[ESSAY]

ILLICIT DRUGS POLICY: LEGAL AND INTERNATIONAL PERSPECTIVES

DRUGS POLICY CONSULTANT COLLIS PARRETT COMMENTS ON THE POSSIBLE IMPLICATIONS FOR AUSTRALIA OF DRUG-LAW NON-ENFORCEMENT AND REFORM AND SURVEYS SOME ALTERNATIVE MODELS

ANY well-functioning democratic society exists essentially by having a healthy balance between individual civil rights on the one hand and the common good or greater good of society as a whole on the other. In my opinion these rights in Australia are in a growing state of imbalance, with the mounting advocacy of so-called individual rights to use illegal drugs for personal use without criminal sanctions. This approach, if acceded to, will increase the overall use of dangerous, mind-altering illegal drugs such as heroin and cocaine, because of their addictive properties. At a certain level of increased use will come stronger calls, even demands, for wider decriminalisation of illicit drugs and eventually legali-

sation. Many in Australia who support this approach also support the so-called harm-reduction strategy, which has failed badly. The strategy of such opponents to prohibition of currently illegal drugs is usually to press initially for legalisation of cannabis, which acts as the spearhead of the anti-prohibition push. If allegedly 'soft' drugs such as cannabis can be freed from prohibition, other harder ones may well follow.

The opposing view or ideology can be given the general description of a compassionate restrictive policy, such as is practised in Sweden, which aims for a drug-free society. Any who might scoff at this as unrealistic are invited to ask themselves if they support the United Nations ideal that human rights must be delivered to all peoples in the world as soon as possible. If the answer is 'yes', then what is so unrealistic about Australia, or any country, having a similar ideal for illegal drug use? Would anyone expect the UN to abandon its ideal because in practice it is breached, at times quite seriously, by certain countries around the world? If the answer to this question is 'no', then why should it not be 'no' also in relation to maintaining this country's aim for a drug-free society, even if that aim could not always be fully achieved in practice as a consequence of some continuing illegal drug-taking?

The reason the drug-free ideal seems far less achievable in the case of tobacco-smoking and alcohol consumption is that these drugs first became socially acceptable, then ingrained in society by addictive characteristics, and were finally legalised and taxed by governments before their terrible morbidity and mortality costs were realised. They are still sufficiently socially acceptable to stop any government wishing to survive, or any opposition wishing to gain office, from attempting to ban them. But a wise government or person would insist our community certainly should not commit the same grave errors in the case of illegal drugs, as the two legal ones are killing thousands of Australians annually.

There is a cry, often by anti-prohibitionists, for heroin prescription trials and/or supervised injecting places because they will save a number of lives, albeit a small number, by preventing overdose deaths. This cry is not infrequently accompanied by a call on the compassion of the community. But many members of the public have told me that while they regard compassion as essential, they have difficulty in reconciling such calls with one that emanates from the same quarters for decriminalisation of illicit drugs. For decriminalisation will increase the availability of such drugs and the numbers taking them and therefore increase the risk of drug deaths.

It is not an 'either/or' situation, in the sense of either we have drug-maintenance facilities or there must be excess deaths. The case of Sweden shows the falsity of this thinking. There the overwhelming emphasis is on primary prevention and earliest effective treatment intervention in order to bring about a drug-free environment. In Australia, drug substitution maintenance (mainly methadone) is more common, and the practices of first contact referral to best-practice detox and medium-to-long-term rehabilitation have been given a much lower priority than in Sweden.

When a person is on dangerous mind-altering drugs, whether in an official maintenance setting or not, there will be a constant risk of overdose death, whereas it is impossible for a person who has become opiate-free to OD. It follows that the greater the number of people made opiate-free, the greater the potential for saving lives. Put another way, are there likely to be fewer heroin deaths from the 'pool' of 6000 heroin addicts in Sweden or from the estimated 75,000 in Australia?

Economic considerations must also be addressed. In 1995, Dr Gabriele Bammer, an epidemiologist at the Australian National University, indicated that the maximum annual cost of treating a heroin-trial participant would be $10,000, whereas the cost to the community of an untreated heroin addict might come to ten times that amount.[1] However, six years later, a trial in Sydney, based on naltrexone use, reported that around 60 per cent of patients were no longer dependent on heroin at twelve months. The cost of conventional detox per patient was estimated at around $6000.[2]

The legal implications of the anti-prohibitionist influence have also not been fully appreciated by its representatives.[3] Perhaps the most weighty of the international narcotics conventions is that known as the Single Narcotics Convention (1961). The recent call for a heroin prescription trial or a supervised injecting place in the ACT has highlighted the need to consider the possible national ramifications of such a step, particularly in the field of law, and our international obligations in this area. It is unhelpful and dangerous just to rely on what has been decided and done in various European nations in this area. Their legal and political systems are quite different from ours, not the least in that they do not follow our traditional Westminster system and the particular approach to the separation and division of powers in the Australian Constitution. Further, in some European countries there has been a disregard or evasion of UN conventions, and some countries (including Switzerland, where heroin trials have been held) have not been parties to some or all the relevant international narcotics conventions.

There cannot be a heroin prescription trial or supervised injecting place involving legal heroin without direct approval from the Commonwealth government, and this has not been given. The only licence the Commonwealth has issued is in Tasmania where poppy growing is allowed under strict supervision for the production of morphine for medical purposes. What are known as Schedule IV drugs, which include narcotic substances, cannot be imported or manufactured without a Commonwealth licence. A state/territory law to the contrary would be constitutionally invalid. Moreover, it would not be seen as a normal procedure under our laws if an Act operated to deprive addicts and their dependants of their common law rights to damages arising from, for example, staff negligence or lack of 'duty of care' at a heroin prescription trial or supervised injecting place. Again, the norms of our Westminster system would not usually countenance the issuing of a 'protocol' by the executive arm of government that would effectively direct the police not to enforce the ordinary law in particular circumstances and to 'look the other way'.

There are compelling reasons why control of heroin should remain under the exclusive control of a central government, including the fact that heroin is classified by the World Health Organisation under its schedules as a dangerous drug. In the 1961 convention there are two pertinent provisions: first, that 'a Party shall adopt any special measures of control which in its opinion are necessary having regard to the particularly dangerous properties of a drug so included'; and, second, that 'a Party shall, if in its opinion, the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import or trade in, possession or use of any such drug, except for amounts which may be necessary for medical and scientific research only, including clinical trials that will be conducted under or subject to the direct supervision and control of the Party.' The 'Party' is the sovereign state—in our case, the Commonwealth of Australia, or in practical terms the federal government of the day. The exception in the second provision does not envisage or extend to wider medical use or application. The clause beginning 'if in its opinion' means that any decision is the prerogative of the Commonwealth alone, and this endorsement of the federal government's opinion could conceivably allow it to frame a new strategy that did not permit or provide for any heroin prescription trials or supervised injecting places.

The Commonwealth Customs Act provides that any person who, without reasonable excuse, has in his possession any prohibited narcotic substances that are reasonably suspected of having been imported in contravention of the Act

shall be guilty of an offence. It is difficult to offer a reasonable excuse if you haven't got a Commonwealth licence in your pocket. And the onus of proof to show that the narcotics were not illegally imported is on the offender. Virtually all narcotic drug offences are prosecuted under the provisions of the Customs Act. To my knowledge, a state/territory law or regulation cannot negate this Commonwealth Customs Act provision. Section 109 of the Constitution states that where a state/territory law is inconsistent with a Commonwealth law, the latter prevails to the extent of the inconsistency. In the light of all these considerations, the position of the present supervised injecting place in Sydney might well attract the scrutiny of any person concerned about its status.

THE NETHERLANDS

Many supporting the decriminalisation of illegal drugs point to the example of the Netherlands. In 1976 the Dutch government approved the primary recommendation of the Baan Commission Report, which had distinguished between List One drugs and List Two drugs—the former being those involving an unacceptable risk (for example, heroin, cocaine, LSD) and the latter being seen as less dangerous or 'softer' ones, including cannabis. On the basis of this recommendation, the Dutch parliament authorised the sale of cannabis products in licensed coffee shops. This action reflected a view that if illegal drugs were decriminalised, and controlled by the state and its mechanisms, all would be well (or at least substantially better). Yet the Dutch experiment stands as a caution to those who imagine that decriminalisation and state regulation will provide a simple answer to illegal drug use. For health and social reasons, there has subsequently been a reduction in the amount of cannabis officially allowed to be sold to a coffee-shop customer (from 30g to 5g), and a fall in the number of licensed cannabis cafés from around 1200 to 800; over the same period of time illegal outlet numbers have increased to over 1400.

SWITZERLAND

In 1991 the Swiss Federal Council formulated a strategy aimed at reducing the drug problem. At that time heroin distribution projects were not permitted. However, in 1992 (under heavy pressure from various interests) heroin trials were authorised. They commenced in about December 1993 and were limited to an experimental period of three years. Subsequently, claims that the trials had been 'successful' found their way around the world. In 1994 the International Narcotics Control Board (INCB) suggested that the Swiss government seek an independent

assessment of the heroin projects from the World Health Organisation(WHO). This led to what is known as an Evaluation Report. The INCB subsequently received numerous enquiries from the public and the media for its opinion on the report.

The WHO position is perhaps best summarised in the letter sent by the director-general of that organisation to the president of the INCB on 12 April 1999. She stated that the Swiss heroin project was an 'observational study without the possibility of making reliable unbiased comparisons between treatment options', that it did 'not provide clear evidence for the benefits of heroin treatment over other substitution agents', and that it established 'no causal link ... between prescription of heroin and improvements in health and social status ...' Therefore, it was 'difficult to conclude that the available results of the Swiss study could assist any other country.'[4]

SWEDEN

IN the mid sixties drug use surged in many countries, including Sweden. It involved mainly younger people. Like most countries, Sweden initially adopted a very stern approach. There was an adverse reaction and in 1965 an experimental project authorising the prescription of hitherto illegal drugs was launched. It aimed to minimise the harmful effects of abuse on society and abusers and, by accompanying legally prescribed drugs with facilities for care, to improve the social and medical status of addicts. The numbers of addicts taking part increased from ten at the start of 1965 to more than 150 in 1967, when the project was curtailed. A study showed that many of the participants in the project regularly supplied their friends and acquaintances with considerable quantities of scripted narcotic drugs. It also showed the number of legal drug users committing criminal offences during the years when issued with drugs was roughly the same as for immediately preceding years. The extensive leakage of scripted drugs into the black market was one of the major reasons for stopping the project altogether, but primarily it was because of a massive backlash by parents and the community who were sick of seeing their children either in a state of drug-enslavement or dead. In the late 1960s the Swedish parliament introduced an expansion of drug-free treatment of drug abusers. This led to many further refinements, and today Sweden has arguably one of the most successful anti-drug policies in the world, aiming as it does for a drug-free society.[5]

If Australia knew of a country, with about half our population, which had thirteen times fewer cardiac cases than ours and nearly five times fewer cancer

cases, should we not quickly adopt the prevention and treatment policies of that country in those particular areas? Sweden has those proportions in its favour compared with Australia, in the first instance in relation to heroin addiction cases, and in the second to total number of addicts and drug dependent persons. Why, then, should we retain, as we appear to do, such an indifference to Sweden's achievements in the field of drugs policy?

NOTES

1. G. Bammer, *Report and Recommendations: Stage 2: Feasibility Research into the Controlled Availability of Opioids* (Canberra, June 1995), p. 12.
2. See *Canberra Times*, 16 July 2001, for report on the trials conducted by Dr Jon Currie, Director of Drug and Alcohol Services, Western Sydney Health.
3. For a detailed account of these implications, see Athol Moffitt CMG AM QC, 'The law and UN conventions cannot be ignored—a List of legal, convention and political power requirements necessary to be addressed on any debate or consideration of drug issues', unpublished paper (May 1999).
4. International Narcotics Control Board Media Release, Vienna, 19 May 1999.
5. Swedish National Institute of Public Health, *Drug Policy—The Swedish Experience* (Stockholm, 1995).

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