Australian Parliamentary Group for Drug Law Reform

& Australian Drug Law Reform Foundation

E-Newsletter – February 2009

About the Groups

The Australian Parliamentary Group on Drug Law Reform

The Australian Parliamentary Group on Drug Law Reform (APGDLR) is a cross party group of 100 MP's from our State and Commonwealth parliaments. The group was set up in 1993 after a meeting in Canberra convened by Michael Moore (ACT Assembly) and Ann Symonds (MLC, NSW).

The Australian Drug Law Reform Foundation

The Australian Drug Law Reform Foundation was established in 1994 when a significant number of people in the community endorsed the Charter for Reform that had been developed by the Parliamentary Group.

The Charter for Reform sets out a series of principles that seek to encourage a more rational, tolerant and humanitarian approach to the problems created by drugs and drug use in Australia.

The APGDLR and the ADLRF meet at least once a year to hear from experts in the field, to share information about what is happening in our jurisdictions and to plan future work. The group also produces occasional newsletters on issues relating to drugs in Australia and international developments.

If you would like more information about the Parliamentary Group or the Foundation or would like more information please contact Dr Mal Washer MP 02 6277 2114 or email Mal.Washer.MP@aph.gov.au or Penny Sharpe MLC on 0292302741 or email Penny.Sharpe@parliament.nsw.gov.au

Editorial

Ensuring the safety of new medications and devices: are naltrexone implants safe?

Alex D Wodak, Robert Ali, David Henry and Lloyd Sansom MJA 2008; 188 (8): 438-439

Naltrexone implants have not been subject to the usual rigorous scrutiny required for new devices in Australia, but are widely used through the Special Access Scheme.

In this issue of the Journal, Lintzeris and colleagues report eight patients with naltrexone implants who developed serious medical complications considered to be related to the implant (Unplanned admissions to two Sydney public hospitals after naltrexone implants).1 Intuitively, naltrexone is an attractive treatment for opioid dependence, as it is inexpensive, long-acting and generally well tolerated, and blocks the actions of heroin when

taken orally. However, empirical support for naltrexone has been unimpressive; [2-4] with research showing that poor adherence to treatment limits its effectiveness. An Australian study found that, while patients who adhered to treatment did well, only 2% were still taking the drug 3 months after conventional inpatient detoxification.[5]

Naltrexone was registered by the Therapeutic Goods Administration (TGA) in 1998 as "an aid in the maintenance of previously opiate-dependent patients who have ceased the use of opioids".[6] However, the Pharmaceutical Benefits Advisory Committee twice rejected applications for the inclusion of naltrexone in the Pharmaceutical Benefits Scheme as a treatment for opioid dependence on the grounds of lack of evidence of efficacy. Controversy over efficacy was followed by growing doubts about naltrexone's safety. Intermittent naltrexone consumption lowers opioid tolerance, thereby increasing the risk of heroin overdose. An Australian study found the death rate for those leaving naltrexone treatment was eight times that recorded among participants leaving treatment with agonists such as methadone or buprenorphine.[7]

As the weakness of the case for oral naltrexone became clearer, a range of interventions were developed to overcome the inherent problems of treatment initiation and poor adherence. The publication in 1997 of an article entitled "I woke up . . . cured of heroin" in a popular Australian magazine[8] sparked intense community and political interest in the initiation of naltrexone treatment during general anaesthesia or heavy sedation, followed by oral administration. This was said to be a novel, dramatically effective treatment for heroin dependence. However, subsequent evaluation showed that these approaches increased the cost of oral naltrexone without increasing efficacy.[9] More recently, depot injections[10] and implants of naltrexone have become the focus of public and political hope.

In this historical context, it is concerning that the recent research on naltrexone implants in Australia has not followed usual scientific processes. In particular, naltrexone implants have not been subject to the usual rigorous scrutiny required for new drug products seeking registration in this country. Nevertheless, they are available through the TGA Special Access Scheme; there is no requirement for TGA approval for access to unapproved goods in Australia for Category A patients under this Scheme, and no apparent requirement for collection of efficacy or safety data. Supporters of the naltrexone implant have argued that heroin injectors meet the criteria for Category A patients under the Scheme as "persons who are seriously ill with a condition from which death is reasonably likely to occur within a matter of months, or from which premature death is reasonably likely to occur in the absence of early treatment".[11]

Most Category A patients have malignant conditions or rare life-threatening diseases. The annual mortality of heroin injectors is in the order of 1%[12] — almost 15 times higher than expected for persons of the same age and sex with no history of heroin use, but hardly in the range generally considered appropriate for the Special Access Scheme. But the inclusion of naltrexone implants in the Scheme and their widespread use (reportedly by more than 1500 individuals) means the product has achieved a substantial market while not undergoing the rigorous evaluation usually applied to drugs before registration.

Some of the implants used in Australia are produced locally, while others are manufactured overseas. There are doubts about the quality of manufacture, as well as deficiencies in the safety and efficacy data. As far as we are aware, no major national drug regulatory authority has licensed naltrexone implants for management of opioid misuse. However, a depot injection of naltrexone has been approved by the Food and Drug Administration in the United States, but only for alcohol, not opioid, dependence.[10]

Although the effectiveness, safety and cost-effectiveness of methadone and buprenorphine treatments for heroin dependence are supported by substantial and compelling evidence, a greater range of pharmacological treatments suited to the broad range of individual patients is required. A recent randomised controlled study of depot naltrexone for the treatment of opioid dependence had encouraging results.[13] The strong theoretical rationale for the usefulness of naltrexone in treating heroin dependence justifies further rigorous

investigations. However, the uncontrolled use of unregistered products of uncertain quality hampers the development of proper clinical trials.

Since the thalidomide disaster in the 1960s, all new medications introduced into Australia have been regarded as ineffective and unsafe until proven otherwise. Constant vigilance is required to ensure that only new medications and devices of proven effectiveness and safety are permitted widespread use. The disturbing suggestions of mortality and morbidity from unregistered naltrexone implants make a strong case for an independent review to determine whether this treatment is sufficiently safe for such widespread use. This review should also assess whether the TGA Special Access Scheme has been used to circumvent the requirement for rigorous assessment of the quality, safety and efficacy of naltrexone implants.

This assessment is the cornerstone of a drug regulatory system designed to protect the public from ineffective and unsafe medicines. The TGA has the power under the *Therapeutic Goods Act 1989* (Cwlth) (s. 31A(2) and s. 41JD) to seek clarification of the Category A classification of patients, and should do so urgently regarding access to unapproved naltrexone products in Australia.

Competing interests
Robert Ali received an untied educational grant from Reckitt Benckiser to convene an annual scientific meeting in Asia. All funds were used for travel, accommodation and living expenses for himself and delegates.
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Some excerpts from The Parliament of Australia's Hansard regarding the safety of Naltrexone
http://www.aph.gov.au/hansard/senate/commttee/s11355.pdf

WEDNESDAY, 22 OCTOBER 2008 SENATE STANDING COMMITTEE ON COMMUNITY AFFAIRS ESTIMATES

Senator CORMANN-Thank you very much, Ms Halton. I have a final question-and Madam Chair will be very pleased that I am within time-and I do have to have my parochial question. In today's West Australian on page 5 there is an article outlining concerns from Dr George O'Neil-who I am sure you have heard about-

Ms Halton-Yes.
Senator CORMANN-that he will be forced to stop producing naltrexone implants. Could you provide us with an update?
Ms Halton-This is actually-
Senator CORMANN-You are going to say that it is a TGA issue, rather than a pharmaceutical-
Ms Halton-I am going to say exactly that. I can tell you-and I am delighted to tell you this-that we do have a requirement in relation to good manufacturing practice that you would be highly aware of. I can tell you that there has been a very long conversation with Dr O'Neil about the need to ensure that, if he is manufacturing, he meets good manufacturing practice. That has not happened, and the TGA is basically discharging its regulatory responsibilities in its dialogue with Dr O'Neil.
Senator CORMANN-Is there any role for the Commonwealth? I am just asking this broadly in the context of access to pharmaceuticals, and I appreciate your indulgence in answering my question. If this is going to the ultimate position of where Dr O'Neil is not able to produce those implants and you have a cohort of people requiring access to those services that will be left without those services, what is our strategy on how to deal with that?
Ms Halton-There are several things here, one of which is whether they can be sourced somewhere else in an environment where they are manufactured according to GMP; secondly, as has been pointed out to Dr O'Neil I do not know how many times, he can ensure that his manufacturing practice meets the standard that is required of every other manufacturer in this country. I do not think that is unreasonable.
Senator CORMANN-Thank you very much. Thank you, Madam Chair.
CHAIR-Thank you. Thank you, Mr Dellar and Mr O'Connor-Cox.
[9.04 pm]

ALCOHOL AND OTHER DRUG TREATMENT SERVICES IN AUSTRALIA 2006-07:

This report presents national, state and territory data on publicly funded alcohol and other drug treatment services and their clients, including information about the types of drugs for which treatment is sought and the types of treatment provided. This is the seventh report in the series of annual publications on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS). This report, along with others in the Drug Treatment series, is useful for policy-makers, planners, researchers and the broader community.
> Read full text **Source:** Australian Institute of Health and Welfare

Alcohol and other drug treatment services in Australia 2006-07: report on the National Minimum Data Set

Australian Institute of Health and Welfare - Posted: 18-10-2008

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> Read full text **Source:** Australian Institute of Health and Welfare

Swiss voters back £14m-a-year health scheme to give addicts free heroin

Heroin users have been taken off the streets and crime by addicts has fallen 60 per cent since the scheme began

David Charter, Europe Correspondent

The free provision of heroin to addicts won the overwhelming support of Swiss voters yesterday. Projections based on early results indicated that 69 per cent of voters approved the programme, believed to be the first of its kind in the world, in a poll called under the country's system of direct democracy.

Crime by heroin addicts has fallen 60 per cent since the initiative to allow health clinics to administer controlled doses of the drug began 14 years ago, according to the Swiss Federal Office of Public Health. The support for the plan came in a referendum called by opponents of a government policy that treats hardened drug users as patients rather than criminals. Critics, including conservatives who called for the referendum, object to the annual cost of 26 million Swiss francs (£14 million), covered by the health insurance that all citizens pay and the Government covers for those who cannot afford it.

RELATED LINKS

- Tough love: a mother's painful lesson
- Heroin is hard work. You don't drift into it
- Number of overdosing children soars

While the Swiss have a more tolerant attitude towards drugs than most European countries, a parallel referendum to legalise small-scale cannabis growing and use was soundly rejected by a margin of about two to one. The heroin scheme was introduced in response to a public outcry over the sight of addicts openly injecting the drug in public parks, as well as a rise in HIV and hepatitis infection. About 1,300 addicts are currently on the programme of carefully supervised doses, measured to satisfy their cravings yet avoid the risks of overdose and catching infections from dirty needles.

The addicts attend one of the country's 23 heroin centres and, in groups of four, inject themselves under the watchful eye of a nurse. They leave after a few minutes — those with jobs going back to work.

Daniele Zullino, of the Geneva University Hospitals, one of the heroin centres, said: “The aim is that the patients learn how to function in society. Heroin prescription is not an end in itself.” Dr Zullino added that after two to three years in the scheme, a third of the patients

started abstinence programmes and another third changed to methadone treatment, a much cheaper option, and the preferred approach in Britain. The majority of users have tried and failed to use the heroin substitute to wean themselves off the drug. Methadone remains the more common treatment in Switzerland, with more than 16,000 patients.

Christoph Buerki, a doctor at the clinic in Berne, which has 210 patients, said: "Their average age is 40 now and they have an average of 13 years of heroin addiction before they enter this programme. Basically we are aiming at a group of people where everything else has failed. We have medicalised heroin in Switzerland. It has the image of an ugly illness, and that is why, I think, numbers of new addicts are falling."

Andreas Kaesermann, a spokesman for the Social Democrat Party, part of the coalition Government, said: "Thanks to this policy we do not have open drug scenes anymore."

Parliament approved the heroin measure in a revision of Switzerland's drugs law in March, but conservatives challenged the decision and forced a national referendum.

Alain Hauert, spokesman for the right-wing Swiss People's Party, said: "I don't believe that health insurance should pay for this." He said that he wanted the State to invest more money in prevention work and law enforcement.

Sabine Geissbuhler, of the Parents against Drugs association, said that giving patients heroin was not helping them to give up the drug. "It is an outrage that the State should give addicts heroin — it is poison. You do not give people poison to make them better."

The US, and the UN narcotics board are also critical, but other governments have followed with experimental programmes modelled on the system. The Danish parliament approved state funding for 500 addicts earlier this year. There is limited legal heroin prescribing in Britain for a small number of long-term addicts.

While the Swiss Government backed the heroin initiative, it opposed the call for marijuana legalisation because it feared that it could cause drugs tourism to Switzerland of the kind that is causing public disorder problems in border towns in the Netherlands. Oswald Sigg, a government spokesman, said: "This could lead to a situation where you have some sort of cannabis tourism in Switzerland because something that is illegal in the EU would be legal in Switzerland."

Swiss MPs voted 106-70 against legalising cannabis for personal use last year. Switzerland has recorded the highest level of cannabis use in Europe, according to a study last July. The use of hard drugs was also increasing among 15-year-olds, according to a report by the Swiss Institute for the Prevention of Alcoholism and Drug Addiction.

The cost

- Drug-related crime costs England and Wales more than £13 billion a year
- Of the people who had HIV diagnosed in 2005, 56.8 per cent of Swiss nationals had contracted it through injecting narcotics
- A survey in 2005 showed that 88.4 per cent of addicts not using clinics occasionally or frequently shared needles
- A report in Scotland showed that 97 per cent of those treated with methadone went back to drugs, compared with 71 per cent who simply went cold turkey

— Regular heroin users have a 20 to 30 times higher risk of death than non-drug users

Sources: US Drug Enforcement Administration; UN, WHO

Note: Australian readers will be interested to know that the Australian Parliamentarians for Drug Law Reform have requested the Assistant Treasurer Hon Chris Bowen to support a review into the real cost of drugs by the Australian Productivity Commission. His recent reply indicates that this would be an important inquiry but at this time the Productivity Commission does not have the capacity to pursue this inquiry. He has indicated that this request will be considered when the Commission has the capacity to undertake such an inquiry.

U.S. Supreme Court: State Medical Marijuana Laws Not Preempted by Federal Law*
<http://www.safeaccessnow.org/article.php?id=5614>

/Medical marijuana case appealed by the City of Garden Grove was denied review today/

<http://www.safeaccessnow.org/img/original/icon_patientsrights.jpg>
Washington, DC -- The U.S. Supreme Court refused to review a landmark decision today in which California state courts found that its medical marijuana law was not preempted by federal law. The state appellate court decision from November 28, 2007, ruled that "it is not the job of the local police to enforce the federal drug laws." The case, involving Felix Kha, a medical marijuana patient from Garden Grove, was the result of a wrongful seizure of medical marijuana by local police in June 2005. Medical marijuana advocates hailed today's decision as a huge victory in clarifying law enforcement's obligation to uphold state law. Advocates assert that better adherence to state medical marijuana laws by local police will result in fewer needless arrests and seizures. In turn, this will allow for better implementation of medical marijuana laws not only in California, but in all states that have adopted such laws.

Read the rest of the article *HERE* <http://www.safeaccessnow.org/article.php?id=5614>.

The New York Times
January 30, 2009

Time Lag in Vienna?

Programs that give drug addicts access to clean needles have been shown the world over to slow the spread of deadly diseases including H.I.V./AIDS and hepatitis. Public health experts were relieved when President Obama announced his support for ending a ban on federal funding for such programs.

Unfortunately, Mr. Obama's message seems not to have reached the American delegation to a United Nations drug policy summit in Vienna, where progress is stalled on a plan that would guide global drug control and AIDS prevention efforts for years to come. The delegation has angered allies, especially the European Union, by blocking efforts to incorporate references to the concept of "harm reduction" - of which needle exchange is a prime example - into the plan.

State Department officials said that they were resisting the harm-reduction language because it could also be interpreted as endorsing

legalized drugs or providing addicts with a place to inject drugs. But the Vienna plan does not require any country to adopt policies it finds inappropriate. And by resisting the harm-reduction language, the American delegation is alienating allies and sending precisely the wrong message to developing nations, which must do a lot more to control AIDS and other addiction-related diseases.

Some members of Congress are rightly angry about the impasse in Vienna. On Wednesday, three members fired off a letter to Susan Rice, the new American ambassador to the United Nations, urging that the United States' delegation in Vienna be given new marching orders on the harm-reduction language. If that doesn't happen, the letter warns, "we risk crafting a U.N. declaration that is at odds with our own national policies and interests, even as we needlessly alienate our nation's allies in Europe."

LATEST UPDATE ON THE UN REVIEW NEGOTIATIONS

The second negotiating meeting on the draft annex of the political declaration took place during the week 24/25/26 November. Here is a summary of the feedback from that meeting, and what we understand to be the next steps in the process.

MEETING PROCESS

The Chair proceeded on the basis previously stated - there would be no further discussion on structure, but the draft text would be negotiated paragraph by paragraph, and delegations could suggest movement of paragraphs as they wished. The 3 days were thereafter taken up entirely with debates on language in the draft. In accordance with the draft, this started with the Demand Reduction section, and by the end of the meeting, had gone through that section, those on money laundering and judicial co-operation, and half of the supply reduction section. Even with the sections covered, there are many paragraphs where consensus was not achieved, so will need further discussion at future meetings. In terms of the issues that we have been most concerned with:

CONTAINMENT - The discussion on this was inconclusive, mostly dealing with where in the document this should be addressed. There is a general intention to enter a paragraph on this into the body of the political declaration.

HARM REDUCTION - Still unresolved, with most countries maintaining the same positions. The EU continues to press strongly for the language and key concepts to be included.

HUMAN RIGHTS - There was overall agreement on the basic principle that drug control needs to be implemented in compliance with human rights obligations, but unresolved whether this should be addressed in the
various sections or only mentioned in an overarching pre-ambular section.

BALANCED APPROACH - There were exchanges on this issue, with many delegations speaking in favour of more balance between supply and demand reduction, but some others noting concerns about watering down the 1998 commitments. Once again, no consensus language yet agreed.

DATA COLLECTION - The need to improve data collection in order to allow for better evidence-based policy making was confirmed in the demand reduction section, but there was difficulty in having similar wording
introduced for the supply side.

ESSENTIAL MEDICINES - There was a disturbing unwillingness of several member states to accept that this issue was part of the CND mandate. Proposals to strengthen the wording of this paragraph could not be agreed, so it will be necessary for those promoting this issue to move quickly to present clear arguments to helpful delegations on this issue before the next meeting.

PROPORTIONALITY - This also hit problems, some countries arguing that the international community should not be telling individual nations what is proportionate. If there is to be any recognition of this concept in the political declaration, then careful compromise language will need to be produced for the next meeting.

ALTERNATIVE DEVELOPMENT - This section was not reached in this meeting, but it is likely to be hotly debated at the next meeting.

Where disagreement was apparent and no quick compromise language could be found, paragraphs and amendments were placed between square brackets
for further deliberation at the next negotiating meeting, scheduled for 10th and 11th December. The Chairwoman's original intention was to finalise the text of the annexes in that meeting, then present the first draft of the body of the political declaration on the following day. Given the number of debates on the annex paragraphs that remain unresolved, however, this timetable now seems unrealistic and the key controversial issues are sure to be debated into the new year. Dates for further negotiating meetings will most likely therefore be needed

PRODUCING OPIUM IN AFGHANISTAN IN 2008

Dr Antonio Maria Costa, Executive Director of the United Nations office on Drugs and Crime (UNODC) recently launched the publication of the 2008 Afghan Opium survey.

There is some good news. The area of opium poppy under cultivation in Afghanistan decreased 19% from 2007. 18 of Afghanistan's 34 provinces are now considered 'poppy free' compared to 13 last year. Also, the proportion of Afghan households involved in the drug trade decreased 28% this year.

But there is also a lot of bad news. The average quantity of opium produced per hectare increased 15% in 2008. This means that, despite a large reduction in the area under cultivation, total opium production only decreased by 6%. Although the extent to which opium accounts for a share of the Afghan economy decreased from 60% in 2004, it still represents about a third of Afghan GLOBAL DRUG PROHIBITION. The potential profits from wheat cultivation have increased by almost 200%; but this means that they are still only about one third of potential profits from growing opium.

Dr Costa saw this report as an indication that the current strategy in Afghanistan was working and should be continued. He describes current international drug problem as being 'contained'. In 1988 UNODC used the slogan 'a drug free world: we can do it!' According to UNODC figures, global heroin production in the next ten years (1988-2007) more than doubled (increasing by 102%). And according to UNODC figures average heroin retail and wholesale prices decreased by at least 75% between 1990 and 2006 in 17 European countries and the United States.

Dr Costa rejected the suggestion that the UN should buy Afghanistan's opium crop arguing that this would create an incentive for growers to produce more opium, that the global market for licit opium remained underdeveloped and that it would be impossible to stop a secondary market developing. But if these arguments apply to the UN buying opium crops surely the

same logic should also apply to illicit drugs that are removed from the market by crop eradication or development of alternative crops.

Australia has a large, dangerous and expensive military operation in Afghanistan. Our military opponents are funded from the lucrative proceeds of opium cultivation and heroin production. According to a confidential estimate prepared for the Blair Cabinet in the UK in 2003, profits of major league heroin traffickers in Afghanistan account for 26-58% of turnover. Does it seem logical to put Australia's soldiers in harm's way yet while continuing to support an international system which guarantees a generous income stream to terrorists?

THE BUDGETARY IMPLICATIONS OF DRUG PROHIBITION.

A recently released report from the Department of Economics at Harvard University examines *The budgetary Implications of Drug Prohibition*. The executive Summary is included below. The whole report can be accessed at the following link. http://leap.cc/dia/miron-economic-report.pdf

Executive Summary

Government prohibition of drugs is the subject of ongoing debate.

One issue in this debate is the effect of prohibition on government budgets. Prohibition entails direct enforcement costs and prevents taxation of drug production and sale.

This report examines the budgetary implications of legalizing drugs.

The report estimates that legalizing drugs would save roughly $44.1 billion per year in government expenditure on enforcement of prohibition. $30.3 billion of this savings would accrue to state and local governments, while $13.8 billion would accrue to the federal government. Approximately $12.9 billion of the savings would results from legalization of marijuana, $19.3 billion from legalization of cocaine and heroin, and $11.6 from legalization of other drugs.

The report also estimates that drug legalization would yield tax revenue of $32.7 billion annually, assuming legal drugs are taxed at rates comparable to those on alcohol and tobacco. Approximately $6.7 of this revenue would result from legalization of marijuana, $22.5 billion from legalization of cocaine and heroin, and $3.5 from legalization of other drugs.

Whether drug legalization is a desirable policy depends on many factors other than the budgetary impacts discussed here. Rational debate about drug policy should nevertheless consider these budgetary effects.

The estimates provided here are not definitive estimates of the budgetary implications of a legalized regime for currently illegal drugs. The analysis employs assumptions that plausibly err on the conservative side, but substantial uncertainty remains about the magnitude of the budgetary impacts.

The following was recently published in the Journal *Nature*

“Society must respond to the growing demand for cognitive enhancement. That response must start by rejecting the idea that 'enhancement' is a dirty word, argue Henry Greely and colleagues.

Today, on university campuses around the world, students are striking deals to buy and sell prescription drugs such as Adderall and Ritalin — not to get high, but to get higher grades, to

provide an edge over their fellow students or to increase in some measurable way their capacity for learning. These transactions are crimes in the United States, punishable by prison.

Many people see such penalties as appropriate, and consider the use of such drugs to be cheating, unnatural or dangerous. Yet one survey[1] estimated that almost 7% of students in US universities have used prescription stimulants in this way, and that on some campuses, up to 25% of students had used them in the past year. These students are early adopters of a trend that is likely to grow, and indications suggest that they're not alone.

In this article, we propose actions that will help society accept the benefits of enhancement, given appropriate research and evolved regulation. Prescription drugs are regulated as such not for their enhancing properties but primarily for considerations of safety and potential abuse. Still, cognitive enhancement has much to offer individuals and society, and a proper societal response will involve making enhancements available while managing their risks." The complete report with recommendations can be viewed at the following link.

http://www.nature.com/nature/journal/vaop/ncurrent/full/456702a.html

Lifting the ban on Harm Reduction

TNI weblog
Wednesday 21 January 2009

The Obama White House announced today that the new President supports lifting the federal ban on needle exchange, which could dramatically reduce rates of infection among drug users. Will he also lift the ban on the concept of harm reduction, which has paralysed the international drug policy debate under his predecessors?

Read the full blog at:
http://www.ungassondrugs.org/index.php?option=com_content&task=view&id=230

Op-ed Wall Street Journal

Ethan Nadelmann
Executive Director
Drug Policy Alliance Network

Let's End Drug Prohibition

December 5, 2008

Page A21

Ethan Nadelmann

Most Americans agreed that alcohol suppression was worse than alcohol consumption.

Today is the 75th anniversary of that blessed day in 1933 when Utah became the 36th and deciding state to ratify the 21st amendment, thereby repealing the 18th amendment. This ended the nation's disastrous experiment with alcohol prohibition.

It's already shaping up as a day of celebration, with parties planned, bars prepping for recession-defying rounds of drinks, and newspapers set to publish cocktail recipes concocted especially for the day.

But let's hope it also serves as a day of reflection. We should consider why our forebears rejoiced at the relegalization of a powerful drug long associated with bountiful pleasure and pain, and consider too the lessons for our time.

The Americans who voted in 1933 to repeal prohibition differed greatly in their reasons for overturning the system. But almost all agreed that the evils of failed suppression far outweighed the evils of alcohol consumption.

The change from just 15 years earlier, when most Americans saw alcohol as the root of the problem and voted to ban it, was dramatic. Prohibition's failure to create an Alcohol Free Society sank in quickly. Booze flowed as readily as before, but now it was illicit, filling criminal coffers at taxpayer expense.

Some opponents of prohibition pointed to Al Capone and increasing crime, violence and corruption. Others were troubled by the labeling of tens of millions of Americans as criminals, overflowing prisons, and the consequent broadening of disrespect for the law. Americans were disquieted by dangerous expansions of federal police powers, encroachments on individual liberties, increasing government expenditure devoted to enforcing the prohibition laws, and the billions in forgone tax revenues. And still others were disturbed by the specter of so many citizens blinded, paralyzed and killed by poisonous moonshine and industrial alcohol.

Supporters of prohibition blamed the consumers, and some went so far as to argue that those who violated the laws deserved whatever ills befell them. But by 1933, most Americans blamed prohibition itself.

When repeal came, it was not just with the support of those with a taste for alcohol, but also those who disliked and even hated it but could no longer ignore the dreadful consequences of a failed prohibition. They saw what most Americans still fail to see today: That a failed drug prohibition can cause greater harm than the drug it was intended to banish.

Consider the consequences of drug prohibition today: 500,000 people incarcerated in U.S. prisons and jails for nonviolent drug-law violations; 1.8 million drug arrests last year; tens of billions of taxpayer dollars expended annually to fund a drug war that 76% of Americans say has failed; millions now marked for life as former drug felons; many thousands dying each year from drug overdoses that have more to do with prohibitionist policies than the drugs themselves, and tens of thousands more needlessly infected with AIDS and Hepatitis C because those same policies undermine and block responsible public-health policies.

And look abroad. At Afghanistan, where a third or more of the national economy is both beneficiary and victim of the failed global drug prohibition regime. At Mexico, which makes Chicago under Al Capone look like a day in the park. And elsewhere in Latin America, where prohibition-related crime, violence and corruption undermine civil authority and public safety, and mindless drug eradication campaigns wreak environmental havoc.

All this, and much more, are the consequences not of drugs per se but of prohibitionist policies that have failed for too long and that can never succeed in an open society, given the lessons of history. Perhaps a totalitarian American could do better, but at what cost to our most fundamental values?

Why did our forebears wise up so quickly while Americans today still struggle with sorting out the consequences of drug misuse from those of drug prohibition?

It's not because alcohol is any less dangerous than the drugs that are banned today. Marijuana, by comparison, is relatively harmless: little association with violent behavior, no chance of dying from an overdose, and not nearly as dangerous as alcohol if one misuses it or becomes addicted. Most of heroin's dangers are more a consequence of its prohibition than the drug's distinctive properties. That's why 70% of Swiss voters approved a referendum this past weekend endorsing the government's provision of pharmaceutical heroin to addicts who could not quit their addictions by other means. It is also why a growing number of other countries, including Canada, are doing likewise.

Yes, the speedy drugs -- cocaine, methamphetamine and other illicit stimulants -- present more of a problem. But not to the extent that their prohibition is justifiable while alcohol's is not. The real difference is that alcohol is the devil we know, while these others are the devils we don't. Most Americans in 1933 could recall a time before prohibition, which tempered their fears. But few Americans now can recall the decades when the illicit drugs of today were sold and consumed legally. If they could, a post-prohibition future might prove less alarming.

But there's nothing like a depression, or maybe even a full-blown recession, to make taxpayers question the price of their prejudices. That's what ultimately hastened prohibition's repeal, and it's why we're sure to see a more vigorous debate than ever before about ending marijuana prohibition, rolling back other drug war excesses, and even contemplating far-reaching alternatives to drug prohibition.

Perhaps the greatest reassurance for those who quake at the prospect of repealing contemporary drug prohibitions can be found in the era of prohibition outside of America. Other nations, including Britain, Australia and the Netherlands, were equally concerned with the problems of drink and eager for solutions. However, most opted against prohibition and for strict controls that kept alcohol legal but restricted its availability, taxed it heavily, and otherwise discouraged its use. The results included ample revenues for government coffers, criminals frustrated by the lack of easy profits, and declines in the consumption and misuse of alcohol that compared favorably with trends in the United States.

Is President-elect Barack Obama going to commemorate Repeal Day today? I'm not holding my breath. Nor do I expect him to do much to reform the nation's drug laws apart from making good on a few of the commitments he made during the campaign: repealing the harshest drug sentences, removing federal bans on funding needle-exchange programs to reduce AIDS, giving medical marijuana a fair chance to prove itself, and supporting treatment alternatives for low-level drug offenders.

But there's one more thing he can do: Promote vigorous and informed debate in this domain as in all others. The worst prohibition, after all, is a prohibition on thinking.

The following items have been taken from the UK Transform News – January 2009

Transform Blog

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International News

ACMD Ecstasy Review – United Kingdom

"Leaving ecstasy in class A on the grounds that "there is no such thing as a safe dose" is public stupidity. On this basis there is no safe alcoholic drink or cigarette. There is no safe tree, no safe ladder and, according to Smith, no safe mobile phone. Do we ban trees, ladders and mobiles?"

Simon Jenkins, The Guardian

The ACMD's (Advisory Council on the Misuse of Drugs) review of ecstasy has continued to dominate the UK media this month. As reported in the Guardian on 5th January it is expected that the ACMD will advise the government to lower ecstasy from Class A to Class B. It is likely however that the Home Secretary Jacqui Smith will ignore this advice and keep it in Class A. The whole situation feels like a déjà vu of the recent cannabis debacle (with the government ignoring the ACMD advice to keep cannabis at class C) and illustrates again how government policy on drugs, is based on populist posturing rather than scientific evidence. Simon Jenkins wrote an excellent article this month in which he heavily criticises the Government for this decision.

Further discussion of the story can be found on the UK Transform's blog here. Transform's submission to the ACMD review can be read in full here.

CANNABIS RECLASSIFIED – UNITED KINGDOM

Cannabis has now been upgraded from Class C drug to Class B since the 26th January. The Home Office have announced that first time possession of cannabis will now result in a warning, followed by and an on-the-spot fine of £80, then prosecution in - an escalating three strikes and you're out style enforcement regime. More on the story can be read here, here, here, here, and here.

Steve wrote a brilliant satire on reclassification back in May entitled 'Millions quit cannabis following reclassification' which is well worth a read as it clearly illustrates the futility of this move.

MEXICO DRUG WAR

Virtually every day for the past few months there seems to have been yet another story coming out of Mexico illustrating just how destructive the escalating Mexican drug war has become. Recent estimates suggest that some 7,000 people have been killed in drug related violence between the drug cartels and Mexican law enforcement officials over the past two years. Some of the most interesting articles on the story can be read below:

- Mexico's Unsuccessful Drug War, Painfully Preserved and Hidden
- U.S. war on drugs has failed, report says
- Mexico's Violent Drug War Wreaks Havoc on Innocent Lives
- The War Next Door
- The £15bn drugs war that has cost 7,000 lives in 2 years
- A series of photos from Mexico's drug war

UNITED STATES OF AMERICA - OBAMA LIFTS FEDERAL BAN ON FUNDING NEEDLE EXCHANGE

With a new president now in control, The White House has launched its new website, [www.whitehouse.gov.](http://www.whitehouse.gov) Under the header "The Agenda - Civil Rights", the site highlights various issues including; homophobia and its affect on HIV/AIDS, contraception (including in prisons), the need to empower women to get involved in the prevention of HIV, and notably: needle exchanges. Aside from a small mention for drug courts and eliminating the cocaine/crack sentencing disparity there isn't much else about drug policy yet, but lifting the disgraceful ban on the funding of needle exchanges is a good start - and the generally pragmatic tone bodes well too. Can we be cautiously optimistic? Yes we can.

"Promote AIDS Prevention: In the first year of his presidency, President Obama will develop and begin to implement a comprehensive national HIV/AIDS strategy that includes all federal agencies. The strategy will be designed to reduce HIV infections, increase access to care and reduce HIV-related health disparities. The President will support common sense approaches including age-appropriate sex education that includes information about contraception, combating infection within our prison population through education and contraception, and distributing contraceptives through our public health system. The President also supports lifting the federal ban on needle exchange, which could dramatically reduce rates of infection among drug users. President Obama has also been willing to confront the stigma -- too often tied to homophobia -- that continues to surround HIV/AIDS.

Empower Women to Prevent HIV/AIDS: In the United States, the percentage of women diagnosed with AIDS has quadrupled over the last 20 years. Today, women account for more than one quarter of all new HIV/AIDS diagnoses. President Obama introduced the Microbicide Development Act, which will accelerate the development of products that empower women in the battle against AIDS. Microbicides are a class of products currently under development that women apply topically to prevent transmission of HIV and other infections."

More on Obama's views on the drug war can be read here, and here.

El Paso City Council calls for legalisation

An interesting article appeared in Dallas News this month regarding Beto O'Rourke, an El Paso city councillor, who called upon the US government to start an open and rational debate on drug legalisation in response to the current drug war in Mexico. More on the story can be read here, here,and here. Beta O'Rourke can be seen discussing his views (and making an awful lot of sense) in a video post here:

http://www.elpasotimes.com/newupdated/ci_11386093

Unfortunately the Mayor of El Paso vetoed this proposal despite the resolution being unanimously agreed upon by the other councillors. The story illustrates how the politics of prohibition can inhibit rational debate even on a local level.

See Transform's blog here for more on the story.

South East Asia suffers withdrawal symptoms from decline in opium

The Transnational Institute has released their latest report 'Withdrawal Symptoms in the Golden Triangle: A Drugs Market in Disarray.' The report questions the successes claimed by

drug control agencies regarding the decrease in opium production in South East Asia. It also illustrates how this decline has had serious adverse impacts on people living in these areas (more people living in poverty, more people engaged in higher-risk drug use etc). The report makes for an interesting read and can be accessed here.

Book Review

'*The Globalisation of Addiction*' by Bruce Alexander

Review by Mike Jay

Bruce Alexander is best known - though deserves to be much better known - for the 'Rat Park' experiments he conducted in 1981. As an addiction psychologist, much of the data with which he worked was drawn from laboratory trials with rats and monkeys: the 'addictiveness' of drugs such as opiates and cocaine was established by observing how frequently caged animals would push levers to obtain doses. But Alexander's observations of addicts at the clinic where he worked in Vancouver suggested powerfully to him that the root cause of addiction was not so much the pharmacology of these particular drugs as the environmental stressors with which his addicts were trying to cope.

To test his hunch he designed Rat Park, an alternative laboratory environment constructed around the need of the subjects rather than the experimenters. A colony of rats, who are naturally gregarious, were allowed to roam together in a large vivarium enriched with wheels, balls and other playthings, on a deep bed of aromatic cedar shavings and with plenty of space for breeding and private interactions. Pleasant woodland vistas were even painted on the surrounding walls. In this situation, the rats' responses to drugs such as opiates were transformed. They no longer showed interest in pressing levers for rewards of morphine: even if forcibly addicted, they would suffer withdrawals rather than maintaining their dependence. Even a sugar solution could not tempt them to the morphine water (though they would choose this if naloxone was added to block the opiate effects). It seemed that the standard experiments were measuring not the addictiveness of opiates but the cruelty of the stresses inflicted on lab rats caged in solitary confinement, shaved, catheterised and with probes inserted into their median forebrain bundles.

Yet despite (or perhaps because of) their radical implications for the data that underpin addiction psychology, the Rat Park experiments attracted little attention. Alexander's paper was rejected by major journals including Science and Nature, and eventually published only in the respectable but minor Pharmacology, Biochemistry and Behavior. Although the experiments have subsequently been replicated and extended, they still inform the science of addiction only at its margins. The Globalisation of Addiction is Alexander's attempt to draw out their full implications for our understanding of addiction, and to chart a course towards forms of treatment that can transform their findings into practice.

His analysis begins with a radical reconception of addiction itself. Throughout the 20th century, as the science and treatment of addiction have developed into vast academic and professional industries, its underlying nature has stubbornly refused to coalesce into any sort of consensus. Is it a physiological condition marked by metabolic responses such as tolerance and withdrawal, a condition produced simply by exposure to 'addictive' drugs? Or is it a psychological affliction, the product of an 'addictive personality' - or, alternatively, a moral weakness, a failure of willpower and abrogation of social responsibilities? And how do these clinical views of addiction relate to the ever-expanding meanings of the term in the wider culture?

For Alexander, all these seemingly disparate accounts are united by their focus on the individual addict; but even a cursory historical and cultural survey reveals that the incidence of addiction is essentially a social phenomenon. Many historical and indigenous cultures have lacked even the concept of addiction - but many of these same cultures, once their traditional structures have been disrupted by conquest or colonisation, have been destroyed by it. All across the Americas, the Pacific and Australia, hundreds of 'demoralised' cultures have descended into vicious spirals of addiction, usually to alcohol, in many tragic cases wiping themselves out entirely. The root causes of addiction, then, must run deeper than any individual pathology: they must be sought in a larger story of cultural malaise and 'poverty of the spirit' that forces individuals, often en masse, into desperate and dysfunctional coping strategies.

Once addiction is recognised as a consequence of broader social currents, it becomes clear that the problem is far more widespread than the professional focus on drugs allows. Uncontrolled and chaotic appetites are extensively diagnosed across our culture not merely for illicit drugs, alcohol and nicotine but for other substances (food), other consumer activities (shopping, gambling), and other sources of emotional support such as romantic love. 'Addictive' is a slogan of enticement used to sell online gaming, exercise programmes and women's magazines. Even successful and high-functioning individuals can often be accurately described as addicted to money, power or status. Throughout the 20th century, these extensions of the concept of addiction were typically marginalised on the grounds that, unlike illicit drugs, these were mainstream activities that generated dysfunctional behaviour only in a minority of subjects. But alcohol has always been both mainstream and addictive, and it is increasingly clear that illicit drugs are used widely without necessarily generating addiction. Any attempt to get to the root of the problem must recognise that addiction is rampant not merely among a subculture of problem drug users but across society at large.

Alexander's search for the drivers behind the modern explosion in addiction leads him to consider the parallel spread of free market societies. Along with their obvious economic benefits, free markets also bring a widespread increase in what he terms cultural 'dislocation'. What were once elaborately reciprocated cultural transactions are reduced to simple commercial exchanges, and 'the competitive marketplace becomes the matrix of human existence'. Social fabrics are loosened as economic winners and losers polarise into their respective ghettoes, and traditional networks of trust are replaced by often brutal demarcations between neighbourhoods and social classes. It is our now endemic culture of competitive, zero-sum individualism that has, in the phrase of Alexander's title, globalised addiction over the last 50 years.

It is, he acknowledges, too simplistic to blame capitalism itself: the fundamental problem, dislocation, can equally be generated by feudalism, communism or any other political system. Nevertheless, a consumer society systemically erodes the sovereign remedy against addiction which, following Erik Erikson, Alexander terms 'psychosocial integration'. This has long been recognised as a necessity for social functioning: even Charles Darwin, whose theory is typically used to support competitive free market ideology, insisted that generating 'social and moral qualities' was a crucial factor in human evolutionary success. Psychosocial integration eliminates the hyperfocused pursuit of individual gratification that manifests as addictive behaviour, and balances individual autonomy with social belonging. Dislocation, though its effects are concentrated among the poor and socially excluded, has pervasive effects on society as a whole, which is why levels of happiness and wellbeing stubbornly refuse to rise in proportion with purchasing power. The greatest modern triumph over drug addiction, in China during Mao's Great Leap Forward from 1949-1955, took place against a background of material poverty but intense social cooperation in rebuilding a shattered society.

This analysis has helped Alexander to understand the successes and failures of treatment programmes in his professional world in Vancouver, where alcoholism and violence remain an intractable problem among many native Canadian Indians. Dislocation, rather than poverty, is their ultimate cause: communities resettled on unfamiliar land can be subsidised to the point where a 4x4 sits in every drive and a satellite dish on every roof, but still manifest higher levels of addiction than those which are allowed to remain in their homelands and follow their traditional subsistence strategies. In the arresting motto adopted by British Columbia's successful aboriginal community projects, 'Culture is Treatment'.

Once addiction is reconceived as a symptom of the dislocation embedded in modern cultures, the practical measures required to manage it become vast in scope. Treatment of addicts needs to become more holistic, and interwoven into a far wider spectrum of social programmes. Education and treatment need to lose their narrow focus on illicit drugs and alcohol, and to encompass addiction in all its forms. Although the prohibition of drugs is a major contributor to social dislocation, legalisation is far from a panacea: the majority of addictions, after all, are to legally available products. (The greatest benefit of legalisation, perhaps, would be to allow communities to determine their own drug policies, thereby providing a crucial lever for increasing psychosocial integration.) Faith-based treatments, whether Christian or more broadly spiritual, have an important role to play: St. Augustine's Confessions remains a powerful template for the addiction recovery narrative, and membership of faith groups can provide an effective antidote to dislocation. Political activism, both global and local, is a tool of social empowerment that can benefit addicts and addiction professionals alike.

All these strategies are eminently sensible, but remain hard to patch into the treatment of addiction as currently constituted. We may accept Alexander's persuasive case that drug addiction, properly understood, is a scapegoat for broader social dysfunction, but it is by no means obvious how to respond effectively. Like it or not, treatment remains focused on individuals, for whom his analysis holds limited explanatory power. Alexander does not deny the existence of personal tendencies to addiction, which may include genetics and neurochemistry, but maintains that they are often marginal factors and poor predictors of individual risk: overall, interventions are more effective at the social level than the personal. But these underlying causes are far easier to identify than to address. Our societies are profoundly structured around the need for individual autonomy; and personal freedom must, on some levels, always include the freedom to become addicted.

The Globalisation of Addiction is a considerable work, highly ambitious in its scope, impressive in its multidisciplinary scholarship, clear in its structure and generous in its references. It is both its strength and its weakness that it integrates addiction so convincingly into broader issues of social and political reform. Like Rat Park, it offers a fundamental critique of the 20th century view of addiction, but also demonstrates how dominant are the processes and structures that drive it.

Transform has published this article with permission from Mike Jay. Mike is a writer and historian (See Mikejay.net) and a trustee of Transform Drug Policy Foundation.

Note: If you have any comments or suggestions about this Newsletter please contact dalma.dixon@aph.gov.au

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