

## The relationship between drug policy and specific outcomes

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The title given to my address does not mention cannabis, but I feel compelled to respond to current proposals for the even greater availability and acceptability of this substance than we already have in this country.

What has been the result of liberalising cannabis laws?

First, in South Australia, the decriminalisation of marijuana and the small penalty attached to the growing of ten (now three) plants for personal use has without doubt led to an increase in use. That result is not only in accord with common sense, but also in line with data from the household surveys on use summarized in a paper by Robert Ali and others from our own Drug and Alcohol Services Council. Furthermore, in the years following decriminalisation, the number of offences for possession and use of marijuana escalated from 5½ thousand in 85/86 to over 17 thousand in 93/94. On top of this, several marijuana anonymous groups have been formed to cater for increasing numbers of people seeking help with addiction to marijuana. Following police crackdowns on cannabis growing in SA earlier this year, what was previously suspected was confirmed, that is, that because of this policy - coupled with hydroponic cultivation - SA has become the supply and distribution state for the country. To this can be added the fact that dope is cheap on the streets of SA. In all, there is no escaping the fact that greater availability and acceptability leads to increased use rates.

This observation is confirmed in Holland's experiment with the liberalising of its cannabis laws. A 1997 article in the international journal *Science* (3 October, 1997) showed that usage in Amsterdam increased dramatically from 15% in 1984 to 44% in 1996 among 18-20 year-olds and from 5% to over 30% amongst 16-17 year-olds. At the same time there was a 49% increase in registered people addicted to cannabis for the years 1991-1993.

If The Netherlands are the prototypical example of good drug policy in action, why do we also find that it has the highest rate of cocaine use in the European Union, a steadily climbing rate of drug-related deaths from 1991-1997, a prevalence of HIV infection in injecting drug users among the top 5 out of 15 nations, a Hepatitis C infection rate in the top 4, a tripling in the number of heroin addicts since the liberalization of drug policies, and arrests for drug offences which showed the most rapid rate of increase for all countries assessed. Furthermore, Dutch per capita rates for breaking and entering, a crime closely associated with drug abuse, are three times the rate of those in Switzerland and the United States, four times the French rate, and 50% greater than the German rate (Interpol, International Crime Statistics, 1995).

On top of this, The Netherlands is also recognized as one of the primary countries in the region for the origin and transit of illicit drugs, with growing concern expressed by neighbouring countries about drug traffic across their borders from The Netherlands. In the words of a senior French narcotics officer, "Holland is Europe's drugs supermarket. Drugs of all kinds are freely available here [and] the price is cheap."

While the Dutch policies set out to separate the 'soft' cannabis market from that for harder drugs, this has not been achieved, and regular visits by undercover officers to Dutch

cannabis cafes reveals a ready supply of all manner of harder drugs. Incidentally, this was confirmed by a colleague of mine who recently visited Amsterdam.

Even among some of the Dutch there is concern. Dr Franz Koopman, director of a rehabilitation clinic in Holland is blunt when he says, "Our liberal drug policy has been a failure, but its advocates are so rooted in their convictions that they can't bring themselves to admit it."

All this may of course not be a problem if cannabis is after all, safe. However, numerous studies prove otherwise, and whilst studying an illegal substance makes it difficult to conduct rigorous scientific studies, there are already ample reasons for concern. Just some of the reported harms include:

Reports of specific cases of cancers of the mouth, tongue, larynx, jaw and lungs that may be attributable to marijuana.

Babies born to mothers who use marijuana during pregnancy have increased behavioural problems including decreased visual perception, language comprehension, attention span and memory.

Children exposed prenatally to cannabis show an eleven-fold increase in nonlymphoblastic leukaemia.

Certain white blood cells display a decreased ability to fight infection.

Cannabis not only induces a short term psychosis, but can lead to the earlier onset of psychotic symptoms in predisposed individuals thereby exacerbating schizophrenia but also perhaps inducing it, although this has not been proven.

A recent study indicates increased risk of cardiac arrest immediately following smoking cannabis.

And addiction has been shown in primates for the first time using a standard protocol by which addiction to cocaine and heroin were also proven.

In light of recent findings in neurobiology some of these effects are not really all that surprising. Emerging roles for the brain's own cannabinoid system include appetite as well as higher functions such as motivation, memory, attention and cognition. Some researchers have even begun talking of a cannabinoid theory of schizophrenia.

When speaking of harms, it is worth remembering that some 50 years of research on tobacco was required to come to the point of clearly defining its harms. With tobacco, the response of the medical community has been to throw its whole weight behind a societal campaign to discourage use. Perhaps another 10 or 15 years will be needed to nail down cannabis harms, and we might hope at that time, that the medical community will respond similarly.

Turning now to proposals for heroin trials, there are several immediate facts to consider. First, contrary to the claims of some, heroin is not simply a good clean relatively harmless drug. While it may be true that if used medicinally for pain control heroin can be an effective analgesic with manageable side-effects, it is altogether different when taken at doses sufficient to go on the nod several times a day, day after day, as in addiction. In this type of use, the immune system is depressed, respiration is depressed, sometimes dangerously, libido is chronically depressed, constipation can be severe, and an unpleasant

withdrawal syndrome results from cessation of use. To this can be added more recent findings on the changes in brain state underlying addiction.

Professor Alan Leshner, Director of the National Institute of Drug Abuse in the USA, describes the changes in brain state in the following way, “The addicted brain is distinctly different from the nonaddicted brain, as manifested by changes in brain metabolic activity, receptor availability, gene expression, and the responsiveness to environmental cues”, and “prolonged drug use changes the brain at the level of gross circuit changes.” Thus addiction itself is a very real harm.

But what does it mean at the personal level? In the words of Jason Van den Boogert who was at times severely addicted to heroin:

“Heroin is an intensely singular and personal drug, a drug of the self. Its experience is all about listening down into the body, as well as being one that is led by the body’s demands. Ultimately though, it is a dehumanising one, in that you become the drug. Little or no ‘human’ concerns break into the heroin oeuvre - no orgasms, no tears, no shit, no pain (as long as you’re stoned). You are no longer flesh and blood but a pillar, if not of salt, at least of dia-morphine. Heroin overturns the body’s normal priorities and preoccupations and subverts them to ones that are very much its own. The King is dead, long live the King.”

And “No matter how you slice it, your life is bondage”

The provision of heroin to addicted individuals like Jason Van den Boogert in a heroin trial not only effectively abandons them to their addiction, but also contravenes a central tenet of medicine, that is, to first and foremost do no harm. And what is also disconcerting is the justification of heroin trials by reference to their claimed ability to reduce crime and the transfer of diseases like HIV and Hepatitis B & C into the community. The Code of Ethics of the Australian Medical Association, when speaking of clinical research, states that, “a physician is to recognise that the well-being of subjects takes precedence over the interests of science or society.” When heroin trials are instituted primarily for the interests of society they are unethical.

And if it is true that addiction to heroin is primarily a disease, then provision of heroin flies in the face of accepted medical practice. For treatment with heroin is to treat the disease with the very agent that causes the disease. To use the words of Terry Parssinen in his book *Secret Passions, Secret Remedies*:

If addiction is a disease, then it is essential to keep the infectious agent away from the potential victim to the greatest extent possible.

But surely the war on drugs has failed and something new must be tried. In this country there is no war on drugs, but what we are now doing is not succeeding, and we must do something differently, but that something need not include heroin trials.

For over 15 years this country has been operating under a harm minimisation model, during which time high dose, long term methadone provision has become the standard treatment; needles and syringes have been freely distributed; responsible recreational use has been taught in our educational programmes; in some jurisdictions marijuana has been decriminalised; an injecting room operates in Sydney; and those in favour of far more permissive policies have become much more vocal. During that time illicit drug use has climbed steadily; hepatitis C is rampant in the injecting community; deaths from overdose

have risen dramatically, and treatment other than by methadone has declined. It may be time to consider that the model needs changing.

But aren't heroin trials simply a compassionate response to serious users who have failed in other treatment options, and this will keep them alive longer.

First, there is no guarantee that individuals will be kept alive longer. A heroin distribution programme, for that is surely what it is since a medical scientific trial is not possible with a mind-altering substance, seeks to provide heroin at 'on-the-nod' doses three times a day funded by the state. Clients will then have the opportunity to top up as needed using street heroin and thereby still be at risk of overdose. Furthermore, numerous studies reveal that most drug-related deaths are polydrug deaths in which a cocktail of drugs are present including heroin, codeine, amphetamine, marijuana, benzodiazepines and others. One cannot save lives simply by providing heroin, the problems are much deeper and require a more holistic approach.

Second, the induction of new users is dependent upon, amongst other things, the perception of risk. If heroin distribution programmes exist, drug use will be even further normalized in the public consciousness as a practice that the state will enable you to carry out as safely as possible if necessary. As the philosopher Germain Grisez notes, "... law's effectiveness depends far more on forming the majority's practical reasoning and judgements than on forcing the unwilling minority to comply." The message counts.

There is little remaining time to comment on the Swiss heroin trials, but a few words from the Australian journalist Piers Akermann will have to suffice. Having taken note of the World Health Organisation report on the Swiss Trials, which highlighted numerous shortcomings, he wrote, "The much relied upon data from the Swiss experiment has more holes in it than that country's famed cheese."

And finally, with any major new proposal in public policy, as a heroin trial represents, we have to know where we are going. It would be naïve to consider heroin trials in abstraction from an overall policy. One of the most outspoken groups on heroin trials has been The Australian Drug Law Reform Foundation, which is closely tied to The Australian Parliamentary Group for Drug Law Reform. At the top of the list in the charter for each group is 'the unequivocal opposition to the policies of prohibition', the alternative I presume being legalisation. What the position of individual members would be on the legalisation of currently illegal drugs is uncertain, but a member who is 'unequivocally opposed to the policies of prohibition' would need to explain what that means. Certainly, some of the leading individuals are open about their commitment to a regulated government controlled supply of most if not all illicit drugs including heroin, cocaine, amphetamine, marijuana and the hallucinogens like LSD. Furthermore, they have strong links to well-funded bodies in the US whose agenda is clearly to legalise these drugs. In fact funding has flowed directly from these US organizations to Australian groups.

I will finish with a quote, again from Terry Parsinnen, who reminds us of past proposals for the prescription of mind-altering drugs. At the turn of the last century he noted that writers were in agreement on the major issues, one of which was that, "substitution of drugs such as cocaine, cannabis, or even heroin – which had been variously recommended in the last three decades of the nineteenth century – was a terrible mistake."

Let's hope that this generation will not make such a mistake.