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# Minimising the Harm of Illicit Drug Use: Drug Policies in Australia

The principle of harm minimisation has formed the basis of the drug policy framework in Australia since 1985. Harm minimisation in this context refers to policies and programs designed to prevent and reduce drug-related harm. The overall aim of this approach is to improve the health, social and economic outcomes for both the community and the individual with the balanced use of three main strategies: supply-reduction, demand-reduction and harm-reduction.

The current national drug policy framework in Australia is the National Drug Strategy (NDS), a cooperative venture between the Commonwealth and State/Territory governments as well as the non-government sector.

In Australia, like other countries, the use of, and harm caused by, illicit drugs is a complex issue, affected by a multitude of factors. While there is general consensus on the need for an integrated approach to the drug problem in Australia, there are divergent views about the effectiveness of the current drug policies and strategies. As a result, some protagonists in the drug debate support new 'innovative' drug strategies, the more radical of which are supervised injecting facilities and heroin prescription trials. This divergence of views has caused a polarisation of the drug debate on such issues.

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**Research Brief No 2002/06**



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**ISSN 1443-7902**

**ISBN 0 7345 2815 9**

**February 2002**

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## **1 INTRODUCTION**

The principle of harm minimisation has formed the basis of the drug policy framework in Australia since 1985. Harm minimisation in this context refers to policies and programs designed to prevent and reduce drug-related harm. The overall aim of this approach is to improve the health, social and economic outcomes for both the community and the individual with the balanced use of three main strategies: supply-reduction, demand-reduction and harm-reduction.

The current national drug policy framework in Australia is the National Drug Strategy (NDS), a cooperative venture between the Commonwealth and State/Territory governments as well as the non-government sector.

In Australia, like other countries, the use of, and harm caused by, illicit drugs is a complex issue, affected by a multitude of factors. While there is general consensus on the need for an integrated approach to the drug problem in Australia, there are divergent views about the effectiveness of current drug policies and strategies. As a result, some protagonists in the drug debate support new ‘innovative’ drug strategies, the more radical of which are supervised injecting facilities and heroin prescription trials. This divergence of views has caused a polarisation of the drug debate on such issues.

This Research Brief outlines the prevalence of illicit drug use in Australia. The paper also describes the development of the current national approach to drug policies and strategies and outlines a range of drug strategies, namely drug diversion, safe injecting rooms and heroin prescription trials, that have featured in the drug debate in Australia in recent times. The paper concludes with a brief overview of some notable drug policies and strategies implemented in the United States, Switzerland, the Netherlands and Sweden.

## **2 THE PREVALENCE OF ILLICIT DRUG USE IN AUSTRALIA**

Over the past decade, the use of illicit drugs has become more prevalent in Australian society. A number of recent surveys and reports have noted this development.

- The results from a 1998 National Drug Strategy Household Survey (NDSHS) suggest that 46.4% of the Australians aged 14 years and over have used an illicit drug at least once in their life, while 22.8% report having used an illicit drug in the preceding 12 months. The most widely used illicit substance in Australia in 1998 was marijuana, with lifetime use (used at any time in one’s life) at 39.1% and recent use (used in the last 12 months) at 17.9%. The prevalence of lifetime use of pain-killers/analgesics (for non-medical purposes) was 12%, followed by

LSD/synthetic hallucinogens (9.9%), amphetamines (8.8%), ecstasy/designer drugs (4.8%), cocaine (4.3%) and heroin (2.2)%.<sup>1</sup>

- The 1998 NDSHS results for Queensland showed that, when compared with the 1995 NDSHS results, there appeared to be a slightly higher rate of use across all categories of illicit drugs referred to in the survey, both in terms of lifetime use and recent use. One in four Queensland respondents approved the regular use of marijuana/cannabis by adults although fewer than one in ten approved the regular use of each of the other illicit drugs included in the survey. Nearly half of the Queensland respondents had used an illicit drug at some time in their lives and over one in five had used illicit drugs in the previous 12 months. Half of the Queensland respondents supported measures designed to reduce harm associated with illicit drug use. About four in five illicit drug users were introduced to illicit drugs by friends and acquaintances, and most continued to obtain their illicit drugs from these sources.<sup>2</sup>
- Data published in a report of the Australian Institute of Health and Welfare (AIHW) in May 2001, *Statistics on Drug Use in Australia 2000*, affirmed the increased prevalence since 1991 of the use of illicit drugs<sup>3</sup> such as marijuana, amphetamines, LSD/ synthetic hallucinogens, ecstasy/designer drugs, cocaine and heroin.<sup>4</sup> In 1991, around 33% of Australians aged 14 years or over had tried marijuana. By 1998, this figure had increased to about 39%. The study also showed that, notwithstanding those results, illicit drug use was unacceptable to most Australians. Similarly, support for the legalisation of illicit drugs was not widespread.

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<sup>1</sup> Australian Institute of Health and Welfare, *1998 National Drug Strategy Household Survey*. More than 10,000 Australians aged 14 and over participated in the 1998 National Drug Strategy Household Survey (NDSHS), the sixth survey in a series that began in 1985. The survey covered tobacco, alcohol and illicit drugs. Survey respondents were asked about their knowledge of drugs, their attitudes towards drugs, their drug consumption histories and related behaviours.

<sup>2</sup> Australian Institute of Health and Welfare, *1998 National Drug Strategy Household Survey: Queensland Results*, Drug Statistics Series, No 4, June 2000.

<sup>3</sup> Barbiturates were the exception to this general trend of increased use in the period 1991–1998 with lifetime use statistics of 5.2% in 1991, 1.4% in 1993, 1.2% in 1995 and 1.6% in 1998 recorded.

<sup>4</sup> Australian Institute of Health and Welfare, *Statistics on Drug Use in Australia 2000*, May 2001. The report collated statistical data from the 1995 and 1998 NHDHS, the 1991 and 1993 National Campaign against Drug Abuse Surveys, the Australian Bureau of Statistics, the Commonwealth Department of Health and Aged Care, the Australian Institute of Health and Welfare, the Australian Transport Safety Bureau, the Australian Bureau of Criminal Intelligence and the National Drug and Alcohol Research Centre.

- The National Drug and Alcohol Research Centre (NDARC) published its findings about drug trends in Australia in 2000 through its illicit Drug Reporting System (IDRS) that monitors the price, purity, availability and patterns of use of heroin, amphetamine, cocaine and cannabis.<sup>5</sup> The study found that:
  - Heroin use continued to increase in most Australian jurisdictions, as did fatal opioid overdoses;
  - Amphetamine use increased in most Australian jurisdictions, with an increase in the availability and use of more potent forms of methamphetamine in all jurisdictions;
  - Cocaine use remained uncommon in all jurisdictions except NSW; and
  - Cannabis remained the most widely used illicit drug in Australia and was readily available in all jurisdictions.
- The results of a NDARC study that applied a number of indirect methods to estimate the number of dependent heroin users in Australia, suggest that a relatively small proportion of Australian adults - about 74,000 - are dependent on heroin.<sup>6</sup> This estimated incidence of heroin dependence in Australia is similar to that in European Union countries.<sup>7</sup>
- Cannabis, amphetamine type substances, cocaine and heroin are the primary illicit drugs used in Australia. Australian law enforcement bodies have noted a growth in demand for “party drugs” like ecstasy and other amphetamine type substances. In Queensland, an increase in the domestic production of amphetamines has occurred. Amphetamine-type substances are cheaper to sell to users, thought to be safer than heroin, and can be made locally and quite easily.<sup>8</sup>
- In June 1999, leading Queensland intelligence agencies reported that the heroin market represented the highest risk to the community of all illicit drug and

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<sup>5</sup> L Topp, S Darke, R Bruno, C Fry, K Hargreaves, R Humeniuk, R McAllister, B O’Reilly & P Williams, *Australian Drug Trends 2000: Findings of the Illicit Drug Reporting System*, Monograph 47, National Drug and Alcohol Research Centre (NDARC), 2001, Executive Summary abstracted at <http://www.med.unsw.edu.au/ndarc/publications/Monograph47.htm>.

<sup>6</sup> Hall, Ross, Lynskey, Law & Degenhardt, *How many dependent heroin users are there in Australia?*, Monograph 44, National Drug and Alcohol Research Centre (NDARC), 2000, p 1. In 2000, the estimates of the number of dependent heroin users in Australia ranged between 67,000 and 92,000 with a median of 74,000, equating to a population prevalence of 6.9 per 1,000 population aged 15 – 54 years.

<sup>7</sup> NDARC, Monograph 44, pp 2,3.

<sup>8</sup> National Crime Authority, *National Crime Authority Commentary*, p 36.

organised crime markets.<sup>9</sup> In November 2000, the Queensland Crime Commission (QCC) assessed the risk posed to the Queensland public by the amphetamine trade as the greatest of all the illicit drugs.<sup>10</sup> Other research by the QCC also indicates that the synthetic “party drug” ecstasy<sup>11</sup> has become more available in Queensland in recent years.<sup>12</sup>

- In February 2001, the Australian Institute of Criminology published *Illicit Drug Use in Regional Australia, 1988 – 1998*<sup>13</sup>, a research paper that analysed data gathered about illicit drug use in metropolitan and regional Australia between 1988 and 1998. The paper noted that illicit drug use is increasing in regional Australia, with rates that approximate those observed in the cities a few years ago.<sup>14</sup> Between 1988 and 1998, use of illicit drugs increased in regional Australia by 77 per cent for heroin, 131 per cent for amphetamines, 37 per cent for cocaine, and 47 per cent for cannabis. The paper concluded that lessons learned from the response to drugs in metropolitan areas should be adopted early if regional Australia is to avoid the levels of drug-related social disruption evident in the cities.

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<sup>9</sup> Queensland Crime Commission, Project Krystal: A Strategic Assessment of Organised Crime in Queensland, *Public Information Paper*, 1999.

<sup>10</sup> Queensland Crime Commission, ‘The Amphetamine Market in Queensland’, *Crime Bulletin* No 2, November 2000, p 1.

<sup>11</sup> Ecstasy (Methylenedioxymethylamphetamine (MDMA)) is the most frequently used amphetamine analogue in Australia. It may cause significant physical and psychological harm through poly-drug use, bingeing, intravenous drug use and the sale of tablets purporting to be MDMA but containing a cocktail of illicit substances: Queensland Crime Commission, ‘The Ecstasy Market in Queensland’, *Crime Bulletin* No 3, August 2001, p 1.

<sup>12</sup> Queensland Crime Commission, ‘The Ecstasy Market in Queensland’, *Crime Bulletin* No 3, August 2001, p 1. The Bulletin notes that the market demand for MDMA will continue indefinitely and is likely to strengthen in line with the reported expansion beyond the rave scene. QCC estimates the value of the MDMA market is from \$10 to \$ 50 million per annum; and its volume to be from 65 to 390 kg.

<sup>13</sup> P Williams, ‘Illicit Drug Use in Regional Australia 1988 – 1998’, Australian Institute of Criminology, *Trends & Issues in Crime and Criminal Justice Series*, No 192, February 2001.

<sup>14</sup> The paper noted that, while current levels are lower than those found in metropolitan Australia, the rates of drug use in regional Australia probably will not contemporaneously match those found in metropolitan areas of the country in the near future.

### 3 HARM MINIMISATION

The principle of **harm minimisation** has formed the basis of the drug policy framework in Australia since 1985. Harm minimisation in this context refers to policies and programs designed to prevent and reduce drug-related harm. The overall aim of this approach is to improve the health, social and economic outcomes for both the community and the individual with the balanced use of three main strategies: supply-reduction, demand-reduction and harm-reduction. Both licit and illicit drugs are the focus of Australia's harm-minimisation strategy.

**Supply-reduction** strategies are those designed to disrupt the production and supply of illicit drugs; **demand-reduction** strategies are those designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use; and **harm-reduction** strategies are those that are designed to reduce drug-related harm for individuals and communities.

### 4 THE DEVELOPMENT OF A NATIONAL DRUG POLICY FRAMEWORK IN AUSTRALIA

This section describes the inception and development of the current national drug policy framework in Australia. This drug policy framework was first implemented in 1985 as the *National Campaign Against Drug Abuse* (NCADA). The NCADA was later redeveloped in 1993 as the *National Drug Strategy* (NDS). The latest stage of the NDS was implemented in 1998 as the *National Drug Strategic Framework*. These developmental stages are the outcome of continued evaluation and review of the drug policies and strategies.

The NDS is a cooperative venture between the Commonwealth and State/Territory governments as well as the non-government sector.

The NDS gives the Commonwealth Government the dual responsibilities of:

- the provision of national leadership in Australia's response to reducing drug-related harm; and
- the implementation of its own policies and programs to contribute to the reduction of drug-related harm.

The NDS gives each of the State and Territory governments the responsibility of providing, within their respective jurisdictions, leadership in the areas of policy development, implementation and evaluation and police, health (including drug treatment) and education services.

The other activities for which State and Territory Governments are responsible under the NDS include:

- the development and implementation of their own drug strategies from the perspective of law enforcement and population health, based on local priorities;
- the control of the supply of illicit drugs through both specialist drug law enforcement units and general duties police officers;
- the enforcement of the regulation of pharmaceutical drugs;
- the enforcement of laws regulating the consumption and availability of alcohol and developing and enforcing legislation relating to tobacco
- the implementation of harm reduction strategies to prevent drink driving;
- community-based organisations to provide drug prevention and treatment programs;
- the regulation and administration of the delivery of methadone services and needle and syringe programs;
- the development of effective and comprehensive professional education and training, research and evaluation strategies, in close cooperation with other jurisdictions so as to achieve consistency;
- assessing measures that allow police to exercise discretion in diverting drug users away from the criminal justice system into appropriate treatment options; and
- the establishment of an appropriate public policy framework to deal with drug use and drug-related harm in areas such as housing, school-based drug education, criminal justice and juvenile justice and liquor licensing.

A number of consultative and advisory structures have been developed to assist with the development and implementation of the NDS. These include structures to facilitate:

- consultation and cooperation between government Ministers and government officials;
- consultation with community organisations working in the field and members of the public; and
- the provision of expert advice to government officials and Ministers.

#### **4.1 THE DEVELOPMENT OF THE NATIONAL DRUG STRATEGY**

In 1977, the Senate Standing Committee on Social Welfare, under the chairmanship of Senator Michael Baume, published a report about drug problems in Australia entitled

*Drug Problems in Australia – an intoxicated society?* (the ‘Baume report’).<sup>15</sup> The Committee perceived that emotive issues clouded the drug debate at that time and that a more moderate and objective approach was needed to achieve a balanced constructive debate:

*The drug use debate has brought forth extremist views. ... The extreme options being presented are heavy legal sanctions for breaking a strict prohibition on one hand, and total permission on the other. ... A multiplicity of options can be found between these extremes. A re-orientation is needed, away from the protection of entrenched moral positions toward a constructive debate which has as its aim the diminution of the problems drugs present to our society. Attachment to this goal rather than emotional attachments to favoured solutions will aid the search for more reasonable and efficacious strategies.*<sup>16</sup>

The Baume report recommended the declaration of a national approach to drug abuse based on a seven point strategy that counselled a pragmatic approach to limiting the adverse effects of drug abuse. This approach emphasised the importance of balancing efforts to reduce the demand for and supply of drugs, as well as the desirability of viewing drug abuse primarily as a social or medical problem rather than a legal one.<sup>17</sup>

#### **4.1.1 The National Campaign Against Drug Abuse (1985 - 1992)<sup>18</sup>**

On 2 April 1985, all Australian governments at a special Premiers’ Conference on Drugs agreed to establish the *National Campaign Against Drug Abuse* (NCADA). The overall aim of the NCADA was to minimise the harmful effects of drugs on Australian society. As a result, the Premiers also agreed to the formation of a Ministerial Council on Drug Strategy (MCDS) to coordinate and direct the NCADA and to have authority to deal with drug related matters.

The NCADA was based on a number of key principles, namely:

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<sup>15</sup> Australia. Senate Standing Committee on Social Welfare, *Drug Problems in Australia – an intoxicated society?*, AGPS, Canberra, 1977.

<sup>16</sup> Senate Standing Committee on Social Welfare, p 13.

<sup>17</sup> Senate Standing Committee on Social Welfare, pp 1-2.

<sup>18</sup> The information in this section is partly abstracted from: Ministerial Council on Drug Strategy, *National Drug Strategic Plan, 1993-97*; Australia, National Drug Strategic Framework 1998-99 to 2002-03, *Building Partnerships: A strategy to reduce the harm caused by drugs in our community*, November 1998, pp 15-19; Intergovernmental Committee on Drugs, Submission to the House of Representatives Standing Committee, pp 5-11.

- A national approach with cooperative effort and mutual support across jurisdictional boundaries;
- A major emphasis on strengthening the capacity of existing institutional and other community structures to deal with drug abuse;
- A comprehensive approach to drug abuse and drug problems, both licit and illicit drugs;
- The collation of reliable data for monitoring programs, the development of new approaches and developments of programs;
- An emphasis on demand reduction programs integrated with supply control strategies; and
- The campaign was to have a degree of permanency and long life rather than a short term focus.

These principles are broadly consistent with those articulated in the Baume report in 1977 and continue to underpin the national drug policy framework.

The NCADA focussed Australian drug policy on public health and harm minimisation and emphasised that drug use should be treated primarily as a health issue. The program was situated within the Commonwealth Department of Health rather than the Commonwealth Attorney General's Department – a decision made in part because of the emergence of HIV/AIDS as a significant health problem.

One of the major initiatives undertaken under the NCADA was to disseminate information to households across the country about major illicit and licit drugs. A significant component of the campaign was the Drug Offensive which used mass media and other information channels (such as sponsorship of cultural and sporting events) to convey messages not only about illicit drugs such as heroin but alcohol and tobacco as well. The campaign also specifically targeted groups with special needs such as women, Aboriginal and Torres Strait Islander people, young people and prisoners.

In 1988, an independent review of the NCADA found that the campaign, with its coherent national approach, had made advances in its goal of minimising harm caused by drugs in Australian society. The MCDS agreed to continue the NCADA for another three years. The next phase of the NCADA continued its focus on the harm associated with all drug use, emphasised the circumstances and needs of youth, women, aboriginal people, prisoners, non-English speaking people and intravenous drug users, expanded the law enforcement components of the program and focussed on meeting the training need of workers in the drug and alcohol field.

A second evaluation of the NCADA occurred in 1992. The evaluation made a number of positive findings about the direction and achievements of the campaign. It also made

66 recommendations, one of which was to relaunch the NCADA as the NDS, based on a new National Drug Strategic Plan.

#### **4.1.2 The National Drug Strategy 1993 –1997<sup>19</sup>**

The NCADA was relaunched as the National Drug Strategy 1993-1997. This updated strategy was governed by the National Drug Strategic Plan which outlined a national approach to reduce problems associated with drug and alcohol use in Australia and broadly outlined directions for action over a five year period.

The strategic plan incorporated recommendations from the two evaluations. It aimed to build on the National Campaign's successes and continued to develop cooperation between the Commonwealth and State and Territory governments in relation to the funding and implementation of policy initiatives.

The States and Territories also agreed to develop three to five year strategies that, while broadly reflecting priorities and strategies outlined in the National Drug Strategic Plan, would specifically address priorities and major problem areas unique to each jurisdiction.

The NDS continued to stress the importance of harm minimisation principles and was constructed around three key policy goals and five key result areas:

The key policy goals of the NDS are:

- To minimise the level of illness, disease, injury and premature death associated with the use of alcohol, tobacco, pharmaceutical and illicit drugs;
- To minimise the level and impact of criminal drug offences and other drug-related crime, violence and antisocial behaviour with the community; and
- To minimise the level of personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the inappropriate use of alcohol and other drugs.

The key result areas of the NDS are:

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<sup>19</sup> The information in this section is partly abstracted from: the National Drug Strategy website at <http://www.nationaldrugstrategy.gov.au/index2.htm>; Australia, National Drug Strategic Framework 1998-99 to 2002-03, *Building Partnerships: A strategy to reduce the harm caused by drugs in our community*, November 1998, pp 15-19; Intergovernmental Committee on Drugs, Submission to the House of Representatives Standing Committee, pp 5-11.

- A reduction in injury, violence and loss of productivity associated with excessive drinking or intoxication in hazardous situations, particularly on the roads, in the workplace and in drinking environments;
- A further reduction in the prevalence and uptake of regular smoking, with particular emphasis on socio-economically disadvantaged groups and young people;
- A reduction in the inappropriate consumption of commonly misused prescription drugs, with emphasis on at risk groups including older people and poly-drug users;
- A reduction in the prevalence of, and the crime and social disruption associated with, the trafficking and the use of illicit drugs; and
- The prevention of the spread of hepatitis, HIV/ AIDS and other infectious diseases associated with the unsafe injecting of illicit drugs and unsafe sex associated with intoxication.

#### 4.1.3 The National Drug Strategic Framework (1998-99 – 2002-03)<sup>20</sup>

The *National Drug Strategic Framework 1998-99 to 2002-03* maintained the policy principles of the previous phases of the NDS and adopted the recommendations made in an evaluation of the NDS, *Mapping the Future: an Evaluation of the National Drug Strategy 1993-1997*.<sup>21</sup> Its focus remains on harm minimisation and strengthening of partnerships between health, law enforcement, education and non-government sectors. As a partnership approach is an evolving feature of the Strategy, “*Building Partnerships*” was adopted as the theme for the next five-year phase of the Strategy.

The mission for the *National Drug Strategic Framework 1998-99 to 2002-03* is 'to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society'.

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<sup>20</sup> The information in this section is partly abstracted from: the National Drug Strategy website at <http://www.nationaldrugstrategy.gov.au/index2.htm>; Australia, National Drug Strategic Framework 1998-99 to 2002-03, *Building Partnerships: A strategy to reduce the harm caused by drugs in our community*, November 1998, pp 15-19; Intergovernmental Committee on Drugs, Submission to the House of Representatives Standing Committee, pp 5-11.

<sup>21</sup> E Single and T Rohl, *The National Drug Strategy: Mapping the Future: An Evaluation of the National Drug Strategy 1993-1997*, AGPS, 1997.

The framework reflects the desire that a nationally coordinated and integrated approach to reducing the harm arising from the use of licit and illicit drugs, including alcohol, tobacco and pharmaceutical drugs, should continue for another five years. The stated objectives of the framework are:

- to increase community understanding of drug-related harm;
- to strengthen existing partnerships and build new partnerships to reduce drug-related harm;
- to develop and strengthen links with other related strategies;
- to reduce the supply and use of illicit drugs in the community;
- to prevent the uptake of harmful drug use;
- to reduce drug-related harm for individuals, families and communities;
- to reduce the level of risk behaviour associated with drug use;
- to reduce the risks to the community of criminal drug offences and other drug-related crime, violence and anti-social behaviour;
- to reduce the personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the harmful use of drugs;
- to increase access to a greater range of high-quality prevention and treatment services;
- to promote evidence-based practice through research and professional education and training; and
- to develop mechanisms for the cooperative development, transfer and use of research among interested parties.

The independent evaluation attributed much of the success of the NDS (1993-1997) to the commitment of the non-government sector that provided the prevention, treatment, education and research services under the Strategy. It was argued that the non-government sector was not sufficiently involved in the development and management of the NDS, and that, as a result, the NDS was weakened by this shortcoming. The significance of the specialised knowledge and expertise of volunteer and community organisations in the drug field was recognised in 1998 with the establishment of the Australian National Council on Drugs (ANCD), an independent body that provides expert advice to government on priorities for policy development and emerging licit and illicit drug issues.

#### 4.1.4 The National Illicit Drug Strategy (1998-)<sup>22</sup>

In November 1997, the Prime Minister, the Hon John Howard MP, launched the next stage of the NDS – the National Illicit Drug Strategy, *'Tough on Drugs'*.

Since its launch, the Federal Government has allocated \$516 million to *Tough on Drugs* in an attempt to reduce the supply and demand for illicit drugs. Of the total funding amount, \$213 million was allocated to fund a range of supply reduction measures with the aim of providing Australian law enforcement agencies with better resources. The remaining \$303 million has been allocated to demand reduction initiatives which cover five priority areas. These areas, with selected examples of relevant programs, are listed below:

- Treatment of users of illicit drugs, including identification of best practice
  - The Non-Government Organisation Treatment Program provides funding for the establishment, expansion, upgrading and operation of non-government treatment services. As at 7 February 2002, 133 projects received funding totalling \$57 million under a national grants process. In addition, COAG agreed in 1999 to a national approach to the development of a drug diversion initiative and supporting initiatives. These initiatives include the support of the diversion of illicit drug users from the criminal justice system into education and treatment with the establishment of assessment services and additional treatment places; increased education, counselling and referral services and the diversification of needle and syringe programs.
- Prevention of illicit drug use
  - The Community Partnerships Initiative provides funds and other assistance to communities to aid in the development of their own community based education and prevention programs. Drug education and information services such as the National Illicit Drugs Campaign and school drug education strategies also form part of this area.
- Training and skills development for front line workers such as medical and law enforcement personnel who come into contact with drug users or at risk groups.
- Monitoring and evaluation, including data collection.
  - The National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD), a three year coordinated national project to evaluate a number of

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<sup>22</sup> The information in this section is abstracted from the website of the Australian Department of Health and Aging: Australia. Department of Health and Aged Care, Population Health Division, National Illicit Drug Strategy, 'Tough on Drugs', downloaded from <http://www.health.gov.au/pubhlth/strateg/drugs/illicit/index.htm> on 7 February 2002. (last updated 11 December 2001)

alternative treatments for opioid dependence, recently reported its findings to the Australian Ministerial Council on Drugs.<sup>23</sup>

- The establishment of illicit drug reporting and information databases, such as the National Drug Strategy Household Survey and the National Illicit Drug Reporting System, to create a system for monitoring demand for and usage of illicit drugs in Australia and the harms resulting from use. These databases are designed to facilitate evidence-based decision-making and act as a strategic early warning system to alert governments to emerging drug problems.
- Research
  - An expanded program of interdisciplinary research to achieve innovation in the prevention and treatment of illicit drug use under the auspices of the National Health and Medical Research Council.

## 4.2 QUEENSLAND

As noted earlier, the NDS gives each of the State and Territory Governments the responsibility of providing, within their respective jurisdictions, leadership in the areas of policy development, implementation, evaluation and police, health (including drug treatment) and education services.

In November 1993, the Queensland Cabinet endorsed a number of broad policy goals and priorities as part of its commitment to develop a drug strategy for Queensland.<sup>24</sup> The *Queensland Drug Strategy 1995-1997* was developed as a result.

The *Queensland Drug Strategy* was viewed as a three-year plan to reduce the individual and social costs of excessive and inappropriate drug use in the State. The Strategy endorsed “*a collaborative, coordinated approach by government departments, the non-government sector and community interest groups to develop*

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<sup>23</sup> The NEPOD taskforce recommended that diversity of treatment options for heroin dependence should be promoted on the basis that patients will require different forms of treatment at different stages of their drug-use career.

<sup>24</sup> Queensland. Queensland Health, *Queensland Drug Strategy: Major Policy Directions 1993 – 1997*; Queensland, Queensland Health, *Queensland Drug Strategy: Examples of Strategies for Implementation*.

*a sound and comprehensive framework within which to tackle the complex issues surrounding alcohol and other drug use and associated problems”.*<sup>25</sup>

The Strategy addressed the priorities of:

- Alcohol use & Aboriginal and Islander people
- Alcohol & intoxication - public safety and health
- Young people
- Mainstreaming and training: Integration into general services
- Communicable diseases associated with injecting drug use & intoxication
- Women: Acceptable, accessible services.

In November 1999, consistent with its support for the NDSF, the Queensland Government released, in November 1999, of its own framework, *Beyond a Quick Fix: Queensland Drug Strategic Framework 1999/2000 to 2003/2004*.<sup>26</sup> This Framework was designed to provide a multi-faceted whole-of-Government mechanism for the development of drug policy in Queensland, involving all Departments with a role in alcohol, tobacco or other drug policy development. The non-government sector is supportive of an ‘all of community’ approach that incorporates the knowledge and experience of those in the alcohol and other drugs field, the business community, educators and the media.<sup>27</sup>

The *Queensland Drug Strategic Framework* encompasses programs such as school education, anti-drug prevention and promotion, drug treatment and rehabilitation services and support for families of people with drug problems. In March 1999 and October 2001, the Queensland Government also conducted Youth Drug Summits to enable young people and youth workers from throughout the State to give advice on effective drug prevention strategies for young people.<sup>28</sup>

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<sup>25</sup> Queensland Health, Queensland Ministerial Taskforce on Drug Strategy, *Queensland Drug Strategy: 1995-1997*, August 1995, p 3.

<sup>26</sup> Queensland, Draft for Consultation, *Beyond a Quick Fix: Queensland Drug Strategic Framework 1999/2000 to 2003/2004*, November 1999. Within the context of the Queensland Drug Strategic Framework, the term ‘drug’ is used generically to include tobacco, alcohol, pharmaceutical drugs and illicit drugs.

<sup>27</sup> Aldred B, ‘Chiefly Speaking: Drugs and the new Beattie Government’, *Drugs in Society*, March 2001, p 1.

<sup>28</sup> Hon Wendy Edmond MP, Minister for Health and Minister Assisting the Premier on Women’s Policy, ‘Summit gives young people a drug prevention opportunity’, *Ministerial Media Statement*, 23 October 2001.

On 4 April 2001, the Queensland Parliament passed a motion that supported the multi-faceted approach of the *Queensland Drug Strategic Framework* to reducing the problem of illicit drug use in Queensland.<sup>29</sup> Specifically the Parliament gave bipartisan support to measures such as:

- *Increased rehabilitation and detoxification facilities and resources*
- *Reform to the justice system which focuses on rehabilitation of drug users including the Queensland Strategy for Illicit Drug Use Prevention and the Drugs Court trial*
- *Enhanced prevention programs and drug education*
- *Properly resourced police and anti-crime agencies to pursue drug producers and suppliers of drugs, including the employment of nearly 1,000 additional police officers over the next three years*
- *Tough sentences for drug traffickers and major drug dealers*
- *Rejection of injecting rooms or the legalisation of marijuana or other illicit drugs as effective measures to address illicit drug trafficking and use*
- *The use of specially trained youth health nurses to work with students and school communities to promote good health and address health issues of concern to Queensland youth such as smoking prevention, alcohol and drug use.*
- *The Positive Parenting Program or Triple P initiative is an important part of the Government's strengthening families strategy giving parents the tools they need to help them overcome problems, such as drug taking, before they take root.*

In a Ministerial Media Statement, released on 29 July 2001, Premier Beattie emphasised that Queensland was committed to continue developing its own tailored action plans and meeting any specific rural and regional demands. Premier Beattie has indicated that, after national agreement is reached, Queensland would draft 'action' plans that would outline further initiatives to be undertaken over the next four years.<sup>30</sup>

In September 2001, Premier Beattie announced a new range of measures partly aimed at drug-related crime. Key elements of the package included:

- Stronger penalties for producing and trafficking amphetamines - up to 25 years in jail, the same as heroin and cocaine.

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<sup>29</sup> The motion was moved by the Leader of the Opposition, Mr M Horan MP and amended by Hon R J Welford MP, Attorney General and Minister for Justice: *Queensland Parliamentary Debates*, 4 April 2001, pp 333-344.

<sup>30</sup> Hon P Beattie MP, Premier and Minister for Trade, 'Queensland Sets Example on Drug and Alcohol Policy', *Ministerial Media Statement*, 29 July 2001.

In September 2001, the Government amended the Drugs Misuse Regulation 1987 (Qld)<sup>31</sup> to upgrade the classification of amphetamines as a dangerous drug from a Schedule 2 Dangerous Drug to a Schedule 1 Dangerous Drug. The effect of the change is to increase the maximum penalties available for the offences of trafficking, supplying, producing and possessing amphetamines to the highest levels available under the Act.<sup>32</sup>

- A wide ranging review of penalties for all dangerous drugs to begin immediately
- Cabinet to consider extending laws on the confiscation of criminal assets
- A new drug diversion program for the Brisbane Magistrates Court from July 2002. The program is designed to complement the Drug Court trial.<sup>33</sup>

## 5 SELECTED DRUG STRATEGIES

Various drug strategies have received much prominence in the public debate on drug policy in recent years. A number of these strategies, namely, drug diversion, drug courts, safe injecting rooms and heroin prescription, are discussed in this section. Each of these strategies, apart from heroin prescription, is under trial in various parts of Australia.

Diversion programs, such as drug courts, are aimed at the rehabilitation and treatment of certain drug dependent offenders. More ‘radical’ strategies like safe injecting rooms and heroin prescription focus on the hygienic maintenance of addiction with the hope of

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<sup>31</sup> See the Drugs Misuse Amendment Regulation (No 2) 2001/174 (Qld). The amending regulation commenced on 21 September 2001.

<sup>32</sup> Earlier, on 10 September 2001, in response to the “*enormous increase in amphetamine use in recent years*” in Queensland, the Shadow Minister for Police and Corrective Services and Member for Callide, Mr Seeney MP, introduced the Drugs Misuse (Amphetamine Offences) Amendment Bill 2001 into the Queensland Parliament as a Private Member’s Bill. The objective of the Bill was to upgrade the classification of amphetamines as a dangerous drug. The Explanatory Notes to the Bill stated that the Bill is consistent with the motion passed in the State Parliament on 4 April 2001 to support a comprehensive drug strategy. It is also noted that the introduction of the Bill followed an offer made on 5 July 2001 by the State Opposition to the Queensland Government of bipartisan support to upgrade the classification of amphetamines and increase the penalties. The Bill was defeated on 17 October 2001. The amendments to the Drugs Misuse Regulation 1987 (Qld) made by the Drugs Misuse Amendment Regulation (No 2) 2001/174 (Qld) are similar in effect to the Bill.

<sup>33</sup> Hon R Welford MP, Attorney General and Minister for Justice, ‘Government unveils new crime package’, *Ministerial Media Statement*, 17 September 2001.

improvement in social behaviour and health.<sup>34</sup> The debate on safe injecting rooms, heroin prescription and the legalisation of illicit drugs is emotive and has resulted in polarised views. Paradoxically, some commentators have suggested that such polarity may be an impediment to the establishment of accepted and effective policies.<sup>35</sup>

## 5.1 DIVERSION PROGRAMS

Diversion programs offer an alternative way of dealing with drug dependent offenders rather than through the traditional criminal justice system. Their general scheme is to enable police or courts to divert drug users away from the criminal justice system into some other activity (such as a program of education or compulsory assessment) that may have a more positive result both for the offender and society. Diversion programs, with their holistic approach, represent an important shift in the management of drug dependent offenders.

One Victorian commentator has cautioned that the full value of diversion programs may be limited if access to assessment and treatment services is inadequate.<sup>36</sup>

### 5.1.1 The Illicit Drug Diversion Initiative

In April 1999, COAG “agreed to work together to put in place a new nationally consistent approach to drugs in the community involving diversion of drug

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<sup>34</sup> Hon Chief Justice de Jersey AC, ‘Drugs Policy – restrictive or laissez faire? – a judicial perspective’, paper presented at the Winter School in the Sun Conference, Brisbane, 4 July 2001, available online at <http://www.courts.qld.gov/publications/articles/speeches>.

<sup>35</sup> Two Australian ethicists, Bill Bush and Max Neutze, in their paper, *In Search of What is Right: The Moral Dimensions of the Drug Debate*, suggest that the protagonists in the drug debate are talking past one another. While some argue that the drug debate is a health and social issue and should be primarily be analytical and based on empirical evidence, others, implicitly or explicitly, treat it as a moral issue. Bush and Neutze suggest that understanding the moral viewpoint of the participants in the debate may help to further the debate and the formulation of common positions: B Bush & M Neutze, ‘In search of what is right: The moral dimensions of the drug debate’, *Australian Journal of Social Issues*, May 2000, pp 129-144, available online at <http://www.ffdlr.org.au/ethics/InSearchOfRight.htm>.

<sup>36</sup> N Comrie, Address to a Joint Sitting of the Legislative Assembly of Victoria and Legislative Council of Victoria on Drugs: Education and Prevention Strategies, *Victorian Parliamentary Debates*, Legislative Assembly, 21 March 2001, p 411.

*offenders by police to compulsory assessment*".<sup>37</sup> The diversionary scheme agreed to by COAG emphasised the diversion of offenders by police at apprehension to maximise the opportunities for early intervention with illicit drug users. COAG subsequently asked the Ministerial Council on Drug Strategy (MCDS) to develop a nationally consistent approach to a diversion initiative.

In June 1999, the MCDS endorsed 19 principles underpinning the national diversion scheme that retained the concepts of jurisdictional flexibility and inter-sectoral and intergovernmental collaboration. The principles are designed to achieve the following outcomes:

- To give illicit drug users early incentives to address their drug use problems hopefully before they incur a criminal record;
- To increase the number of illicit drug users diverted into drug education, assessment and treatment; and
- To reduce the numbers of people appearing before the courts for use or possession of small quantities of illicit drugs.

Under the general framework of the diversion scheme, police are asked to exercise discretion with regard to whether a particular offender is eligible for referral to health authorities for assessment and treatment. In some jurisdictions, police will divert certain offenders directly to drug education. While each jurisdiction is expected to develop their own diversion eligibility criteria, the nationally-agreed diversion framework provides that certain minimal criteria should apply to the determination of eligibility for diversion. Additionally, minimal compliance requirements are provided in relation to 'notices of diversion' so as to ensure that sufficient information about compliance is collected to enable evaluation of the Initiative.<sup>58</sup>

The Commonwealth Department of Health and Aged Care administers funds for a range of diversion initiatives (such as a program to support the diversion of illicit drug users by police into education, counselling, or treatment) in addition to a range of supporting measures (including funds for the development and dissemination of cannabis cessation strategies for adults and adolescents).

As part of the COAG Illicit Drug Diversion Initiative, funding of \$104.1 million has been allocated to the States and Territories for the four-year period 1999/2000 to 2002/2003. Of this amount, \$19.5 million is allocated to Queensland for the Queensland Illicit Drug Diversion Initiative, a major element of which is the Police Diversion Program.

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<sup>37</sup> Council of Australian Governments (COAG), *Communique*, COAG meeting, April 1999.

The Police Diversion Program applies to offenders apprehended by police with small amounts of cannabis (50 grams or less) for personal use. Under the program, eligible offenders may opt to attend an authorised assessment and education intervention program rather than be charged.<sup>38</sup>

### 5.1.2 Drug Courts

Drug Court programs are designed to assist drug dependent offenders overcome their drug dependence and stop their associated criminal behaviour through court enforced and supervised treatment programs.<sup>39</sup> The strategy for achieving this aim is to divert such offenders into programs designed to reduce or eliminate their drug dependence. The premise of the program is that, by reducing a person's dependence on drugs, their need to commit crime to support that dependence should also be reduced.

Drug Courts offer a relatively new approach to legally coerced treatment in Australia. Notwithstanding the development of Drug Court programs in Australia and overseas, there have been relatively few comprehensive evaluations of their efficacy.<sup>40</sup> Proper evaluation of Drug Court programs is critical to assess their success in meeting either criminal justice or therapeutic goals.

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<sup>38</sup> Hon P Beattie MP, Premier and Minister for Trade, 'Cannabis users offered a chance to reform', *Ministerial Media Statements*, 20 March 2001. Violent offenders and those dealing in drugs are ineligible.

<sup>39</sup> Related Queensland Parliamentary Library publications about Drug Court programs in Queensland and other jurisdictions are: RBR 3/01 *Drug Courts* (QPL Mar 2001), RN 3/99 *Drug Courts: Breaking the Link between Drugs and Crime* (QPL Mar 1999) and LN 9/99, *Drug Rehabilitation (Court Diversion) Bill 1999* (QPL Dec 1999).

<sup>40</sup> New South Wales, Bureau of Crime Statistics and Research (BOSCAR), *New South Wales Drug Court Evaluation: Interim Report on Health and Well-Being of Participants*, No 53, February 2001, pp 1-2 citing a number of studies in the United States of America and Australia. Downloaded from the BOSCAR website at <http://www.agd.nsw.gov.au/bocsar1.nsf/pages/index> on 10 February 2001. A number of such evaluations are also perceived to have methodical limitations such as a lack of adequate comparison groups, limited outcome measures and inadequate follow-up periods.

Drug Courts have been established overseas and in Queensland, New South Wales, South Australia and Western Australia.<sup>41</sup> On 28 November 2001, Victoria introduced legislation to establish a Drug Court on a three-year pilot basis.<sup>42</sup>

The system of drug courts in Queensland and New South Wales is discussed below.

### *Queensland*

In June 2000, the Magistrates Courts at Beenleigh, Ipswich and Southport began trialling a 30-month Drug Court program for non-violent drug dependent offenders.<sup>43</sup> The Drug Court program caters for drug dependent people who are charged with specified offences<sup>44</sup> and who face the prospect of a custodial sentence. An additional criterion of eligibility is that the drug dependency of the person must have contributed to committing the offence. Eligible offenders are sentenced to an Intensive Drug Rehabilitation Order that includes assessment and treatment for their drug dependence. Offenders are required to comply with all scheduled treatment and reporting requirements so as to remain out of prison.

In December 2001, the Attorney General and Minister for Justice, the Hon Rod Welford MP, announced that since the Drug Court trial began in June 2000, more than 200 offenders had been placed on intensive rehabilitation programs, and 9 people so far had completed the programs.<sup>45</sup> As at 31 January 2002, the Drug Court had received 400 referrals, in respect of which 190 Intensive Drug Rehabilitation Orders were made. Of this group, 24 people failed to appear at their next scheduled court appearance, 55 were

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<sup>41</sup> The drug courts in Queensland and New South Wales are established on the basis of specific legislation: *Drug Rehabilitation (Court Division) Act 2000* (Qld), s 7 and *Drug Rehabilitation (Court Division) Regulation 2000* (Qld).

<sup>42</sup> *Sentencing (Amendment Bill) 2001* (Vic).

<sup>43</sup> A detailed overview of the Drug Court program is available at the Department of Justice and Attorney General (Qld) website at [http://www.justice.qld.gov.au/courts/factsht/qc\\_fact3.htm](http://www.justice.qld.gov.au/courts/factsht/qc_fact3.htm) and [http://www.justice.qld.gov.au/courts/factsht/qc\\_fact4.htm](http://www.justice.qld.gov.au/courts/factsht/qc_fact4.htm)

<sup>44</sup> Drug Court program participants must be free of any outstanding charges for disqualifying offences. Disqualifying offences are offences of a sexual nature (excluding prostitution) or indictable offences involving violence against another person (apart from common assault, assault with intent to steal and some types of serious assaults): *Drug Rehabilitation (Court Division) Act 2000* (Qld), s 7 and *Drug Rehabilitation (Court Division) Regulation 2000* (Qld).

<sup>45</sup> Hon R Welford MP, Minister for Justice and Attorney General, 'Drug Court Continues Success Story', *Queensland Media Statement*, 14 January 2002.

removed from the program, 6 left the program of their own accord, 2 died, 93<sup>46</sup> were continuing with the program and 10 people have graduated.<sup>47</sup> A series of evaluation reports is planned on the Drug Court program: an interim evaluation report in March 2002, a final evaluation report in March 2003 and a follow-up study two years after the 100<sup>th</sup> graduation.<sup>48</sup>

In June 2001, the Queensland Government recently committed additional funding of \$1.67m to support the Drug Court program pilots, including an expansion of the program to Cairns and Townsville.<sup>49</sup>

In September 2001, the Queensland Government announced a proposal for a 12-month trial of a new drug diversion program that shares a similar objective to the Drug Court program of creating alternatives to the imposition of a custodial sentence for eligible drug offenders.<sup>50</sup> The new scheme, proposed to be trialled at the Brisbane Magistrates Court from July 2002, is designed to divert drug users who have been charged with the possession of small amounts of illicit drugs to counselling or treatment before they become addicted to drugs.

In addition there are a range of informal offender drug diversion programs in Queensland. These include diversion practices that are applied at various stages in the criminal justice process but are not part of a specific purpose program. Informal diversion includes police cautioning and referral, self referral of offenders on bail to community treatment programs, probationary orders and early release from prison to treatment on Leave Of Absence or Parole provisions.

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<sup>46</sup> The 93 continuing program participants consisted of 25 inpatients and 68 outpatients.

<sup>47</sup> Communication from staff of the Courts Directorate (Queensland) on 12 February 2002.

<sup>48</sup> Communication from Department of Justice and Attorney General, Legal and Corporate Services Division, on 12 February 2002.

<sup>49</sup> Hon R Welford MP, Minister for Justice and Attorney General, 'Government Boosts Drug Court Trial', *Queensland Media Statement*, 19 June 2001; Hon R Welford MP, Minister for Justice and Attorney General, 'Three More Drug Court Graduations', *Queensland Media Statement*, 11 December 2001.

<sup>50</sup> Hon R Welford MP, Minister for Justice and Attorney General, 'Government Introduces New Drug Diversion Program', *Queensland Media Statement*, 17 September 2001.

### *New South Wales*

The New South Wales Drug Court was established on 8 February 1999 as a special court to which non-violent drug-dependent offenders who would otherwise be imprisoned may be referred. The Court was the first of its type in Australia.

The NSW Drug Court Program is designed to take approximately 12 months to complete and is comprised of three phases: stabilisation, consolidation and reintegration. Each phase has a distinct goal, which must be achieved before a participant moves on to the next phase of their program. The components of the program are: intensive judicial supervision; treatment for drug addiction; intensive supervision and case management by the Probation and Parole Service; provision of a range of support services for educational, vocational and health issues; random testing for drug use and the use of incentives and sanctions to compel compliance in the program.<sup>51</sup>

Each participant in the NSW Drug Court Program must also undertake to comply with the conditions of their individual program such as completing a drug treatment program, not taking any illicit drug, not committing any new offences, submitting urine samples for drug testing, attending court regularly and attending counselling, personal development courses, educational courses, employment interviews and other appointments.

The NSW Bureau of Crime Statistics and Research (BOCSAR) has designed three studies to monitor and evaluate the Drug Court trial:

- A cost-effectiveness study which compares the Drug Court participants with a comparison group to determine the cost-effectiveness of the Drug Court Program in reducing reoffending;
- A study measuring changes in indicators of health and social functioning of Drug Court participants; and
- Ongoing monitoring of key aspects of the Drug Court.

Based on preliminary data from the studies, intake on the Drug Court Program is to continue until 30 June 2002.

Preliminary data from the Drug Court Program record that:

- On average 19 offenders entered the Drug Court Program each month;
- 87% of participants had not been sentenced for an offence committed while on the Drug Court Program;

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<sup>51</sup> New South Wales, NSW Health, Drug Programs Bureau, *New South Wales Drug Courts Program*, downloaded at [http://www.health.nsw.gov.au/public-health/dpb/projects/drug\\_court.htm](http://www.health.nsw.gov.au/public-health/dpb/projects/drug_court.htm) on 13 February 2002.

- Community methadone was the most common treatment type utilised; and
- The majority of Drug Court participants (72.3%) were receiving treatment in a community-based setting.<sup>52</sup>

New South Wales also conducts a Youth Drug Court Pilot Program in which young offenders may participate in a six-month program plan based on an intensive multi-disciplinary assessment.<sup>53</sup> This program began operating in New South Wales on 31 July 2000 in two Children's Courts in Western and South Western Sydney. Its aim is to reduce drug use and offending behaviour among young people charged with serious offences, where alcohol or other drug use is a contributory factor.

An implementation review of the first nine months of the operation of the Youth Drug Court Pilot Program noted a number of factors which had impacted on the implementation and operation of the program. These include high operational demands and a shortage of accommodation and residential treatment services for participants. Overall, the small number of participants sampled viewed the program as positive.<sup>54</sup>

## 5.2 HEROIN PRESCRIPTION TRIALS

One of the most contentious issues in the Australian drug debate is the prescription of heroin as an additional form of maintenance treatment for a small number of heroin dependent people. Heroin maintenance trials have not proceeded in Australia to date, although there appears to be a gradual increase in the public acceptance of the concept. The issue raises moral arguments about making a

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<sup>52</sup> NSW Health Website, Drug Programs Bureau, 'NSW Drug Courts Program', downloaded at [http://www.health.nsw.gov.au/public-health/dpb/projects/drug\\_court.htm](http://www.health.nsw.gov.au/public-health/dpb/projects/drug_court.htm) on 13 February 2002; K Freeman, R Karski & P Doak, New South Wales Drug Court Evaluation: Program and participant Profiles, *Number 50*, Bureau of Crime Statistics and Research (BOSCAR), April 2000, available at <http://www.nsw.gov.au/boscar.nsf/pages/cjb50text>.

<sup>53</sup> NSW Health Website, Drug Programs Bureau, 'NSW Youth Drug Court', downloaded at [http://www.health.nsw.gov.au/public-health/dpb/projects/youth\\_drug\\_court.htm](http://www.health.nsw.gov.au/public-health/dpb/projects/youth_drug_court.htm) on 10 February 2002.

<sup>54</sup> M Flick & T Eardley, UNSW Evaluation Consortium, Social Policy Research Centre, Evaluation of the NSW Youth Drug Court Pilot Program: First Implementation Review, A Report for the Youth Drug Court Monitoring and Evaluation Committee, June 2001.

currently illicit substance available under carefully controlled conditions and the value of maintenance treatment.<sup>55</sup>

Advocates of heroin maintenance suggest that the health and social problems associated with heroin use could be reduced if heroin is made legally available in a controlled manner.<sup>56</sup> Supporters of heroin prescription trials refer to the results of clinical trials with medical prescription of narcotics in Switzerland in the 1990s. The Swiss studies were designed and initiated as a response to “*difficult local problems of populations of addicts who appeared to be refractory to, and unable to engage with, the treatments then currently available*”.<sup>57</sup> Based on its positive evaluation of the trials, the Swiss Government subsequently introduced heroin-assisted therapy as an authorised treatment for a defined group of severely addicted drug users in specialised treatment centres (see **Section 6.2**).

Opponents of heroin maintenance doubt that its perceived benefits would eventuate and have suggested that there could be attendant risks associated with a heroin trial, including that any city introducing such an option would attract dependent heroin users from around the country; that controlled availability of heroin would encourage illicit drug use; and that a prescription heroin trial would face insurmountable logistical problems.<sup>58</sup>

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<sup>55</sup> See for a discussion of the moral issues surrounding the issue of heroin trials in Australia: W Rosevear, ‘The road to safety to legalise or not?’, *Drugs in Society*, September 2000, pp 12-17. See also B Bush & M Neutze, ‘In search of what is right: The moral dimensions of the drug debate’, *Australian Journal of Social Issues*, May 2000, pp 129-144, available online at <http://www.ffdlr.org.au/ethics/InSearchOfRight.htm>.

<sup>56</sup> In particular, proponents of heroin maintenance argue that:

- dependent heroin users do not have to commit crime to buy expensive illicit heroin and that it will remove them from the illicit drug scene, so that they no longer use illicit heroin or other drugs. Another perceived outcome is a noticeable reduction in property crime, the largest social cost associated with dependent heroin use;
- access to, and the use of, pharmaceutically pure heroin in a clinical environment will remove the health risks associated with heroin use such as the risks of transmission of HIV/AIDS and hepatitis; and
- the removal of people from the illegal drug scene into a treatment environment will give them time and access to resources to allow them to become more socially integrated.

<sup>57</sup> Hassela Nordic Network, ‘The Who Report on the Swiss Heroin Trial’, *Press Release*, 16 April 1999, available at (<http://www.hnnsweden.com/1999/apr99/99apr16-001.htm>) quoting the *Executive Summary of the Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts* (WHO).

<sup>58</sup> G Bammer, *Report and recommendations of stage 2 feasibility research into the controlled availability of opioids*. Canberra: National Centre for Epidemiology and Population Health, Australian National University and the Australian Institute of Criminology, 1995, pp 31-35.

In 1990, the Government of the Australian Capital Territory (ACT) appointed a Select Committee to inquire into, and report on, HIV, illegal drugs and prostitution in the ACT.<sup>59</sup> At the behest of the Select Committee, the National Centre for Epidemiology and Population Health (NCEPH) and the Australian Institute of Criminology (AIC) subsequently studied whether it was feasible to conduct a heroin prescription trial to assess the therapeutic value of adding heroin to the maintenance treatment options for heroin dependence. As a result, the NCEPH and AIC recommended that two carefully controlled pilot studies be conducted in Canberra. The recommendation was made with the caution that:

*... the addition of diacetylmorphine to maintenance treatment must not be linked with permissive attitudes to illicit drug use and must be coupled with continuing law enforcement and prevention activity against illicit drug use.*<sup>60</sup>

The ACT Government adopted that recommendation and the proposed ACT heroin trial was later approved by the majority of Australian Health Ministers. However, the proposal was abandoned in August 1997 after it was vetoed by the Federal Cabinet, under Prime Minister Howard.<sup>61</sup>

Since then, the issue of heroin trials has resurfaced periodically as a number of key figures from health and law backgrounds have publicly supported, or at least indicated a willingness to consider, the concept of a scientific trial of prescription heroin.<sup>62</sup>

Some Australian experts in the field of drug dependence and treatment regimes suggest that the main reason for a scientific trial of heroin prescription in Australia is to develop an effective way of managing severely entrenched heroin injectors who do not benefit from all available treatments. In an August 2001 newspaper commentary about prescription heroin, Dr Alex Wodak, the director of the alcohol and drug service at St Vincent's Hospital in Sydney, commented that:

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<sup>59</sup> Australian Capital Territory. Legislative Assembly, Select Committee on HIV, Illegal Drugs and Prostitution. Second interim report. *A Feasibility Study on the Controlled Availability of Opioids*. Canberra: Legislative Assembly for the Australian Capital Territory, 1991.

<sup>60</sup> G Bammer, Report and recommendations of stage 2 feasibility research into the controlled availability of opioids. Canberra: National Centre for Epidemiology and Population Health, Australian National University and the Australian Institute of Criminology, 1995, p ix (Executive Summary).

<sup>61</sup> Matthew Franklin, 'Cabinet scraps heroin trial', *Courier-Mail*, 20 August 1997, p 2.

<sup>62</sup> Matthew Franklin & Craig Spann, 'Edmond seeks drug answers overseas', *Courier-Mail*, 10 August 2001, p 8 (The Queensland Drug and Alcohol Foundation).

*Over the last several decades, worldwide efforts to try to control illicit drug use by relying on law enforcement have failed resoundingly. To achieve sustainable progress, illicit drugs must be regarded principally as a health and social issue, albeit with strong continuing support from law enforcement. Efforts to improve the way the community responds to illicit drugs must be allowed to benefit fully from scientific research. A heroin prescription trial is no panacea but it is an important centrepiece of a comprehensive approach likely to deliver better outcomes.*<sup>63</sup>

In August 2001, the Chairman of the National Crime Authority, Gary Crooke QC, suggested that consideration be given to a heroin prescription trial:

*While unrelenting concentration should be directed towards apprehending those who traffic and profit from the misery and degradation of others, there is a need for strategies to be constantly reviewed. This is a field where dynamics do not remain static. The risk and cost to the community may well mount to a point where different measures or a different concentration of measures should be considered.*

*There are always balances to be struck. It does, however, seem safe to observe...that there is hardly a household in Australia that does not have personal knowledge or experience of the evils of drug addiction and its associated effects.*

*...[E]xperience should encourage us not to rule out consideration of new options or reconsideration of options previously deemed unpalatable. We must respond to the ongoing progression of [the drug] problem. Among the many measures worthy of consideration is to control the market for addicts by treating the supply of addictive drugs to them as a medical and treatment matter subject to the supervision of a treating doctor and supplied from a repository that is government controlled. [note added]*<sup>64</sup>

Crooke QC also noted:

*Whatever steps are taken, the scale of the illicit drug problem and its onward progression is such as to demand the highest attention of government and the community – it simply is not a battle that can be won by law enforcement alone or in partnership with the health sector. A co-ordinated and holistic approach is required, building upon and updating the foundation already established.*<sup>65</sup>

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<sup>63</sup> Alex Wodak, 'Overseas heroin trials point the way ahead', *Sydney Morning Herald*, 10 August 2001, (online).

<sup>64</sup> Crooke G QC, National Crime Authority Commentary 2001, p 23.

<sup>65</sup> Crooke G QC, National Crime Commission Commentary 2001, p 23.

Also in August 2001, a Bill for a referendum on the questions of a heroin trial and a supervised injecting place was introduced into the ACT Legislative Assembly but was subsequently defeated.<sup>66</sup>

The continued policy of the Federal Government is to oppose heroin trials in Australia. In the Federal Parliament on 8 August 2001, Prime Minister Howard rejected the new round of calls to implement a heroin prescription trial. The Prime Minister restated the Federal Government's opposition to such a course and reiterated its commitment to a three pronged approach, under the current National Illicit Drug Strategy, *Tough on Drugs*, of providing greater resources for law enforcement, education and treatment.<sup>67</sup>

Major Brian Watters, the Chairman of the Australian National Council on Drugs, earlier explained why *Tough on Drugs* does not incorporate a trial of heroin addicts:

*Giving heroin to an addicted individual does not rehabilitate them, rather, it enables them to continue in their addiction. A government sanctioned trial of a dangerous and addictive substance could send a message that this activity is 'acceptable' to the Australian population and particularly to its young people. The very public debate regarding a heroin trial may even succeed in increasing the number, particularly of young people, who experiment with this drug as the health risks of use are diminished in the mind of the young person. When considering a proposed heroin trial, it is possible that in focussing on the 1-2% of heroin users, an unintended outcome could be the increase in heroin and other drug use for the other 98% of the population. Our society should be sending a clear message that drug use is dangerous and unacceptable and that we as a society will do all in our power to prevent others becoming trapped in addiction.*<sup>68</sup>

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<sup>66</sup> The Referendum Bill (2001) ACT. The Bill was defeated (8:7) on 21 August 2001. The Bill posed two questions: (1) Do you approve the running, in the ACT, of a trial of a supervised injecting room for people dependent on heroin? and (2) Do you approve the conducting of a clinical trial, in the ACT for the controlled provision, under medical supervision, of heroin to people registered as dependent on heroin?

<sup>67</sup> Hon John Howard MP, Prime Minister, Response to Question without Notice: National Crime Authority: Report on Heroin Treatment, *Commonwealth Parliamentary Debates*, 8 August 2001, p 29428. In a newspaper article on 10 August 2001, the then Federal Health Minister, the Hon Michael Wooldridge MP, also cast doubts on the methodology of the Swiss trial and the resultant data, the efficacy of prescription heroin over traditional methadone treatment and the relative cost-effectiveness of heroin prescription: Hon Michael Wooldridge MP, 'Best medicine to be found in tried and tested methods', *Sydney Morning Herald*, 10 August 2001, (online).

<sup>68</sup> Major B Watters, 'The road to safety? To legalise – or not?', *Drugs in Society*, September 2000, pp 13, 16.

The stated aim of the Federal Government is to implement safe therapies for the management of heroin and other opioid dependence based on a recent national evaluation of treatments and approaches for the management of opioid dependence.<sup>69</sup>

The Queensland Government does not support the conduct of heroin trials or the establishment of heroin injecting rooms in Queensland. In the view of the Queensland Health Minister, the Hon Wendy Edmond MP, based on her observation of heroin trials in Netherlands, Denmark and Switzerland, methadone treatment remains the treatment of choice for heroin dependence.<sup>70</sup>

The debate in Australia about heroin maintenance is likely to continue. Public support for its introduction reportedly increased from 38 per cent when the ACT proposal was vetoed in 1997 to 45 per cent in August 2001.<sup>71</sup>

A recent development in the debate is a proposal to conduct a pilot medical trial of the drug hydromorphone, a registered opiate with similar effects to heroin, to test its potential as part of treatment regime for heroin dependence.<sup>72</sup> It is perceived that the use of an opiate drug which is already registered may overcome some of the conceptual and practical difficulties posed by the use of heroin.<sup>73</sup>

### 5.3 SAFE INJECTING ROOMS

Safe injecting rooms (also known as safe injecting facilities, safe houses, injecting rooms or safety clinics) are legally sanctioned, indoor facilities where injecting drug use occurs

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<sup>69</sup> Hon Michael Wooldridge MP, 'Best medicine to be found in tried and tested methods (alternative treatments for heroin addicts)', *Sydney Morning Herald*, 10 August 2001, (online).

<sup>70</sup> Matthew Franklin & Matthew Hart, 'Heroin shooting galleries rejected', *Courier Mail*, 12 November 2001, p 11.

<sup>71</sup> Ian Henderson, 'Almost half of us won over to heroin trials (Newspoll results)', *The Australian*, 15 August 2001, p 1. The article also reported 47 per cent of adults polled in August 2001 were opposed to the introduction of a heroin trial.

<sup>72</sup> Julie Rowbotham, 'Let addicts inject fake heroin, say doctors', *Sydney Morning Herald*, 24 January 2002, p 3.

<sup>73</sup> 'Alternative to heroin for trial', *UQ News Online*, 24 January 2002 downloaded from <http://www.uq.edu.au/news>. The practical difficulties associated with heroin use include the need to change Federal legislation (which has so far prevented the use of heroin) and the need for oversight of heroin importation and distribution by the International Narcotics Control Board.

under the supervision of medically trained personnel, and in safe and sterile conditions with access to a full range of sterile injecting equipment. The aim of these facilities is to reduce the health and public order problems associated with illegal injection drug use.

The expected benefits of such facilities relate to their potential to help reduce some of the harms associated with injecting drug use, such as the incidence of fatal and non-fatal heroin overdose, blood-borne virus transmission (hepatitis C and B, and HIV) and the prevalence and impact of street-based injecting<sup>74</sup>, in addition to improved access to health and welfare services for drug users. Opponents argue that these facilities may “send the wrong message”, condone drug abuse, congregate drug users and drug dealers in the locality and delay the entry of drug users into drug treatment.<sup>75</sup>

Government-sanctioned safe injecting rooms have operated in some cities within the Netherlands, Switzerland and Germany variously for a number of years, and are typically housed within integrated centres which also incorporate cafes, counselling facilities, primary medical care services and opportunities for referral to appropriate services (drug treatment, material aid services, advocacy, etc). These centres were established as a pragmatic harm reduction strategy for highly concentrated open drug scenes, characterised by deteriorating health conditions for drug users who frequented them, and increasing public nuisances associated with highly visible street based drug purchase and use.<sup>76</sup>

Some Australian researchers suggest that it is difficult to assess the precise impact of the establishment of safe injecting rooms in Europe as outcome research into these facilities is limited and little is published in English. The findings appear to be positive with decreases in the levels of public nuisance in some areas, the number of overdose deaths and complications from non-overdose deaths, risk behaviour associated with the transmission of blood borne viruses and improvement in health and social functioning of clients.<sup>77</sup>

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<sup>74</sup> The public nuisance aspects of street based injecting include inappropriate discarding of injecting equipment, public injecting and intoxication and visible drug dealing.

<sup>75</sup> K Dolan, J Kimber, C Fry, J Fitzgerald, D McDonald and F Trautmann, ‘Drug Consumption Facilities in Europe and the establishment of supervised injecting centres in Australia’, *Drug and Alcohol Review* 19(3), 2000, p 338, available online at <http://www.drugpolicy.org/library/focal6.html> and follow the link. A range of arguments for and against the establishment or trial of injecting rooms is also canvassed in chapter 4 of the report of the New South Wales Parliamentary Joint Select Committee into safe injecting rooms: New South Wales Parliament, Joint Select Committee Into Safe Injecting Rooms, *Report On The Establishment Or Trial Of Safe Injecting Rooms*, February 1998.

<sup>76</sup> K Dolan, J Kimber, C Fry, J Fitzgerald, D McDonald and F Trautmann, p 338.

<sup>77</sup> K Dolan, J Kimber, C Fry, J Fitzgerald, D McDonald and F Trautmann, p 334.

The increasing visibility of street based heroin markets and the related health and other harms for both users and the broader community have facilitated recent Australian interest in supervised injecting rooms as a potentially beneficial harm reduction strategy with which to address these matters. The suitability of safe injecting rooms in Australia has been debated at all levels of government, by researchers, professional bodies and advocates in the drug field, within the media and at the community level. In recent years, trials of safe injecting rooms have been proposed in New South Wales, Australian Capital Territory and Victoria. New South Wales is the only Australian State to date that operates such facilities.<sup>78</sup>

In New South Wales, the prelude to the introduction of safe injecting rooms was a recommendation in support of their establishment made by the Wood Royal Commission into the New South Wales Police Service in 1997. The Report of the Commission explained that:

*At present, publicly funded programs operate to provide syringes and needles to injecting drug users with the clear understanding they will be used to administer prohibited drugs. In these circumstances, to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short-sighted. The health and public safety benefits outweigh the policy considerations against condoning otherwise unlawful behaviour.*<sup>79</sup>

A study of injecting drug users' attitudes to safe injecting rooms, conducted before the injecting facilities in NSW opened, noted that a significant proportion of fatal and non-fatal heroin overdoses episodes occurred within private settings such as the home. The study concluded that safe injecting rooms should be viewed as but one part of an integrated and multifaceted set of initiatives and strategies designed to reduce the harms associated with injecting drug use.<sup>80</sup>

The 1999 Drug Strategy of the Australian Capital Territory, *From Harm to Hope*, included the possibility of establishing a scientific two year trial of a safe injecting facility.

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<sup>78</sup> By the end of the second month, the centre had registered over 600 injectors, accommodated almost 1500 injecting episodes and managed 17 drug overdoses: A Byrne, 'Injecting Room Up and Running in Sydney: Government Initiated 18 Month Trial of a Medically Supervised Injecting Facility, Kings Cross, Sydney', *In the News*, The Lindesmith Center – Drug policy Foundation, USA, July 2001, p 1.

<sup>79</sup> New South Wales, Royal Commission into the New South Wales Police Service (Wood Royal Commission), *Final Report*, Vol II: Reform, 1997, p 222.

<sup>80</sup> C Fry, S Fox and G Rumbold, Establishing safe injecting rooms in Australia: Attitudes of injecting drug users', *Australian and New Zealand Journal of Public Health*, 23(5), 1999, pp 501-504.

Legislation to allow the trial to be conducted, the *Supervised Injecting Place Trial Act 1999* (ACT), was enacted on 9 December 1999. The trial ultimately did not proceed in that parliamentary term as a result of a number of factors, including funding constraints and the failure in the parliament of a proposal to conduct a referendum about the trial. Recently, the newly elected chief minister of the ACT, Jon Stanhope, raised the possibility that a trial may be conducted in the Territory if the New South Wales trial had a positive outcome.<sup>81</sup>

In late 1999 in Victoria, the newly elected Labour Government appointed a Drug Policy Expert Committee to develop recommendations about the implementation of the drug policy of the government and to report to the government in two stages. Stage One related to issues of local drug strategy development within existing areas of high usage and the establishment of a five-site trial of supervised injecting centres in Melbourne. Stage Two covered broader policy issues such as service delivery reform and expansion as well as legislative and regulatory changes. The Committee suggested a detailed framework for the conduct of a rigorous, multi-site trial of injecting facilities, and a planning process led by local government.<sup>82</sup> The trial ultimately did not proceed, as legislation to support the trial was not subsequently passed in the Victorian Legislative Council.

The Queensland Government does not support the establishment of safe injecting rooms in Queensland.<sup>83</sup>

## 6 DRUG POLICIES IN OTHER COUNTRIES

### 6.1 THE UNITED STATES OF AMERICA

The drug policy framework in the USA emphasises the strategies of law enforcement and drug prohibition. The results of a recent national survey of householders in the USA indicate that in 2000 about 14 million people used illicit drugs nationwide.<sup>84</sup>

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<sup>81</sup> Maria Moscaritolo, 'Injecting rooms for ACT', *Courier-Mail*, 5 November 2001, p 15.

<sup>82</sup> Victoria, Drug Policy Expert Committee, 'Drugs: Responding to the Issues - Engaging the Community', *Stage 1 Report*: April 2000.

<sup>83</sup> Matthew Franklin & Matthew Hart, 'Heroin shooting galleries rejected', *Courier Mail*, 12 November 2001, p 11.

<sup>84</sup> United States of America, Office of National Drug Control Policy, 'Summary of the Current Situation, The National Household Survey', p 10, Downloaded from

In 1980, the federal budget for drug control was approximately US \$1 billion – about one third to one half of that allocated in state and local budgets. By 1997, the federal drug control budget reached US \$16 billion, two thirds of it for law enforcement agencies. State and local funding increased to approximately the same level. The President has requested \$19.2 billion be allocated for drug control in 2002.

The USA produced a National Drug Control Strategy (NDCS) in 1989 and updated it each year until 1999. The President now reports annually to Congress on the progress made in implementing the NDCS. Historically, the focus of the NDSC is upon demand reduction and supply reduction, and the bulk of Federal drug control spending is committed to those areas. The NDSC acknowledges that no single approach can solve the multi-faceted problem of drug use. The five strategic goals of the NDCS are:

- To educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco
- To increase the safety of America's citizens by substantially reducing drug-related crime and violence
- To reduce health and social costs to the public of illegal drug use
- To shield America's air, land, and sea frontiers from the drug threat
- To break foreign and domestic drug sources of supply.<sup>85</sup>

The National Drug Control Strategy Annual Report 2001 notes that:

*Through a balanced array of demand-reduction and supply-reduction actions, we strive to reduce drug use and availability by half and the consequences of drug abuse by at least 25 per cent by 2007. If this goal is achieved, just 3 per cent of the household population aged twelve and over will be using illegal drugs. This level would be the lowest documented drug use rate in American history; drug-related health, economic, social and criminal costs are expected to drop commensurately.<sup>86</sup>*

The NDCS determines the relationship between goals and available resources. Recent innovations in the 'war against drugs' include drug courts, which divert arrested non-violent users to treatment.

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<http://www.whitehousedrugpolicy.gov/drugfact/nov2001.ppt> on 15 November 2001. This level of drug use was about the same as for the previous year.

<sup>85</sup> United States of America, Office of National Drug Control Policy, *Annual Report on Implementing the National Drug Control Strategy*, pp 6,7, available at <http://www.whitehousedrugpolicy.gov/publications/policy/ndcs01/index.html>

<sup>86</sup> United States of America, Office of National Drug Control Policy, *Annual Report on Implementing the National Drug Control Strategy*, 2001, p 4.

## 6.2 SWITZERLAND<sup>87</sup>

In 1991, the Swiss federal government decided, as a result of an increasing drug problem, to adopt a series of objectives oriented to the reduction of harm to the individual user and the community.

To achieve these objectives, Switzerland formulated a drug policy with four strategic elements or “pillars”:

- **Law Enforcement**

The Swiss drug policy is reliant on the strict regulation and prohibition of certain addictive substances and products. This encompasses criminal prosecution of illicit production, trafficking and consumption of substances regulated by the law as well as the strict control of the authorised use of narcotics so as to prevent abuse.

- **Prevention**

Health promotion and prevention is described as the most important strategic element of the Swiss drug policy.

The Swiss drug policy places additional emphasis on certain target groups, such as socially deprived youth and migrant populations, or social settings like schools, youth homes, youth events and sports clubs.

- **Therapy**

The Swiss drug policy encourages drug-dependent people to enter therapy to achieve abstinence and social reintegration and rehabilitation. In 1999, there were approximately 100 in-patient institutions in Switzerland specifically designed to provide drug therapy and rehabilitation.

- **Harm Reduction**

Under the Swiss drug policy, measures to limit harm aim at protecting the health of addicts (eg from the risks of being infected with HIV and hepatitis) during the addiction period as much as possible. As a result, since the mid-1980s, the Swiss federal government has supported measures such as needle-exchange programs, injection rooms, housing and employment programs.

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<sup>87</sup> The Swiss Drug Policy: A fourfold approach with special consideration of the medical prescription of narcotics (1999), downloaded from [http://www.emcdda.org/policy\\_law/national/strategies/strategies.shtml](http://www.emcdda.org/policy_law/national/strategies/strategies.shtml) on 19 December 2001, Swiss Federal Office of Public Health.; Swiss Federal Office of Public Health, Narcotics/Drug Policy page, downloaded from xxx on ; United Nations, International Narcotics Control Board, Report of the International Narcotics Board, 1999, downloaded from [http://www.incb.org/e/ind\\_ar.htm](http://www.incb.org/e/ind_ar.htm) on 19 December 2001.

In the 1990s Switzerland chose to reject two referendums which advocated drug policies with divergent objectives. The first referendum, *Youth Without Drugs*, presented in 1993 and rejected by the Swiss voters in 1997, proposed a strict abstinence-oriented drug policy with elements of repression, prevention and therapy. The second referendum, *For a Reasonable Drug Policy*, presented in 1994 and rejected by popular vote in 1998, proposed the decriminalisation of drug use, cultivation of plants used to produce drugs, possession of drugs and purchase of drugs for personal use. It also suggested that the State should supervise the cultivation, import and production of narcotics and thereby make trade in narcotics for non-medical purposes possible within a defined legal framework.<sup>88</sup> The rejection of these referendums was viewed by the Swiss government as an endorsement of its fourfold approach.

Switzerland's drug policy has a strong "harm reduction" component. In 1987, syringes became available in pharmacies and, in 1991, a nation wide syringe exchange and availability program that includes dispensing machines was initiated. This program now includes syringe exchange in all prisons and heroin distribution in one prison. Methadone treatment programs also became increasingly available during this period. Switzerland also tolerates safe injecting facilities.

In the early 1990s, although Switzerland had a variety of drug therapy programs, it was perceived that for a group of heavily addicted people no treatment program seemed to fit. In 1994, Switzerland began a three-year clinical trial with the medical prescription of narcotics. Those people selected for the trial were heavily addicted people with a history of at least two failures in other treatments. Swiss authorities concluded from the trial results that heroin assisted treatment, used as part of a program including health care, therapy and social assistance, could result in health and lifestyle improvements for heroin addicts.<sup>89</sup> However, in 1999, an independent Committee established by the World Health Organisation (WHO) to evaluate the Swiss Heroin Trial found that:

*The Swiss studies were not able to examine whether improvements in health status or social functioning in the individuals treated were causally related to heroin prescription per se or a result of the impact of the overall treatment programme. Hence from a rigorous methodological viewpoint, it was not possible to obtain internally valid results with respect to the research question*

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<sup>88</sup> Switzerland, Swiss Federal Office of Public Health, *The Swiss drug policy: A fourfold approach with special consideration of the medical prescription of narcotics*, p 8, available at <http://www.bag.admin.ch/sucht/politik/drogen/e/drugpol.pdf>.

<sup>89</sup> A Uchtenhagen, F Gutzwiller & A Dobler-Mikola (eds), Programme for a medical prescription of narcotics: Final Report of the research representatives – Summary of the Synthesis Report (Summary of the results of the Swiss heroin prescription experiment), 10 July 1997, available online at <http://www.drugpolicy.org/library/focal1.html> and follow the link.

*of heroin prescription being causally responsible for improvements in health status or social functioning in the individual treated.*<sup>90</sup>

Notwithstanding the perceived deficiencies in assessment, the WHO evaluation generally favoured the program as feasible and safe.

In 1998, Switzerland passed a bill that authorised the prescription of narcotics for a limited group of severely addicted drug users<sup>91</sup> in specialised treatment centres.<sup>92</sup> As a result of a national vote taken in 1999, the bill is valid until December 2004. In August 2001, the Swiss Federal Office of Public Health reported an enrolment of about 1,000 patients in the heroin-assisted treatment program at the end of the previous year.<sup>93</sup> The SFOPH noted that *“heroin-assisted treatments that end positively in withdrawal or a switch to a methadone programme last about 23 months on average. This is the period needed to give the patient the necessary stability for tackling the next phase of life”*.<sup>94</sup>

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<sup>90</sup> World Health Organisation, *Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts*, April 1999, Executive Summary reproduced by Hassela Nordic Network, downloaded from the website of the Hassela Nordic Network <http://www.hnnsweden.com/1999/apr99/99apr16-001.htm> on 13 February 2002.

<sup>91</sup> The admission criteria are: heroin addiction for at least 2 years, more than 18 years old, at least two relapses to drug use after failures in out- or in-patient treatment and obvious adverse effects of drug use on health and/or social relations: The Swiss drug policy: A fourfold approach with special consideration of the medical prescription of narcotics, p 8.

<sup>92</sup> An account of the Swiss drug programs and the problems associated with their possible translation to Australia is detailed by the Queensland Chief Justice, the Honourable Chief Justice Paul de Jersey AC in his paper: ‘Injecting insanity-Whither a sane solution’, Sir Gerrard Brennan Lecture, Bond University, 11 March 2000, available online at the Supreme Court Library website at <http://www.courts.qld.gov.au/publications/articles/speeches>.

<sup>93</sup> Switzerland, Swiss Federal Office of Public Health, *Heroin Assisted Treatment (HeGeBe) in 2000* (abridged version), 28 August 2001, p 2.

<sup>94</sup> Swiss Federal Office of Public Health, *Heroin Assisted Treatment (HeGeBe) in 2000* (abridged version), 28 August 2001, p 5.

### 6.3 THE NETHERLANDS<sup>95</sup>

The drug policy in the Netherlands is based on the concepts of risk minimisation and harm reduction. Its main objective is to reduce the risks that drug abuse poses for the users themselves, their immediate environment and society as a whole.

Drug control policy in the Netherlands is based on the *Opium Act*. The Act, which dates back to 1919, was fundamentally amended in 1976 to introduce a differentiation in penalties between drugs and offences according to their potential medical, pharmacological, sociological and psychological risks. The 1976 *Opium Act* differentiated between drugs presenting unacceptable risks (unofficially called "hard drugs") and cannabis products (unofficially called "soft drugs"), with emphasis on the control of "hard drugs" such as heroin, cocaine, amphetamines and LSD. For example, penalties for possession of small quantities of cannabis were reduced, whereas penalties for dealing in illicit drugs increased.

The *Opium Act* also includes provisions against drug trafficking while the *Penal Code* provides for the confiscation of illegal assets and the prevention and prosecution of money laundering activities. The *Abuse of Chemical Substances Act* enables the monitoring of the trade in precursors.

Part of the national drug policy is decentralised to the local level. The drug policy at the local level, which must comply with national guidelines, is co-ordinated in consultation between the mayor, the chief public prosecutor and the chief of police.

The arrest and criminalisation of users possessing small quantities for personal use of any drug is not regarded as a priority according to the Dutch drug policy. When the principle of 'separating the markets' between dangerous drugs and cannabis was codified in 1976, coffeeshops gradually emerged as the 'official/unofficial' sale points of cannabis, albeit under strict conditions. Coffeeshops are tolerated in the attempt to keep young people, who experiment with cannabis, away from other more dangerous drugs. The sale of small quantities of cannabis in coffeeshops is therefore technically an offence, but prosecution proceedings are only instituted if the operator or owner of the shop does not meet the criteria issued by the Prosecutor General.

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<sup>95</sup> Part of the material in this section is abstracted from the websites of the European Legal Database on Drugs>Country Profiles>The Netherlands at [http://eldd.emcdda.org/databases/eldd\\_national\\_reviews.cfm?country=NL](http://eldd.emcdda.org/databases/eldd_national_reviews.cfm?country=NL), downloaded on 26 November 2001; the Australian Institute of Criminology>International Responses>The Netherlands at <http://www.aic.gov.au/research/drugs/international/netherlands.html>, downloaded on 26 November 2001 and the International Narcotics Control Board>Report of the International Narcotics Board for 2000>Chapter 3D: Analysis of the World Situation: Europe at <http://www.incb.org/e/index.htm?>, downloaded on 26 November 2001.

The Dutch drug policy is based upon the principle that steps should be taken to stop drug users from entering the criminal underworld where they would be out of reach of the institutions responsible for prevention and care. Law enforcement priority and resources are therefore given to the investigation and prosecution of production and trafficking in drugs.

Drug addicts who have committed a small offence are increasingly pressured to participate in treatment programs. Arrested drug addicts may opt for treatment by suspension of preventive custody, provided they enter clinical treatment and complete the program, they will be granted permission by a judge to leave the prison to be admitted to a rehabilitation clinic as soon as they have served at least half their sentence, up to a specified maximum. Moreover, part of a prison sentence can be substituted for alternative sanctions such as the supervised performance of socially useful work.

The prison system also operates Addiction Counselling Departments where assistance is offered to drug addicts in order to stimulate their motivation for further treatment.

Another recent scheme is the compulsory placement of drug addicts, who repeatedly commit crimes due to their status of addiction and who have failed voluntary treatment and coercion, in a Penitentiary Treatment Institution. The maximum duration of the admission is two years, divided into three phases. Phase 1 is meant for detoxification and to prepare the participants for behavioural change. In Phase 2 and 3 training is offered in the skills needed for social reintegration. This concept is based on research results from America and Sweden that showed positive effects on drug use, criminality rates, recidivism and social behaviour. The scheme received a positive evaluation from participants.

In 1998, a 3-month heroin prescription trial was launched in Amsterdam and Rotterdam. In 1999, the trial was extended to four additional cities, The Hague, Utercht, Groningen and Heerlen.

#### **6.4 SWEDEN<sup>96</sup>**

Sweden has a restrictive policy on drugs – the policy promotes an attitude of zero tolerance to illicit drug use with the aim of achieving a drug free society. The policy does not focus exclusively on law enforcement measures but promotes a close interaction between information and opinion formation, local prevention, control policy and the

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<sup>96</sup> Parts of this section are abstracted from the website of the European Legal Database on Drugs at <http://eldd.emcdda.org/>.

treatment of drug users with a view to limiting both the supply of, and demand for, illicit drugs.

The country's reported lifetime prevalence of drug use was reported in 1999 as 9% for people aged 16–29 years. Methadone maintenance treatment has been practised in Sweden as a method of treatment for persons with heroin dependence since the end of the 1960s. The number of patients that may participate in the national methadone program is restricted. The cultivation of cannabis sativa is banned.

The main Swedish law regulating narcotic drugs offences is the *Narcotic Drugs Criminal Act 1968:64*. Although there is no distinction made between narcotic preparations and psychotropic substances, the nature of the substance is one of the criteria that determine if an offence is considered minor or serious. As a result, while all drugs are considered illegal, judicial authorities have a legal base to apply a distinction between different drugs when punishing illegal activities.

Since 1998, drug offenders who are drug dependent may access treatment by entering a 'treatment contract' that creates contractual rights and obligations between the offender and the Court. Such contracts mandate that a number of conditions must be fulfilled by the offender: the person must need treatment and he/she must be motivated to undergo treatment; he/she is a misuser of drugs; and the drug habit contributed to the drugs crime, which should not be serious (less than 2 years foreseen as penalty). The offender is not sent to prison and a personalised plan of treatment is established. Health authorities are responsible for the treatment and are required to report to the local prison and probation administration and to the public prosecutor if the probationer seriously neglects the obligations stated in the personal plan.<sup>97</sup>

In January 2001, the Government-appointed Swedish Drugs Commission published a report that evaluated public drug policy measures in Sweden since the mid-1980s. The main conclusion of the Commission was that:

*Swedish drug policy has come to a crossroads. One direction calls for a significant augmentation of resources in the form of commitment, direction, competence and funding. The other implies a lowering of sights and a considerable acceptance of drug abuse.*<sup>98</sup>

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<sup>97</sup> Information obtained from the website of the European Legal Database on Drugs > Country Profiles > The Netherlands at [http://eldd.emcdda.org/databases/eldd\\_national\\_reviews.cfm?country=SE](http://eldd.emcdda.org/databases/eldd_national_reviews.cfm?country=SE)

<sup>98</sup> Sweden, Drugs Commission, *Final Report of the Swedish Government's Narcotic Commission*, January 2001, p 33.

In the view of the Commission, the drugs issue was not promoted as a political priority. It observed that more young persons were taking an increasingly permissive attitude towards narcotic drugs while the care and treatment of drug users was subject to expensive cuts and downgradings by Swedish municipalities. The Commission concluded that there were “*no arguments or facts to suggest that a policy of lowering society’s guard against drug abuse and drug trafficking would do anything to improve matters for individual abusers or society as a whole. On the other hand, the results of Sweden’s present policy on narcotics could – and must be – improved*”. As a result, the Commission advocated the restrictive policy on drugs be continued and supported so as to create a more coherent, balanced and strengthened policy.<sup>99</sup>

The Commission made a number of proposals about how the restrictive policy on drugs could be strengthened and made more coherent:

- Stronger leadership of drug policy, with the Government playing a more active role, both nationally and internationally;
- The implementation of local drug policy strategies by municipalities and county councils, with support from the State government, particularly in the areas of the development of methods and competence;
- Central Authorities assume greater responsibility for the active prosecution of questions concerning knowledge transfer and the development of methods and competence;
- More effective support of prevention programs and care and treatment through the development of a structure capable of “*improving and deepening policy measures and bringing about processes which can lead to development in the long term*”. (As part of this concept, the Commission proposed the formulation of guidelines for drug education in schools and that all young persons and parents have access to voluntary drug counselling.); and
- Long-term initiatives to facilitate the care and treatment of drug users. The Commission noted the existence of inadequacies in the programs to care for drug users and their actual capacity.<sup>100</sup>

## 7 CONCLUSION

The current national drug policy framework in Australia is based on the concept of harm minimisation policies and programs that are designed to prevent and reduce drug-related

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<sup>99</sup> Sweden, Drugs Commission, p 34.

<sup>100</sup> Sweden, Drugs Commission, pp 34-42.

harm. The overall aim of this approach is to improve the health, social and economic outcomes for both the community and the individual with the balanced use of three main strategies: supply-reduction, demand-reduction and harm-reduction.

While there is general consensus on the need for an integrated approach to the drug problem in Australia, there are divergent views about the effectiveness of current drug policies and strategies. Protagonists in the drug debate differ about their preparedness to embrace new drug strategies. This has resulted in a polarisation of the drug debate in relation to more 'radical' drug strategies such as safe injecting rooms and heroin prescription trials.

Some commentators on the drug debate in Australia suggest that an understanding of the causes of drug use and consensus about how to address such issues is paramount to the development of effective drug policies:

*Good drug policies require a community consensus on what should be done to reduce drug use and the harms that it causes to people who use drugs, their families and the broader community. Community dissension and intolerance of different opinions undermine good policy. So does advocacy of policies that are not based on an understanding of how many people use which licit and illicit drugs, what harms such use causes, and what type of policy responses are most likely to reduce drug use and the harm it causes.*<sup>101</sup>

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<sup>101</sup> National Drug and Alcohol Research Centre (NDARC), Submission 72 to the House of Representatives Standing Committee on Family and Community Affairs: Inquiry on Substance Abuse in Australian Communities, *Discussion Paper*, 24 September 2001; See also N Comrie, Address to a Joint Sitting of the Legislative Assembly of Victoria and Legislative Council of Victoria on Drugs: Education and Prevention Strategies, *Victorian Parliamentary Debates*, Legislative Assembly, 21 March 2001, p 411.

## **APPENDIX A – MINISTERIAL MEDIA STATEMENTS**

### **The Hon Rod Welford MP, Attorney-General and Minister for Justice 14 January 2002**

#### **Drug Court Continues Success Story**

Another three young people have graduated from the Queensland Drug Court after intensive rehabilitation to overcome drug addiction.

Attorney-General and Minister for Justice, Rod Welford, said three young men with amphetamine addictions had successfully reclaimed their lives.

"This takes to nine the number of young people who have got themselves back on track since the Drug Court program started in June 2000," Mr Welford said.

"The Drug Court provides an opportunity for people addicted to drugs, who have committed serious offences, to undergo rehabilitation rather than going to jail.

"Every successful rehabilitation means less house-breakings, car theft and other crimes committed by drug-addicted offenders to pay for their habit."

Mr Welford said the three latest graduates originally appeared before the Beenleigh Drug Court in the latter part of 2000 on charges including stealing, shoplifting and motor vehicle offences.

"These crimes were committed to fund their drug habits and the Magistrate gave them a chance to undergo rehabilitation instead of going to jail," he said.

"The young men - aged 23, 24 and 30 - seized the opportunity to undergo treatment to kick their habits and have now reclaimed their lives.

"These graduations show the Drug Court program can make a difference in breaking the drugs cycle and reducing crime in our communities."

The Drug Court trial began in June 2000 and since that time nearly 200 offenders have been placed on Intensive Drug Rehabilitation Orders (IDROs).

The length of treatment depends on the extent of the addiction but most offenders are required to undergo a 12-month rehabilitation program.

"The use of illicit drugs is a major concern for the Government and the Drug Court provides a realistic initiative to break the cycle of drug dependence," Mr Welford said.

Contact: Ian McGoldrick on 323 93478 or 0438 769 091

**The Hon Peter Beattie MP****20 March 2001****Cannabis users offered a chance to reform**

Premier Peter Beattie said today he was pleased to join Prime Minister John Howard in a \$19.5 million program designed to stop people using illegal drugs.

The two leaders announced an agreement where the Federal Government will provide up to \$19.5 million over four years for the Queensland Illicit Drug Diversion Initiative.

"The Initiative is part of the 'Tough on Drugs' program announced by Mr Howard in 1999 and fits in with the Queensland Government's 'Tough on Crime, Tough on the Causes of Crime' strategy," said Mr Beattie.

"Drug diversion gives certain people who are caught using drugs the chance to undertake education or treatment aimed at helping them to stop using drugs, rather than getting caught up in the criminal justice system," said Mr Beattie.

"The major element of this initiative will be a Police Diversion Program for offenders caught with minor amounts of cannabis (50 grams or less) for personal use.

"Offenders who meet the strict eligibility criteria will be offered an opportunity to attend an authorised assessment and education intervention program to address their cannabis use rather than be charged.

"Violent offenders and those dealing in drugs will not be eligible.

"Further treatment services will also be offered to those people who are dependent on cannabis and would benefit from more intensive treatment.

"This initiative will be implemented across Queensland from June 24 this year, providing services as close as possible to where people live.

"The initiatives resulting from this agreement will maximise the opportunities for drug users to break away from drugs and take personal responsibility for their lives.

"The program will provide many offenders with an incentive to address their drug use early and before incurring a criminal record.

"The Police Diversion Program will complement the Queensland Drug Court Trial.

"The diversion program targets first time offenders, while drug courts provide longer-term treatment programs to drug dependent offenders with a serious criminal history.

"The Drug Court Trial is a Queensland initiative wholly funded by the State Government.

"The State Government will review the diversion program within two years to assess whether it should be extended to people arrested for using small amounts of other illegal drugs.

"The present enforcement system is not preventing people from using Cannabis.

"In the 1998/99 year there were more than 13,000 charges of cannabis possession involving 50 grams or less of the drug.

"Charging people and requiring them to appear in court is not deterring people from smoking cannabis.

"The 1998 National Drug Strategy Household Survey found that nearly 18 per cent of people surveyed in Queensland had used cannabis in the previous 12 months.

"That's more than one in six of every person surveyed. This program is not about legalising or decriminalising cannabis use - or giving people an easy escape route from the courts.

"Possession of cannabis will still be illegal and offenders will be offered one - and only one - chance to seek professional help under this program and have no charge recorded against their names.

"If they are caught again after taking part in this program they will not have a second chance."

Media contact: Steve Bishop 07 3224 4500

**The Hon Peter Beattie MP, Premier****24 January 2000****Southport, Ipswich and Beenleigh to Trial Drugs Courts**

The State Government will test the effectiveness of special drugs courts in breaking the drug-crime cycle by trialing them in Southport, Ipswich and Beenleigh from April, Premier Peter Beattie announced today.

"The 30-month trial program is a major shift in the way Queensland's criminal justice system deals with drug-related crime and presents a real opportunity to attack the causes of crime in the community," said Mr Beattie.

"This trial helps address the concerns of victims of housebreaking, car theft and other crimes which have been committed by addicts to feed the hunger for more drugs.

"And it offers the addicts who commit these crimes the chance to break that cycle of committing crimes to raise money for more drugs.

"As many as two out of three crimes involving theft are drug-related so this is a frontal attack on a major cause of crime.

"During the trial, drug addicted offenders facing a jail term could instead be diverted to intensive drug rehabilitation programs.

"The Government's aim is to conduct this trial program and, if it proves as successful as we hope, progressively extend the system throughout the State.

"Southport, Beenleigh and Ipswich were chosen as the sites for the trial after extensive consultation between justice, police, health and correctional services agencies.

"I stress that the drugs court trial is no soft option for offenders.

"Drug-addicted offenders must meet strict criteria to be eligible for the program, they will be monitored carefully and if they breach their rehabilitation order, they could find themselves in jail."

Attorney-General Matt Foley said one magistrate would conduct the trial drugs court at the three centres, to ensure consistency in sentencing and assessment of results.

Up to 600 offenders will take part in the trial. Mr Foley said Southport, Beenleigh and Ipswich were chosen as the sites for the trial to represent a cross section of the community within the south-east corner.

Rehabilitation options under the drugs court program could include counselling, methadone maintenance therapy, medical, psychological or psychiatric treatment and/or in-patient therapeutic community placement.

Mr Foley said offenders eligible for the program will be those who:

- are dependent on illicit drugs
- are charged with an offence which does not involve physical violence or sexual violence

- have no offences involving physical or sexual violence pending before any other court
- plead guilty to the offence
- are genuinely facing a jail term
- are willing to participate in the program
- are adults.

"Being tough on the causes of crime means we have to give the courts the extra power and flexibility to divert drug-dependant offenders into programs to break the cycle of crime," Mr Foley said.

Legislation to establish the drugs court trial was introduced in the State Parliament in November.

Mr Foley said he expected the legislation to be passed in March, allowing the trial to begin in April.

Contact: Steve Bishop 07 3224 4500

**APPENDIX B– NEWSPAPER ARTICLE**

**Title**            **Heroin shooting galleries rejected.**  
**Author**        **Matthew Franklin, Matthew Hart**  
**Source**        **Courier-Mail**  
**Date Issue**   **12/11/01**  
**Page**          **11**

The Beattie Government has ruled out conducting free heroin trials or establishing "shooting galleries" for addicts in Queensland.

Health Minister Wendy Edmond, who recently visited European nations conducting these trials, said yesterday she had seen enough to confirm the Government opposition to free heroin or so-called shooting galleries.

Every government conducting the trials had concluded the best way to treat heroin addicts was to prescribe methadone - a drug used in Australia for years to help addicts kick heroin.

"I think that what we found out is that we are on the right track," Ms Edmond said.

Ms Edmond's trip followed heavy pressure for the creation of free heroin trials as a way to remove the need for addicts to commit crime to feed their habits and calls to treat drug addiction more as a health problem than a crime problem.

Premier Peter Beattie had always opposed such trials, but sent Ms Edmond to The Netherlands, Denmark and Switzerland to examine trials already under way.

Ms Edmond said yesterday she had seen nothing to justify changes in the Government's position.

"Everywhere we went they see methadone as the best treatment program by far," Ms Edmond said.

Many injecting rooms were less about addict care and more about getting drug users and dealers out of public areas such as railway stations, she said.

"Once you take that step, the next step is you have to provide the heroin," she said.

And in places where governments provided heroin, some also provided methadone and used heroin simply to attract addicts and encourage them to use methadone.

"I think I'd rather spend the money we've got improving rehabilitation programs instead of on a heroin trial," she said.

The Beattie Government's stance now mirrors that of Prime Minister John Howard, who has consistently opposed heroin trials.

But other Labor identities, including Brisbane Lord Mayor Jim Soorley and federal Labor leader Kim Beazley, have supported the trials as a possible way of reducing the drug-related crime.

Amid controversy and objections, Australia's first legal heroin injecting room opened for business in May this year in Sydney's Kings Cross.

With that trial still continuing, Queensland Alcohol and Drug Foundation chief executive officer Bob Aldred said it was too early for the Beattie Government to take a stance against heroin trials and shooting galleries.

"What we need to do is closely look at the results of these trials when they are held in Australia and make a judgment on their application to Queensland," he said.

Australian Medical Association Queensland president Bill Glasson said he supported the Government's decision as it was based on scientific data, but he said Queensland needed to be open to other potential solutions to the drug problem.



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