugs, a policy on non-enforcement of the laws regarding use of these drugs is also followed. The Dutch Government instead pursues a policy of 'normalisation' intended to de-mythologise and de-glamourise the image of the 'junkie'. In place of older policies aimed solely at abstinence, health policies are now aimed at improving addicts' physical and social well-being and helping them to function in society. Considerable efforts have been made to ensure that addicts are in contact with treatment services through fieldwork,

open-door centres for prostitutes, supply of methadone from buses which travel round Amsterdam and the like. Where addicts are arrested for drug-related crimes pressure is put upon them to undergo treatment as an alternative to imprisonment. The trafficking of 'hard' drugs, on the other hand, incurs penalties of up to 12 years imprisonment.[15]

6.16 What has been the result of these initiatives? The prevalence of cannabis use in the Netherlands is low and has remained low. In the age bracket between 10-18 years, 4.2 per cent have ever used cannabis and only 1.8 per cent are current users. In Amsterdam a survey in December 1987 of 4,370 persons 12 years and older found that only 22.8 per cent had ever used cannabis and that 5.5 per cent had used cannabis within the last month. These are lower than the comparable Australian percentages. Estimates of the number of drug addicts in the Netherlands vary between 15,000 and 20,000 out of a total Dutch population of 14.7 million. In Amsterdam there are estimated to be 4,000 to 7,000 addicts out of a population of 640,000, of whom 60 to 80 per cent are being reached by some form of government assistance. Only 8 per cent of all 605 Dutch AIDS patients were drug addicts as at 1 October 1988 compared to a rate of 23 per cent for the whole of Europe. The policy of 'normalisation' has not produced a higher rate of crime in the Netherlands than in neighbouring countries. The average age of drug users is increasing and, despite the fact that some 6,300 addicts are receiving daily doses of methadone, there have never been so many drug addicts asking for detoxification and drug free treatment as at present.[16]

3. Decriminalisation

6.17 There are objections to a system of discretionary non-enforcement, however, in that it places very great power in the hands of those responsible for enforcing the law, both police and prosecutors. If some persons are prosecuted they will argue

that the law is being applied unevenly and that favouritism has been shown. Such a policy also offers the opportunity to law enforcement to organise a systematic protection racket. This has not occurred in the Netherlands in respect of the cafes and bars which are permitted to sell cannabis products there but the Australian experience with an unspoken policy of discretionary non-enforcement of the laws relating to prostitution would not encourage one to be sanguine about similar prospects here.

6.18 Decriminalisation avoids this problem. It was recommended in respect of cannabis both by a majority of the Senate Standing Committee on Social Welfare in its 1977 report, Drug Problems in Australia - an Intoxicated Society?, and by a majority of the New South Wales Joint Parliamentary Committee Upon Drugs in 1978. However, as the Sackville Royal Commission remarked in rejecting it, it really only regularises the present situation where entirely predictable fines are imposed for cannabis offences. Its only significant effect is thus a saving in court time and even that prospect may be illusory if the South Australian experience is any guide. Of the 3,540 'expiation notices' issued under the new law in that State from 1 May 1987 to 29 February 1988, only 1,567 or 44.3 per cent were paid. The majority of offenders have therefore chosen to be prosecuted in the normal manner.[17]

6.19 Partial prohibition was the alternative advocated by the Sackville Royal Commission in respect of cannabis, and it is probably only feasible in respect of that drug. The cannabis plant can be cultivated quite readily in Australia and much of the market could be supplied in this fashion. By contrast, while opium may also be grown in this country, the extraction of heroin is a more complex process and it is not possible to envisage persons making heroin from their own opium poppies for personal use. Similar considerations apply in respect of the extraction of cocaine from coca leaves. The amphetamines are manufactured in home laboratories at present but their quality is unreliable. Where cannabis is concerned it is said that partial prohibition

would avoid making criminals of otherwise law-abiding people and that it would undercut much of the illicit market. Dr S.K. Mugford noted in his submission to this Committee that there would be no quality control on the product under this alternative, no monitoring of the amounts used by individuals or use by persons under the age of 18 and no benefit to government in terms of taxation revenue. He also argues that a substantial illicit market would remain to service those who would prefer not to grow their own.[18]

6.20 One fear that is raised in relation to decriminalisation is that it would lead to an increase in the use of cannabis. It is too early to draw any conclusions in respect of the change to the law in South Australia but the experience in the United States is relevant. Eleven States have decriminalised the possession of marihuana for personal use in various ways, some by imposing fines only (as in South Australia) and others by imposing civil penalties. Four - Oregon, Maine, Ohio and California - have conducted studies on the effects of the change to the law. While the percentage of adults admitting to use of marihuana in Oregon increased from 20 per cent in 1974 to 24 per cent in 1977, this was no greater than the national increase in the same period. In Maine less than 1 per cent of adults and 3.1 per cent of high school students reported any increase in their use as a result of the change to the law. In Ohio the rate of use in the past month grew from 27.4 per cent in 1974 to 33.4 per cent in 1978 among those aged 18-24 and from 5.6 per cent in 1974 to 19.1 per cent in 1978 among those aged 25-34. The State of California conducted two surveys, one 11 months before the change to the law and one 10 months after. Of the population aged 18 and over, those who reported ever using marihuana grew from 28 per cent in February 1975 to 35 per cent in November 1986. Annual trend studies conducted in San Mateo county in California indicate that neither use nor heavy use by adolescents were affected by the change to the law, so that it seems safe to conclude that the increase in use was made up of older users, the greatest increase being among

those aged 30-39. General population surveys demonstrate that marihuana use has declined significantly in the United States since the late 1970s and the States which decriminalised are not exceptions to this trend. In 1983 a survey found that 12 per cent of adults in California smoked marihuana, down from 17 per cent in 1979. There were significant decreases in arrests and savings in law enforcement costs associated with decriminalisation: the total costs of marihuana enforcement in California dropped 74 per cent between the first six months of 1975 and the first six months of 1986.[19]

4. Prescription

6.21 The impracticality of decriminalisation as an option in respect of the so-called 'hard' drugs has led those wishing for some change to the law to advocate that all such drugs, or heroin at least, should be made available on prescription from doctors or through special clinics. Reference is often made in this context to the British experience in supplying heroin as a maintenance drug to addicts in much the same way that we supply methadone to addicts as a maintenance drug in this country. When, following the prohibition of non-medical use of opium, morphine, heroin and cocaine in the United Kingdom in 1920, the question arose as to whether it was proper for doctors to prescribe these drugs to addicts, a committee was formed under the chairmanship of Sir Humphrey Rolleston, President of the Royal College of Physicians. The Rolleston Committee reported in 1926 that it was legitimate to use heroin and morphine for the relief of pain due to organic disease such as inoperable cancer even if it might lead to addiction. It also concluded that it was legitimate to use such drugs for the treatment of addicts undergoing gradual withdrawal. Finally it concluded that it was legitimate to prescribe such drugs for persons who would otherwise develop such serious symptoms that they could not be treated in private practice and for those who were capable of living a normal and

useful life so long as the supply of the drug in small quantities was continued.[20]

6.22 It is important to note that most of the British addicts in this post-war period and indeed for the next thirty years had become addicted to opiates in the course of medical treatment. The system established by the Rolleston Committee began to break down, however, when a new class of non-therapeutic addicts appeared, seeking the drugs for their euphoric effects. Most doctors felt unhappy about prescribing drugs of addiction to such addicts and this task therefore fell on a few marginalised doctors who received little support from the rest of the profession. Some were no doubt quite sincere in what they were doing while others were simply interested in the potential profits to be made. Addicts were receiving massive doses of both heroin and cocaine for their own use and were also re-selling part of what they received to occasional users who in turn became addicted. In March 1967 OZ magazine reported the way in which the black market operated around Piccadilly Circus at the time:

> 'One of the most amenable pushers is a blonde well-built American girl of 22 who collects her heroin every evening between six and seven. "I think your English Health Service is wonderful!" The usual routine is to follow her until she stands by the left-luggage lockers in Piccadilly Tube after six o'clock. After a brief conversation she will sell heroin at [3 shillings and fourpence a 10 mg pill or one pound for six pills]. This has been the standard price for some time; such heroin is good unadulterated [National Health Service] heroin.'[21]

6.23 Two points should be made about the British system prior to 1968. First, so far from eliminating the black market it actually created one, although it was entirely supplied by the over-prescribing of a few doctors. Secondly, despite the fact that addicts were being supplied with heroin of known purity and strength, they still died of overdoses and their overall mortality rate was 28 times the normal mortality rate and over

twice that of heroin addicts in New York. There is probably an element of self-selection in these cases (in that only a very small group of persons following deviant lifestyles were addicted to heroin in Britain during this period) but it does seem that a supply of pure and unadulterated heroin is not on its own a sufficient condition for addicts to live long and productive lives. This is borne out by other studies of the British system both before and after it changed in 1968 which point to the existence of a number of different types of addicts, some of whom adopted a 'junkie' lifestyle as a matter of preference, while others, given the chance, stabilised their lives. The experience of a number of Canadian addicts who migrated to Britain for the free heroin supports this. Twenty-five of these addicts were traced in 1969 and 13 of them were employed and had been employed for periods of between 6 months and 7 years. In Canada the 25 addicts had been convicted a total of 182 times, an average of 7 times each, and they had spent 141 years and 2 months in prison, an average of 7 years each (although the group included two who had served no time at all). In England, though six of them had done time, the total was only two years and five months.[22]

6.24 The British Government responded to this increase in non-therapeutic addiction caused by the over-prescribing of a few *doctors* by *restricting the power of doctors to prescribe heroin* and cocaine except for the relief of organic disease or injury to doctors specially licensed for that purpose. This inaugurated the so-called 'clinic system' which has applied in Britain since 1968 where heroin, cocaine and methadone are provided through special clinics generally located in major hospitals.[23] Although at the outset heroin was provided to the vast majority of addicts the clinics have progressively substituted methadone so that it is now very rare for newly registered addicts to be given heroin although there are still significant numbers of addicts who became addicted in the pre-1968 days who are being maintained on heroin. Stimson and Oppenheimer argue that the switch from heroin to methadone came partly as a result of doctors' preferences and

partly as a result of pressure from the Home Office. Doctors felt that they should be doing something to treat addicts whereas addicts saw the purpose of the clinics as a mechanism for dispensing their drugs to them. The doctors felt that offering oral methadone rather than injectable heroin was more confrontational and therefore a step in a therapeutic direction. Peer pressure also operated to keep the prescribing of heroin down.[24]

6.25 *Whether one considers, as some submissions to this* Committee have suggested, that 'the British system' has failed depends largely on one's view of its objectives. It has clearly failed to stop the growth of a black market in heroin in Britain but it is arguable that the prescribing of addictive drugs can never hope to do this. If prescribing is restricted to those who are addicted there will always be a substantial number of occasional and experimental users who remain outside the system because they are ineligible to obtain prescriptions. Once they have developed a bad enough habit they will appear at the clinics but they may also continue to supplement their legal supplies of drugs with black market drugs, either because they are not being prescribed what they consider to be a sufficient dose or because they are not being prescribed their drug of preference, usually heroin.[25] There is substantial evidence, on the other hand, that maintenance systems such as the British system and that operating in this country using methadone do provide addicts who wish to do so with an opportunity to stabilise their lives and, in some cases to get off the opiates altogether. In Stimson and Oppenheimer's follow-up study of 128 addicts who had been receiving prescriptions for heroin at London clinics in 1969 they found that by 1979 15 per cent had died, 38 per cent were still attending clinics and still receiving prescriptions, 38 per cent were abstinent from opiates and were leading reasonably ordinary lives and the remaining 9 per cent were of uncertain status. Of those receiving prescriptions, 38 had jobs. Stimson and Oppenheimer argue that stability is not a necessary consequence

of maintenance schemes, but that they provide the opportunity for those who wish to do so to stabilise their lives. Those addicts whom they characterised as leading a 'junkie' lifestyle in their initial study in 1969 tended by 1979 to be abstinent, in prison or dead. By contrast, the 'stable' addicts of 1969 tended still to be receiving prescriptions from the clinics in 1979.[26]

6.26 Prescription or maintenance schemes suffer from the inevitable defect that they create two markets for the illegal drugs. Those who can establish they are addicts receive their drugs on prescription free or at nominal cost while occasional or social and new users must continue to seek their drugs on the black market. This may be thought to serve the ends of policy in that non-dependent users will be discouraged from using drugs by the high price and risk and difficulty attendant on buying them in this fashion, as at present. Unfortunately this gives the dependent users every incentive to divert part of the supplies they obtain on prescription into the black market. They may even inflate the size of their habits to obtain more heroin or methadone for diversion. Those administering the scheme may suspect that this is occurring, but the only sanctions they can apply are to reduce the amount of the drug prescribed - which may lead the addict to supplement the legal drug with illegal drugs obtained on the street - or to terminate the addict from the scheme altogether, which defeats its purpose.[27]

6.27 One solution to the problem of diversion is not to allow the dependent users to take their drugs home but to require them to consume them under the supervision of an independent observer on the premises where they are supplied. This works readily in the case of methadone, which may be taken orally and which, because it is longer-acting, need only be taken once a day. Even so it is inconvenient for many persons, depending on the arrangements for dispensing the drug in the different States. By contrast heroin is normally injected and must generally be taken at least three times a day by dependent users. In the Australian

context it has been suggested that clinics could be established where users could inject themselves and 'nod off' but it is not known how attractive this option would prove to dependent users and it is certain to prove unattractive to residents of the neighbourhoods where such clinics might be established. Moreover, whereas one of the attractions of the provision of drugs on prescription in its simple form is its low cost, such 24 hour a day clinics would be very expensive to run.[28]

6.28 Because of the need to inject three times a day, heroin maintenance is probably less likely than methadone maintenance to allow dependent users to lead relatively normal lives and to obtain employment although the British experience certainly indicates that this is possible. Methadone maintenance schemes in particular have shown great potential in cutting rates of property crime, even though, as adverted to in the previous chapter, it may be unrealistic to expect all reformed addicts to abandon crime altogether. All maintenance programmes suffer from the difficulty involved in determining whether a person is dependent and therefore eligible to participate in the scheme. It has been alleged that unsatisfactory screening has led to the participation in such schemes of many people who were not addicted, thus creating addiction to an opiate where none previously existed. On the other hand rigorous screening makes such programmes unattractive to addicts. Maintenance programmes also place great power in the hands of the doctors administering them and it may be thought undesirable to give someone, however well qualified, the power to terminate an addict from such a programme with no right of appeal.[29]

6.29 Making the illegal drugs available to dependent users on prescription has generally only been discussed in relation to heroin. However the threat of the spread of human immuno-deficiency virus (HIV) infection among intravenous drug users has led to proposals that not only heroin but also cocaine and amphetamines be made available on prescription in injectable

form to users of these drugs. On 2 November 1988 the National Health and Medical Research Council endorsed a proposal for a trial under which a selected group of intravenous drug users would be given injectable drugs on prescription in single use syringes. The chief merit of such proposals from the AIDS perspective is said to be that they will remove any need to share needles. It is not clear why the unrestricted provision of clean needles and syringes cannot be expected to have the same effect, especially if steps are taken to repeal any laws which prohibit the possession of equipment for injection or which make the possession of such equipment presumptive evidence in the prosecution of offences relating to illicit drug use. Moreover it is by no means a foregone conclusion that occasional or social users, who constitute by far the largest group of intravenous drug users, will be prepared to obtain their supplies through doctors or clinics.[30]

5. Licensing

6.30 An alternative approach for the controlled supply of drugs which was advocated by Dr Mugford in his submission is that users should be required to be licensed in much the same manner as people wishing to purchase firearms are under present laws. They would be required to be over 18 and to have undertaken a course in drug education and they would be required to wait for a 'cooling off' period between applying for and actually obtaining their licence. They would be able to purchase over the counter supplies of quality controlled, government taxed drugs on production of their licence. Details of all purchases would be filed in a central computer allowing monitoring of levels of use. Those users with heavy levels of use could be identified in this fashion and counselled and those suspected of re-selling could likewise be monitored.[31] Dr Mugford does not spell out the consequences of re-selling but it is presumed that the user's licence might be suspended or cancelled. The concept of a central computer monitoring users' levels of use has significant privacy

implications but over and above this it is not very clear why Dr Mugford believes that users will be attracted into such a scheme. The idea of making drug use boring and bureaucratic is a good one to the extent that it de-glamourises drugs but at the same time it makes the scheme unattractive to the very sort of people who are most likely to get into trouble with the illegal drugs. The scheme could prove attractive to occasional or social users if privacy objections could be overcome - who would want it to be known, for example, that they were a licensed, card-carrying heroin user - but it is unlikely to reach the young, disaffected polydrug abusers who seem to provide the core group for heroin addiction in particular. Moreover, because the scheme is not restricted to dependent users it approximates far more closely to a system of free availability and, as discussed below, could therefore lead to a dramatic increase in the incidence of use of those drugs which are presently illegal.

6. Regulation

6.31 Two options are available if the possession, use, supply, importation and exportation of the illegal drugs are to be made the subject of regulation, rather than of prohibition. First, the market could be regulated in the same way as it is with alcohol and tobacco. Restrictions could be imposed on the age at which persons would be permitted to use the drugs, the premises where they would be sold could be required to be licensed and advertising could be prohibited or restricted. The government could impose an excise which would make the previously illegal drugs more or less expensive based on an assessment of their potential for abuse and ordinary controls on the quality and purity of the products could apply. This model, generally referred to as commercial sale, has proved unattractive to most submittors.[32] Secondly, the production and sale of the previously illegal drugs could be handled by a government monopoly. Senator Wheeldon (as he then was) posited such a system in relation to cannabis in a reservation appended to the report of the Senate

Select Committee on Drug Trafficking and Drug Abuse in 1971 and the Sackville Royal Commission canvassed a similar option but rejected it on the grounds that it posed an unacceptable risk of a significant increase in use.[33] Under this option cannabis would be cultivated under licence from a government agency. A similar system obtains in respect of the cultivation of opium poppies in Tasmania today and the system could presumably be extended to include the manufacture under licence of heroin and other drugs which require more processing than cannabis. The government agency would then be responsible for marketing the products through licensed retail outlets - possibly pharmacies - with labelling giving details of purity and strength. Sale to minors and all advertising would be prohibited. As with commercial sale, an appropriate excise would be imposed. Both of these alternatives would be in breach of Australia's obligations under the Single Convention on Narcotic Drugs and it would be necessary for the Government to withdraw from the Convention before it could proceed down this path.[34]

6.32 The arguments for doing so are drawn from a number of sources. The libertarians take their text from John Stuart Mill:

> '[T]he only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forebear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right.'[35]

6.33 Mill opposed attempts to control the opium trade in the name of the liberty of the opium smoker, he opposed laws requiring a prescription to buy certain drugs and he opposed prohibition in respect of alcohol, which temperance movements made a live issue in his lifetime. He argued that you may educate and persuade people not to misuse drugs, or not to use them at

all, and you may punish them for the harm they do to others produced by the use of drugs, but each person must be the guardian of their own health and morals. What adults do is none of the business of the state so long as it does not violate a specific duty to the public or occasion perceptible harm to any individual.[36]

6.34 The most significant objection to the acceptance of Mill's principle as the basis for policy in this area is that the great majority of people in modern society probably do not agree with it. Increasingly we have recognised self-harming conduct as an appropriate subject for official prohibition. Laws requiring motorists to wear seatbelts and motorcyclists to wear helmets are cases in point. Libertarians stress that we are inconsistent in this regard, permitting many recreational activities such as mountain climbing which are inherently dangerous, but where recreational drug use is concerned the prohibition is regarded as justifiable because we do not recognise the recreational use of drugs as satisfying any legitimate need or desire. The libertarians are on stronger ground when they point to our hypocrisy in permitting the promotion of the legal drugs, alcohol and tobacco, both of which are as damaging in their own ways as cannabis, for example. Prohibition of these drugs would clearly be unacceptable although Mill's concept of education and persuasion is working to reduce the level of tobacco use.[37]

6.35 Those arguing for regulation make great play of the failure of alcohol prohibition in the United States. The modern view of prohibition has been somewhat distorted by the proponents of reform like the journalist Franklin P. Adams who, responding to President Hoover's Commission on alcohol prohibition, observed:

> 'It's left a trail of filth and slime;
> It's filled the land with vice and crime;
> It don't prohibit worth a dime.'[38]

6.36 In fact prohibition almost certainly reduced alcohol consumption. Cirrhosis of the liver, for example, dropped sharply. Death rates from cirrhosis were 29.5 per 100,000 in 1911 for men, and 10.7 in 1929. Alcohol became relatively expensive and in consequence the poor in particular drank less.[39] Most people never saw a speakeasy and the conspicuous consumption of the rich cannot be taken as indicative of the habits of the population as a whole. The repeal movement was led by hotel and real estate interests and emphasised taxes, jobs and the elimination of enforcement costs, all important in depression America. As Bakalar and Grinspoon observe:

> 'Repeal came not because prohibition was totally ineffective, but because we decided - although we seldom express it this way - that we wanted the pleasure of convenient, legal alcohol more than we feared an increase in drunkenness and alcoholism. It is still unthinkable to make the same kind of balancing judgment about any other drug, even to come to a different conclusion.'[40]

6.37 This last observation is borne out in the submissions received by the Committee. No one argues that consumption of any of the illegal drugs except marihuana is a good thing and the proponents of regulation generally argue that the recreational use of all drugs, legal and illegal, should be discouraged. They do invite the Committee, however, to balance the benefits of the present policy of prohibition in deterring new users and encouraging existing users to seek treatment against its costs both to society in terms of law enforcement, crime and corruption and to the users themselves in terms of damage to their health and even their deaths. Regulation, they argue, would not lead to a vast increase in the number of users or the number of addicts, that is, those for whom the drug becomes an overwhelming preoccupation to the exclusion of other aspects of their lives. Dr Les Drew argues, for example, that only 5-10 per cent of Australians would ever be prepared to inject themselves with heroin. If heroin were sufficiently cheap and readily available, however, a greater number might be prepared to use the drug by

other methods of administration, for example 'chasing the dragon' (inhaling the fumes of the drug). Even Dr Drew's estimate would represent a ten-fold increase in levels of heroin use in this country.[41]

6.38 Proponents of regulation argue that against this possible increase in use must be balanced the benefits which would flow from the elimination of the illicit market. Even if legal supplies were heavily taxed to act as a disincentive to widespread use it would still be possible to undercut the illicit market which would therefore die away. There would be savings in law enforcement costs, in court time, and in the costs of imprisonment. At the same time the proceeds derived from taxes could be used to fund drug education and rehabilitation programmes. The costs to the community of drug-related organised crime, corruption and property crime would be eliminated. Crime and corruption would of course not disappear but they would no longer be fuelled by the need to purchase drugs at artificially inflated black market prices. The illegal drugs would no longer have the glamour of forbidden fruit. Heroin users would no longer suffer the consequences of injecting drugs of uncertain strength and purity and barriers to their seeking medical treatment would be removed. No longer pariahs to mainstream society they would come forward more readily for medical treatment and could be targetted for education on such issues as the risk of sharing needles in the age of AIDS. Cheaper heroin in particular could be expected to lead to a reduction in injection and a change to other methods of administration which pose fewer dangers to the health of the user. Informal social controls might develop which would operate as barriers to heavy use and addiction.[42]

6.39 Opponents of regulation argue, correctly, that much of the projection of its effects is pure speculation. Data drawn from studies of the use of the illegal drugs in societies where there are long traditions of such use - for example 'ganja' (cannabis) in Jamaica and opium in Pakistan - is of little assistance in

projecting the consequences of the lifting of the prohibition on the presently illegal drugs in societies where there are no informal social controls. Besides, as noted above, societies like Pakistan and Thailand where opium smoking has been a tradition are experiencing their own problems with the more refined form of this drug, namely heroin. The prevalence of heroin addiction in our own society before prohibition was imposed may also not provide a valid indicator since the phenomenon of non-therapeutic addiction was virtually unknown throughout the world apart from the United States until the late 1950s. The experience of the United States with decriminalisation of marihuana suggests that projections of enormous increases may be inaccurate but it can be argued that there are significant differences between decriminalisation, where societal disapproval and a legal sanction are maintained, and regulation. Availability is an important determinant of use as the experience of the United States soldiers in Vietnam demonstrates. The representatives of the Queensland Government also pointed to the extent of abuse of the opiates among medical professionals who have access to these drugs through their work as a possible indicator of the potential levels of opiate use in our society were such drugs to be made legally available.[43]

6.40 Not only is there disagreement about the potential increase in use were the illegal drugs to be made available subject to regulation, there is also disagreement about whether the benefits outlined above would eventuate. For example it is argued that if only heroin were to be made available, the black market would turn to other drugs such as cocaine. Although heroin users appear to prefer heroin, they might turn to cocaine if it were more readily available, as in the United States at present, and novice users might find cocaine more attractive than heroin because it has a 'party' image whereas heroin has a 'heavy' character.[44] If all drugs which might conceivably be used recreationally must be made available in order to undercut the black market then we would face the unpalatable prospect of legal amphetamines, legal

barbiturates, and even legal hallucinogens such as LSD and PCP (phencyclidine piperidine). Furthermore it is argued that, even if we were to succeed in getting organised crime out of the drug market, it would simply turn its attention elsewhere as it did on the repeal of prohibition in America. Likewise, it is said, we would be foolish to think that what we now call drug-related crime will go away just because the criminals no longer need to steal to buy drugs: they will very likely continue their criminal careers, perhaps at a reduced level, and will spend their ill-gotten gains in other ways. Nor will regulation necessarily mean an end to needle sharing or the health problems of drug users. As in Britain, some addicts would stabilise their lives but others would continue to conform to the chaotic 'junkie' lifestyle. The health problems associated with the present legal drugs indicate something of the additional costs which might be expected if there were a net increase in drug use. It cannot be assumed that only a static proportion of the community will get into trouble with drugs: as noted in Chapter 2 our response to drugs depends on the complex interaction of the drugs themselves, our personal 'set' and the 'setting' of drug use. To the extent that users of drugs such as heroin, cocaine and amphetamines continue to use intravenous injection as a mode of injection there will be inevitable health problems irrespective of the legality or purity of the substance being injected. Lastly, Mr Milton Luger of the James McGrath Foundation, which runs Odyssey House, argued that making the previously illegal drugs available subject to regulation was a way of evading the real causes of drug abuse in our society: inadequate family role modelling, irrelevant school curricula, youth unemployment, lack of family communication skills, stereotyped sexual roles, racial and ethnic discrimination, incest and physical abuse.[45]

Conclusion

6.41 Although very brief, this discussion of the options available indicates that there is no easy solution to the problem

of how the law should deal with the use of those drugs which are presently illegal. Each option involves trade-offs between costs and benefits. The present policy raises prices and restricts access, thus making it more risky and difficult for both new and existing users to obtain drugs. It deters new users and may push existing users into treatment and rehabilitation programmes. At the same time it imposes an enormous cost on the users themselves - through damage to their health and now the threat of the spread of AIDS through sharing needles - and on society at large through drug-related street crime, corruption and the direct costs of law enforcement. At the other end of the spectrum making the presently illegal drugs available subject to government regulation would eliminate many of the social costs although not necessarily diminishing the health problems of addicts or improving their employment prospects. At the same time, however, it could lead to a dramatic increase in the use of the drugs and almost certainly to an increase in addiction. The alternatives along the continuum between the two extremes of prohibition and regulation each carry some of the costs and benefits of those two options. Thus decriminalisation of cannabis does not provide quality controls, controls on the use of the drug by underage persons or the possibility of taxation revenue while it would no doubt diminish the illegal market to a significant degree. Prescription of heroin to dependent users may ease some of their health-related problems and draw them into counselling on needle-sharing and treatment programmes but it leaves the occasional or social users and new users still seeking their supplies of the drug on the black market.

1. See Drew, L.R.H., 'Editorial: Minimising drug problems: the importance of harm reduction strategies', in Australian Drug and Alcohol Review, vol.7, no.2 (April 1988), pp.139-40.
2. E.g. Evidence, Western Australian Government, pp.204-6; Professor D. Hawks, p.320.
3. Dobinson, I., and Ward, P., Drugs and Crime - Phase II (N.S.W. Bureau of Crime Statistics and Research, Sydney, 1987), p.41.
4. Submission from the Western Australian Council on Addictions, p.5; Evidence, Mr M. Luger, pp.1234, 1239.
5. See for example, Evidence, Mr M.Marx, p.1455.
6. In Camera Evidence, A Judge of a State Supreme Court, p.30; Evidence, Fitzroy Legal Society, p.93; Mr M. Luger, p.1231; Mr M. Marx, pp.1462-3.
7. Trebach, A.S., 'The Need for Reform of International Narcotics Laws' in Hamowy, R., ed., Dealing With Drugs - Consequences of Government Control (Lexington Books, Lexington, 1987), pp.103-136 at pp.112-3; Krivanek, J.A., Heroin: Myths and Reality (Allen & Unwin, Sydney, 1988), p.113; Submission from the Australian Federal Police, p.3.
8. Submissions from Dr. S.K. Mugford; Dr. G. Wardlaw, p.6; Evidence, Mr P. Delianis, p.34.
9. Evidence, Commonwealth Attorney-General's Department and Department of Community Services and Health, pp.535, 537-40.
10. Joint Committee on New York Drug Law Evaluation, The Nation's Toughest Drug Law: Evaluating the New York Experience (National Institute of Law Enforcement and Criminal Justice, U.S. Department of Justice, Washington, 1978), pp.3-11, 17.
11. Ibid., p.25.
12. Submission from the Queensland Government, p.3; Evidence, pp.159-60.
13. Submission from the Fizroy Legal Service, p.9.
14. Engelsman, E.L., 'Responding to drug problems: Dutch policy and practice', unpublished paper delivered at the International Conference on Drug Policy Reform, Washington, 20-23 October 1988, p.8. The Committee is indebted to Dr Engelsman for providing it with a copy of this paper.
15. Ibid., pp.14-18, 22; see also Scheerer, S., 'The New Dutch and German Drug Laws: Social and Political Conditions for Criminalization and Decriminalization', 12 Law and Society (Summer 1978), pp.585-606.
16. Engelsman, op.cit., pp.9, 19-24.
17. Senate Standing Committee on Social Welfare, Drug Problems in Australia - an Intoxicated Society? (Parliamentary Paper No.228/1977, A.G.P.S., Canberra, 1977), p.165; New South Wales Joint Parliamentary Committee Upon Drugs, Report Into Drug Abuses (N.S.W. Government Printer, Sydney, 1978), p.215; South Australia, Royal Commission into the Non-Medical Use of Drugs, Cannabis - A Discussion Paper (Adelaide, 1978), pp.82-3; Submission from the South Australian Government (Drug and Alcohol Services Council), Attachment, p.18.
18. South Australia, Royal Commission into the Non-Medical Use of Drugs (Chairman: Professor R. Sackville), Final Report (S.A. Government, Adelaide, 1979), pp.309-11; Submission from Dr. S.K. Mugford.

19. Single, E., 'The Impact of Marijuana Decriminalization', in Research Advances in Alcohol and Drug Problems, vol.6 (1981), pp.405-24; Maloff, D., 'A review of the effects of the decriminalization of marijuana', in Contemporary Drug Problems, Fall 1981, pp.307-22; Lasagna, L., and Lindzey, G., 'Marijuana Policy and Drug Mythology', in Society, vol.20, no.2 (Jan./Feb. 1983), pp.67-78 at pp.71-3; Brownell, G.S., 'Marijuana and the Law in California: A Historical and Political Overview', in Journal of Psychoactive Drugs, vol.20(1), Jan-Mar 1988, pp.71-4.

20. Bucknell, P., and Ghodse, H., Misuse of Drugs (Waterlow, London, 1986), p.8.

21. Quoted in Stimson, G., and Oppenheimer, E., Heroin Addiction - Treatment and Control in Britain (Tavistock, London, 1982), p.59.

22. Judson, H.F., Heroin Addiction in Britain (Harcourt, Brace, Jovanovich, New York, 1973), pp.50-1; Bewley, T.H., Ben-Arie, O., and Pierce James, I., 'Morbidity and Mortality from Heroin Dependence', in British Medical Journal, 1968, vol.1, pp.725-6; Stimson and Oppenheimer, op.cit., pp.234-5; Zinberg, N.E., Drug, Set and Setting (Yale U.P., New Haven, 1984), pp.ix-x.

23. Bucknell and Ghodse, op.cit., pp.11-12.

24. Stimson and Oppenheimer, op.cit., pp.101, 113, 116, 118, 214, 216-9.

25. Edwards, G., 'Some Years On. Evolutions in the "British System".', in West, D.J., ed., Problems of Drug Abuse in Britain (Papers presented to the Cropwood Round-Table Conference, December 1977), (University of Cambridge Institute of Criminology, Cambridge, 1978), pp.1-45 at pp.7, 10, 12-13; Burr, A., 'The Piccadilly Drug Scene', in British Journal of Addiction, vol.78 (1983), pp.5-19; Burr, A., 'A British View of Prescribing Pharmaceutical Heroin to Opiate Addicts: A Critique of the "Heroin Solution" With Special Reference to the Piccadilly and Kensington Market Drug Scenes in London', in The International Journal of the Addictions, vol.21, no.1 (1986), pp.83-96.

26. Stimson and Oppenheimer, op.cit., pp.5, 125, 129-30, 132, 136; see also Sargent, M., and Smith, V., 'Drug Policy: Views of Women Users and Agency Workers in Sydney, London and Amsterdam' (to be published in the NCADA Monograph series), pp.36-7.

27. Evidence, Dr. J.A. Krivanek, p.1312; Professor D. Hawks, p.321; Submission from Dr. S.K. Mugford; cf. Evidence, Dr. A.D. Wodak, p.1033.

28. Evidence, Professor D. Hawks, p.322; Dr. A.D. Wodak, p.1036; Professor R. Penny, p.1413; Submission from Dr. G.B. Chesher, p.17; Kaplan, J., The Hardest Drug - Heroin and Public Policy (U. Chicago Press, 1983), pp.173-7. See also Evidence, Fitzroy Legal Service, p.70; N.S.W. Bar Association, p.1206; Submissions from Mrs M. White and Mr J. White; Mr M.T. Gleeson; the Humanist Society of Victoria; Dr. S. McLean; the Royal Australian and New Zealand College of Psychiatrists; the N.S.W. Bar Association; Dr. G. Wardlaw, p.7.

29. Kaplan, op.cit., p.178; Stimson and Oppenheimer, op.cit., pp.105, 115-8; Submissions from the Rev. Dr. J.K. Williams, p.10; Dr. S.K. Mugford; Evidence, N.S.W. Department of Health, pp.935-6; Dr. G.B. Chesher, p.1377; Baldwin, R., 'Policy on the Use of Methadone Maintenance', in Bush, R.A., ed., Exploring the Alcohol and Drug Crime Link: Society's Response (Proceedings of a Seminar held at Sydney University, 16-19 August 1983), (Australian Institute of Criminology, Canberra, 1986), pp.241-8; Dobinson, I., and Ward, P., Drugs And Crime - Phase II (N.S.W. Bureau of Crime Statistics and Research, Sydney, 1987), pp.54-5.

30. Submissions from Professor R. Penny; Professor D. Hawks; Dr. S.K. Mugford; Evidence, Professor R. Penny, pp.1413, 1417.

31. Submission from Dr. S.K. Mugford; see also Dr. L.R.H. Drew, 'Editorial - Drug policies: alternative supply control strategies', in Australian Drug and Alcohol Review, vol.7, no.3 (July 1988), pp.229-30; Evidence, Dr. L.R.H. Drew, p.900.

32. E.g. Submissions from Mr J. Bourke, pp.9-10; Dr. C. Mathers; Mr D. Reilly.

33. Senate Select Committee on Drug Trafficking and Drug Abuse, Report (Parliamentary Paper No.204/1971, A.G.P.S., Canberra, 1971), p.96; South Australia, Royal Commission, Cannabis, pp.88-94; Sackville, op.cit., p.309.

34. Submission from the Commonwealth Attorney-General's Department and the Department of Community Services and Health, pp.36-7.

35. Mill, J.S., 'On Liberty' (1859), in Three Essays (O.U.P., 1975) p.15.

36. Bakalar, J.B., and Grinspoon, L., Drug Control in a Free Society (Cambridge U.P., 1984), pp.1-3; Kaplan, op.cit., p.104.

37. Ibid., pp.106-7; Bakalar and Grinspoon, op.cit., pp.14-18.

38. Quoted in ibid., p.79.

39. Aaron, P., and Musto, D., 'Temperance and Prohibition in America: A Historical Overview', in Moore, M.H., and Gerstein, D.R., eds., Alcohol and Public Policy: Beyond the Shadow of Prohibition (National Academy Press, Washington, 1981), pp.127-81 at p.165.

40. Bakalar and Grinspoon, op.cit., p.33; see also pp 85-7.

41. Submission from Dr. L.R.H. Drew, p.4; Evidence, Dr. S.K. Mugford, p.751; Mr I.R. Dobinson, pp.1168-9.

42. Submissions from Mr J. Bourke, pp.14-15; Dr. L.R.H. Drew, p.11; Mr R.H. McLeod, p.16; Mr P. Delianis, pp.17-19; the Humanist Society of W.A.; Dr. C. Mathers; Perth Inner City Youth Service; Mr D. Reilly; Dr. G.B. Chesher, pp.15-16; Evidence, A Judge of a State Supreme Court, p.21; Dr.R. Marks, p.1117-9; Dr. G.B. Chesher, p.1377.

43. Evidence, Queensland Government, pp.151-2; see also Submissions from the Salvation Army, p.5; Mr A. Biven.

44. Evidence, Mr I.R. Dobinson, pp.1169, 1173; Dr. A.D. Wodak, p.1037; N.S.W. Department of Health, pp.918-9.

45. Evidence, Queensland Government, pp.183; Western Australian Council on Addictions, p.305; The James McGrath Foundation, p.1235; Submissions from Youth Projects Broadmeadows; Professor D. Hawks; Mr A. Mykolajenko; The James McGrath Foundation; The Salvation Army; Cyrenian House; Mr A. Biven; Dr. J.N. Santamaria, pp.5-7, 11; Mrs E. Walters; N.S.W. Police, pp.7-9; W.A. Council on Addictions.

CHAPTER SEVEN

WHERE DO WE GO FROM HERE?

7.1 In summary, the present policy of prohibition imposes very considerable costs on society for a gain that seems illusory. Even if, as the Committee has suggested, the Australian law enforcement agencies have been more successful in seizing and destroying drugs than they have been given credit for, they still have no prospect of stopping the trade in the illegal drugs altogether. To the contrary, the more successful they are, the greater the returns will be to the traffickers. The submissions received by the Committee indicate that a large number of persons who have given this situation serious consideration believe that some change to the present policy is necessary. As Mr Justice Fox said in the Federal Court when dealing with the appeal of a person who had sought to obtain money for drugs through attempted blackmail:

> 'The situation seems to call for urgent, but thoughtful, attention to be given to ways of taking profit out of the equation, or at least greatly reducing it. The principal object would be to lessen crime and corruption, although hopefully the welfare of users could at the same time be enhanced. Existing laws appear not to be successful in either direction.'[1]

7.2 The submissions received by the Committee indicate that although there is agreement on the need for change there is no agreement on what that change should be. There is, however, agreement that change should not be precipitate.[2] It is recognised that there is a need in the first instance for the Australian community to gain a better understanding of the

properties of the prohibited drugs and of the costs imposed by the present policy. As Dr. Engelsman remarks in the context of his own country, it is indeed somewhat remarkable that our society can regard the death of 17,000 people every year from tobacco smoking with equanimity while equating the supply of heroin to an addict with premeditated murder.[3] The Committee hopes that this report may assist in this process of public education.

7.3 The Committee has already made three recommendations which should enable a better evaluation of the effectiveness of present law enforcement strategies to take place. The Committee considers it regrettable that up until now there has been very little attempt to link law enforcement efforts to the stated ends of the policy of prohibition, namely to reduce or eliminate use of the prohibited drugs in our society. It is not enough to measure law enforcement success in terms of quantities of drugs seized if these are in fact a diminishing proportion of the drugs actually reaching the market. The Commonwealth Attorney-General's Department told the Committee that they would need two and a half years to demonstrate the effectiveness of their latest initiatives in drug law enforcement but they did not nominate indicators against which their success might be measured.[4]

7.4 If the Committee's earlier recommendations are acted on it should prove possible to develop appropriate indicators demonstrating the effects of these new initiatives in the marketplace. What the Committee is proposing in this regard is not new. The Williams Royal Commission into Drugs stated in 1980 that to evaluate the effectiveness of drug law enforcement efforts it was necessary to consider:

(a) the purity of the drug being trafficked at street level;

(b) the availability of the drug at street level;

(c) the price of the drug at street level;

(d) the number of seizures and prosecutions together with the volume of the drug involved;

(e) the success rate of prosecutions;

(f) the importance of a convicted person in the trafficking hierarchy; and

(g) the relative roles played by different agencies where there is more than one agency.[5]

Nothing has been done to gather information on these indicators in any systematic fashion in the intervening years and no attempt has been made to set targets in terms of these indicators which would enable some objective measurement to be undertaken of the effectiveness of drug law enforcement efforts.

7.5 **Recommendation: The Committee reinforces the views of the Williams Royal Commission and recommends to the Commonwealth Government that it set targets as indicators of the success of its latest initiatives in curbing the drug trade.**

7.6 Should these latest initiatives fail to make any significant inroads on the market then it would be appropriate to consider some relaxation of the present prohibitions as an alternative policy. In the meanwhile the Committee hopes that there will continue to be an active debate within the community on the various options outlined in the previous chapter. The Committee wishes to emphasise its concern that the present policy of prohibition results in an absence of government control over the chemistry of the drugs being sold, the outlets where the drugs are sold and who the drugs may be sold to. This would not matter if the policy were succeeding in its original aim: if, in other words, none of the illegal drugs were being sold, or if there were even a realistic prospect of the trade being brought to a halt. Such is not the case, and the Committee believes that it is time to consider alternatives to the present policy.

7.7 **Recommendation: The Committee recommends that the Federal and State Governments and the community at large give earnest consideration to the options by which governments might impose more controls on the sale and marketing of the presently illegal drugs.**

7.8 The Committee also supports the continuation of the emphasis on demand reduction which has been the major thrust of the National Campaign Against Drug Abuse. The Committee believes that the ultimate solution to the problem of drug abuse in our society lies not in law enforcement but in demand reduction and that the two are not interdependent: that is, demand reduction strategies do not require the assistance of legal prohibitions to be effective. In this connection the Committee agrees with Dr Alex Wodak that one of the answers to reducing the use of the illegal drugs by young people may lie in reducing their early use of the legal drugs.[6] The Committee recognises that initiatives have already been taken in this direction under NCADA but it believes that this end should be borne in mind when developing policies on alcohol and tobacco.

7.9 The Committee has a particular concern with the advertising of the legal drugs, especially alcohol and tobacco. Although there is no evidence that alcohol advertising increases total demand for alcohol, there is evidence that the total ban on tobacco advertising implemented in Norway in 1975 has caused a marked decline in the sales of cigarettes in that country. Studies have also found a decline in the number of teenagers taking up smoking in that country.[7] The Committee found considerable support for a ban on all alcohol and tobacco advertising in the course of gathering evidence around the country.[8]

7.10 One of the points that was made with most force to the Committee was that young people in our society are faced with conflicting messages regarding the acceptability of drug taking.

We attempt to convince them that drugs are harmful through public service advertising and through education programmes in schools but at the same time they are bombarded with advertisements on television and in the press which promote the use of alcohol, tobacco and certain pharmaceutical drugs. Educating children to refuse offers of the illegal drugs is made much more difficult by advertising which encourages them to say yes to the legal drugs. The Committee believes that the continued promotion of the legal drugs alcohol and tobacco in particular undermines the credibility of the attempt through the National Campaign to reduce the consumption of the illegal drugs.

7.11 **Recommendation: The Committee recommends that the Commonwealth Government ban all advertising of alcohol and tobacco products on radio, television, in cinemas and in print, so far as it is within its constitutional power to do so. (*Senators Alston and Hill, Mr MacKellar and Mr McGauran dissent from this recommendation: see dissent at page 127*).**

Peter Cleeland
<u>Chairman</u>

May 1989

1. Benasic v. R. 77 ALR 340 at 343.
2. E.g.Submissions from Mr I.R. Dobinson, pp.5-6; Mr D. Reilly; A Judge of a State Supreme Court, p.6; The Royal Australian and New Zealand College of Psychiatrists, p.6; Krivanek, J.A., Heroin: Myths and Reality (Allen & Unwin, Sydney, 1988), pp.238-9, 244-7.
3. Engelsman, E.L., 'Responding to drug problems: Dutch policy and practice', unpublished paper delivered to the International Conference on Drug Policy Reform, Washington, 20-23 October 1988, p.13. Heroin trafficking ranked second to murder in a survey of community attitudes to the seriousness of offences conducted by the Australian Institute of Criminology: see Wilson, P., Walker, J., and Mukherjee, S., 'How the public sees crime: an Australian survey', Trends and Issues (Aust. Institute of Criminology), no.2 (October 1986).
4. Evidence, Commonwealth Attorney-General's Department and Department of Community Services and Health, pp.535, 537-8.
5. Royal Commission of Inquiry Into Drugs (Commissioner: The Hon. Mr Justice E.S. Williams), Report (A.G.P.S., Canberra, 1980), p.B225.
6. Evidence, Dr. A.D. Wodak, p.1050.
7. Reilly, C., and Homel, P., Strategies for the Prevention of Drug and Alcohol Problems (N.S.W. Directorate of the Drug Offensive, Sydney, 1988), pp.18-22.
8. Evidence, Western Australian Government, p.229; Professor D. Hawks, pp.333-5; South Australian Government, pp.398, 404-5; Dr. S.K. Mugford, pp.755-7; Dr. G.B. Chesher, p.1387.

DISSENT BY COMMITTEE MEMBERS

We dissent from recommendation 7.11 which proposes a ban on all advertising of tobacco and alcohol products. The Committee's Terms of Reference did not allow a full investigation of advertising and its impact. The evidence submitted therefore does not justify a recommendation in these absolute terms.

We would support a ban on tobacco advertising but we are not satisfied that a ban on the advertising of alcohol products is justified.

We are concerned about the multitude of alcohol advertisements, especially on television, and we are concerned in particular about those advertisements which are apparently directed at young people and which promote a clear association between alcohol and success.

We believe that there is a need for continued monitoring of alcohol advertising and effective sanctions to ensure that a seductive but misleading picture of the virtues of an alcohol oriented lifestyle is not created.

Senator R.K.R. Alston | The Hon. M.J.R. MacKellar, MP

Senator R. Hill | Mr P.J. McGauran, MP

APPENDIX 1

Individuals and Organisations Who Made Written Submissions to the Committee

1. Mr D. Dowling
2. Mr P. Dykstra
3. Mrs M. and Mr J. White
4. Mr R. Todd
5. Mr M.T. Gleeson
6. Mr M.E. La Delle
7. Drs J.A. Doeleman
8. Mr L. W. Schwinning
9. Mr W. Gripske
10. Dr S. Chand
11. Mr L. Haines
12. Mr A. Aoun
13. Mr R.J. Swan
14. Mr N. Ritchie
15. Mr A.C. Bennett
16. Mr A.J. Tweedie
17. Rev. Dr J. K. Williams
18. South Australian Council for Civil Liberties, Inc.
19. Mr D.D. Reidpath
20. Mr J. Bourke
21. Mr C.R.T. Warneminde
22. Mr K.B. Burnett
23. Mr D. Dowling
24. Youth Projects, Broadmeadows, Incorporated
25. Professor D. Hawks
26. Dr L.R.H. Drew, AM
27. Mr R.H. McLeod
28. Det. Senior Sergeant G.V. Francis
29. Mr R.F. Rogers
30. Mr P. Delianis
31. Humanist Society of Victoria
32. Mr N.G. Wainwright
33. Humanist Society of W.A.
34. Mr P. George
35. Messrs S. Pinn and M. Fitzgerald
36. Dr S. McLean
37. Mr K. Hansen
38. Dr J. Krivanek
39. Mr A. Mykolajenko
40. Strider
41. Mr I.R. Dobinson
42. Woman's Christian Temperance Union of South Australia Inc.
43. Division of Social Justice, The Uniting Church in Australia, Synod of Victoria
44. Dr C. Mathers
45. Mr M. Fryszer
46. Mr J. MacNeill
47. Perth Inner City Youth Service
48. Mr L.E. McDonald

49. Mr A.B. Newton
50. Mr B. McDonald
51. Mr D. Reilly
52. Sr. Bernardine Daly
53. Mr M. Marx
54. Mr A. Arthur
55. Lions/ADFA Foundation Inc.
56. Mr L.P. McLeay
57. The Royal Australian and New Zealand College of Psychiatrists
58. Prisoner Support Group, Queensland
59. Mr R. Veltmeyer
60. Australian Federal Police Association
61. Dr G.B. Chesher
62. Australian Federal Police
63. The James McGrath Foundation
64. Fitzroy Legal Service
65. The Law Society of New South Wales
66. Mr R. Walsh
67. Dr R. Marks
68. Killara House Drug & Alcohol Rehabilitation Centre Inc.
69. Mr D. Dowling
70. Dr S.K. Mugford
71. The Salvation Army, Australia
72. Cyrenian House Drug Treatment and Rehabilitation Centre
73. Professor R. Penny
74. Dr D.A. Pocock
75. Banyan House for Drug Rehabilitation
76. Co. As. It.
77. The Hon. R.S.L. Jones, MLC and Mr A. Ozols
78. Government of South Australia
79. The Hon. M. Yabsley MP, Minister for Corrective Services, NSW
80. The New South Wales Bar Association
81. Mr A. Biven
82. Mr I. Campbell
83. Centre for Education and Information on Drugs & Alcohol
84. The National Organisation for Reform of Marijuana Laws, NSW Inc.
85. Dr J.N. Santamaria
86. International Federation of Parents for Drug-Free Youth
87. Law Council of Australia
88. Alcohol and Drug Foundation, Australia
89. Mr R.R. Beshay
90. New South Wales Police
91. Ms J. Dallas
92. Queensland Government
93. Australian Customs Service
94. A Judge of a State Supreme Court
95. Commonwealth Attorney-General's Department and Department of Community Services and Health
96. Western Australia Police
97. Western Australian Council on Addictions
98. Dr G. Wardlaw
99. Dr H.J. Marrable

APPENDIX 2

Individuals and Organisations Who Appeared as Witnesses Before the Committee at Public Hearings

Date of Hearing	Individuals or Organisations	Represented By
1989 16 February (Melbourne)	Mr P. Delianis, North Balwyn, Victoria	
	Fitzroy Legal Service	Mr S.P. Bailey, Solicitor
		Mr J.M. Giddings, Solicitor
	The Honourable D.L. Chipp, Kallista, Victoria	
17 February (Brisbane)	Queensland Government	Dr M.H. Bolton, Director, Alcohol and Drug Dependence Services, Department of Health
		Detective Inspector M.C. Butler, Officer in Charge, Drug Squad, Queensland Police Department
		Sergeant D.A. Smith, Legal Section, Queensland Police Department
		Mr B.A. Stewart, Director, Legislation and Research Program, Justice Department
21 February (Perth)	Western Australian Government	Dr M. Angus, Executive Director, Schools Division, Ministry of Education
		Detective Senior Sergeant R.T. Gascoigne, Research and Liaison Officer, Drug Squad, Western Australian Police

Date of Hearing	Individuals or Organisations	Represented By
		Detective Chief Superintendent D.L. Hancock, Criminal Investigation Bureau, Western Australian Police
		Dr A.J. Quigley, Acting Director, Clinical Services, Alcohol and Drug Authority of Western Australia, Department of Health
		Mr T.W. Simpson, Assistant Director-General, Department for Community Services
	Dr D.A. Pocock Dalkeith, Western Australia	
	Western Australian Council on Addictions	Dr C. Hammersley, President
		Mr R.C. Hammersley, Director-Founder
		Mr G. Lysle, Program Director
		Mr D.P. Walsh, Counsellor
	Professor D.V. Hawks, Director, National Centre for Research into the Prevention of Drug Abuse, Curtin University of Technology	
22 February (Adelaide)	South Australian Government	Dr R.L. Ali, Acting Director, Medical Services, Drug and Alcohol Services Council

Date of Hearing	Individuals or Organisations	Represented By
		Mr P.W. Bradley, Project Manager, Program Planning Division, Department for Community Welfare
		Detective Chief Inspector D.F.C. Eason, Drug Squad, South Australian Police Department
		Ms E. McNeil, Director, Youth Health Centre, Department for Community Welfare
27 February (Canberra)	Commonwealth Attorney-General's Department and Department of Community Services and Health	Mr G.M. James, Assistant Secretary, Drugs of Dependence Branch, Department of Community Services and Health
		Dr A. Proudfoot, Acting Chief Medcial Adviser, Department of Community Services and Health
		Mr T. Slater, First Assistant Secretary, Health Advancement Division, Department of Community Services and Health
		Miss D.E. Stafford, Senior Assistant Secretary, International Branch, Criminal Law and Law Enforcement Division, Attorney-General's Department

Date of Hearing	Individuals or Organisations	Represented By
		Mr H. Woltring, First Assistant Secretary, Criminal Law and Law Enforcement Division, Attorney-General's Department
	Australian Federal Police	Mr R. Farmer, Deputy Commissioner, Operations
		Mr P.J. Lamb, Assistant Commissioner, Investigations
	Australian Customs Service	Mr N. Mullins, Director, Enforcement Intelligence
		Mr C.F. Vassarotti, National Manager, Barrier Control
	Dr G.R. Wardlaw, Fisher, ACT	
	Dr S.K. Mugford, Cook, ACT	
	Dr L.R.H. Drew, Queanbeyan, NSW	
15 March (Sydney)	New South Wales Department of Health	Dr M.G. MacAvoy, Director, Directorate of the Drug Offensive
	New South Wales Police	Chief Superintendent W.R. Donaldson, Drug Enforcement Agency
		Assistant Commissioner E.S. Strong, Director, Drug Enforcement Agency

Date of Hearing	Individuals or Organisations	Represented By
	New South Wales Department of Corrective Services	Mr R.G. Woodham, Acting Assistant Director, Special Operations*
	Dr A.D. Wodak, Director, Alcohol and Drug Service, St. Vincent's Hospital	
	Law Society of New South Wales	Mr D. Brezniak, Council Member
16 March (Sydney)	Dr R.E. Marks, Senior Lecturer, Australian Graduate School of Management, University of New South Wales	
	Mr I.R. Dobinson, Bondi, NSW	
	New South Wales Bar Association	Mr J.S. Coombs, QC, Vice-President
17 March (Sydney	James McGrath Foundation	Mr M. Luger, Executive Director
	Dr J. Krivanek, Head, Department of Health Management, Hunter Institute of Higher Education	
	Dr G.B. Chesher, Paddington, NSW	
	Professor R. Penny, Director, Centre for Immunology, St Vincent's Hospital	
	Mr M.L. Marx, Bondi, NSW	

* Evidence partly taken in camera

APPENDIX 3

Individuals and Organisations Who Appeared as Witnesses Before the Committee at In Camera Hearings

---

A Judge of a State Supreme Court.