Drug policies contravening international Drug Conventions

OVOM

GLOBAL SUPPORT FOR A DRUG FREE LIFESTYLE

Table of Contents

Executive Summary

The International Drug Conventions are being whittled away to the point that for some countries they no longer exist. With cannabis legalised for recreational use in various countries and States, and with the other illicit drugs decriminalised and amounting to a quasi-legalisation measure, there is little left to deter drug use.

OVOM exists to remind populations across the world that there were overwhelming rationales for the Drug Conventions. The key is the unacceptable harms of illicit drugs, not just to the user him/herself but to the constellation of people around each user so severely affected - their partner, children, their children's grandparents, siblings, friends, workmates, other road users, the community in general.

These harms are so unacceptable that almost every country has introduced Harm Reduction programs. The very nomenclature 'Harm Reduction' implicitly expresses that drug harms are so egregious and unacceptable they demand tax dollars be spent on minimising them.

Australia shows that drug prevention is the ultimate harm reduction. The highly successful Tough on Drugs Federal Policy liberated 75,000 families from the grief of possibly losing a family member and brought down drug use by 42% when compared drug for drug against Portugal, which has taken an opposite approach. The scrapping of Tough on Drugs in Australia, and a return to an ascendent Harm Reduction policy in 2007 saw 104,000 new families opened to the jeopardy of losing a family member.

It is that grief that drove the need for Drug Conventions back in 1912. Now they have been effectively dismantled, we have the whole world opening up to the unspeakable grief of an upward and widening spiral of drug-related deaths and other unmitigated harms for that constellation of others around each drug user.

Drug Legalisation

More and more countries and States are embacing the legalisation of drugs for recreational use.

Colorado created loose medicinal cannabis laws in 2009, legalised recreational cannabis use in 2013, and by 2015/16 had seen a doubling of adult cannabis use, a 360% increase in cannabis-related hospitalisations, a 230% increase in cannabis-related road deaths and a 410% increase in cannabis-related suicides. All this while the black market for cannabis mushroomed. This Harm Reduction measure increases death tolls.

This is clearly unacceptable, but a complicit worldwide media downplays or remains silent on the real harms of drug legalisation.

Drug Decriminalisation

The experience of Portugal, which started the worldwide rush to decriminalising the use of all illicit drugs in 2001, demonstrates why this Harm Reduction measure will significantly add more drug-related mortality and harm.

Portugal's adult drug use increased 59% by 2016, with use by high-school minors shooting up by 80% by 2011, but in 2019 back to 24% above 2001 levels. Portugal's overdose mortality though, is increasing in exactly the same way as Australia's deaths sharply increased under its predominant Harm Reduction policy, showing that decriminalisation significantly adds to death tolls.

Harm Reduction multiplies harm

Australia moved to a Harm Reduction framework called Harm Minimisation in 1985 - the world's leader with its novel Harm Reduction approach. ***Under its patronage illicit drug use went to the highest levels in the OECD developed world by 1998***, effectively double that of almost any OECD nation. Opiate overdose deaths peaked in 1999 at 7 per 100,000, with the media clamouring for change.

In 1998 the Tough on Drugs policy commenced, giving drug prevention, rehabilitation and drug interdiction precedence over harm reduction. Use of any illicit drug decreased 39%-42% (depending on which measure is used), with opiate deaths reducing by 67% (6.8 down to 2.2/100,000) through to 2007. This is a stark contrast to the experience of drug-liberal

countries such as Portugal.

Cannabis use was halved, such that 1 in every 4 Australian families was freed from the grief deriving from the use of this drug, which causes more than twice as many cancers as tobacco, along with involvement in over 90% of birth defect types.

In 2007, Tough on Drugs was scrapped, with Harm Reduction again given the ascendency. Illicit drug use increased 34% by 2022, ***and opiate deaths increased back towards pre-Tough on Drugs levels at around 5.75/100,000, two-and-a-half times higher than 2007.***

The pattern of sharp increases in drug use and drug related deaths under a predominant Harm Reduction approach holds true for every illicit drug type, as well as alcohol use. The boom-bust-boom pattern holds for all.

In the absence of any viable confounders, Australia's experience with Harm Reduction suggests causality in regards to increased use and deaths, and demonstrates that Harm Reduction does produce unacceptable levels of harm.

Because Harm Reduction interventions have consistently failed to decrease actual drug harms, Australia has been the beneficiary, under any ascendent Harm Reduction policy, of demonstrably increased drug-related mortality and other harms.

The seeds of HR failure lie in its derogation of drug prevention, where, as for shoplifting, it is happy for people to be educated it is harmful, while not lifting a finger against it. This is the internal dynamic of Harm Reduction's failure and increased use and harm.

Conclusion

The United Nations Office of Drug Control seems to have been overwhelmed by the assault on the International Drug Conventions, and needs to find the will to engage with all member countries, demonstrating the Conventions' central rationale while communicating the failure of Harm Reduction, drug decriminalisation and drug legalisation policies.

Why we have Drug Conventions

Introduction

Illicit drug use adversely affects a whole constellation of people:

- the drug user's partner
- their children
- their children's grandparents
- siblings, friends
- workmates
- other road users
- the rest of the community (crime, welfare etc)

all drawn into the vortex of their drug use.

In a submission to a 2007 Australian Parliamentary Inquiry into the impact of drugs on families the Catholic Women's League of Australia summarised as follows:

> *The incredible mood swings, and dangerous, erratic and unpredictable behaviour of the addict, has family, friends and colleagues walking on egg-shells. Living with an addicted person is a recipe for madness that frequently results in nervous breakdown and serious physical illness in people riding the roller coaster of pain and uncertainty that is the daily experience of those living with addiction.*

The unacceptable harms of drug use are attested by a simple fact – our governments have spent hundreds of millions of dollars on 'harm reduction' programs for drug use – it's in the name.

Such a description can apply even to functioning addicts, however with a drug like heroin, most users are dysfunctionally dependent, and in those countries that provide welfare, dependent on government systems for stability. In Sydney Australia 61% of heroin users are typically on welfare benefits and 10% in the inner city involved in sex work.

The unacceptable harms of drug use are attested by a simple fact – our governments have spent hundreds of millions of dollars on 'harm reduction' programs for drug use – it's in the name. Yet harm reduction programs do close to nothing for the constellation of people being harmed by the user.

The constellation - immediate family

From the same report:

The family member's problem is typically related to the drug use, but separate, such as:

- *I have no real relationship with my child;*
- *All the family income goes on drugs;*
- *My partner is not emotionally available to me;*
- *I am scared to ask for my basic needs;*
- *I am placing the needs of the addicted member above the needs of other family members;*
- *My partner/child does not respect my home/my right to a peaceful/clean space; and*
- *My friends no longer visit our house*

For many families these conditions are intolerable.

Impact on Children

Again, from the same report:

The impacts of parental drug use on growing children were related by many inquiry participants. They included:

- *inadequate nutrition and periods without food;*
- *a lack of clothing;*
- *inadequate health care, including a lack of immunisation,*
- *lack of attention to the child's health problems or disabilities,*
- *irregular washing, dental decay, a filthy home environment and untreated head lice;*
- *poverty and financial disadvantage;*
- *physical, sexual and emotional abuse;*
- *traumatic and frightening experiences, such as parents overdosing or losing consciousness;*
- *family breakdown and conflict;*
- *parental mental health problems;*
- *frequent change of residence and carers;*

- *involvement in criminal activity;*
- *poor education outcomes due to learning and behavioural difficulties and interruptions to schooling;*
- *social problems, including social isolation and lack of attachment and connection to others; and*
- *problems with emotional development*

Child Safety

More from the same report:

Parental illicit drug use may compromise child safety through:

- *increased likelihood of physical and sexual abuse, neglect or inadequate supervision. Parental drug use is not in itself sufficient to trigger a notification to statutory child protection services. It features significantly, however, in the caseload of child protection authorities in all states and territories.*
- *In 2005-06, there were 266,745 reports to child protection departments around Australia and the most frequently substantiated maltreatment types are child neglect and emotional abuse — the maltreatment types most frequently associated with parental drug use. According to Odyssey House, parental drug or alcohol problems account for approximately 50 per cent of all substantiated cases of child abuse or neglect in the child protection system in Australia.*

Impact on child's grandparents

The negative impact of drug use causing neglect of children doesn't just fall upon the user's own parents, but also on their partner's parents as these grandparents take responsibility for their grandchildren.

Centrelink also reported that the transfer of family support payments along with care of the children was an issue. Grandparents who assumed care of the children were 'emotionally blackmailed' into not claiming the payments they were entitled to:

> *Grandparents in particular, may be emotionally blackmailed by their child into NOT claiming or pursuing entitlement to a Centrelink payment so they are able to support grandchildren. Usually it is not until an extreme event occurs that grandparents or relatives eventually claim a payment. They are very aware that when they claim a payment, the parent's payment will cease or be dramatically reduced and there will be work obligations for the parent of the child.*

Centrelink also reported a case in which two men were attempting to gain custody of their respective children. 'Both males reported that their partners had drug issues, and did not care for the children but wanted the money for their own drug use'.

Siblings

Further:

Unsurprisingly, one family member's illicit drug use can often be the underlying cause of another's health problems. Many report that they have needed counselling and treatment themselves to cope with depression and anxiety, or that they have developed chronic health conditions through failing to pay attention to their own health needs. The committee heard examples of where siblings also become drug users: a mother in Western Australia told the committee that four of her five children had been addicted to illicit drugs; once one of them had started using, the 'family morality' broke down and 'the other children then saw it as being an okay thing to do.'

The financial costs to families can also be significant, with theft and property damage a common experience, as well as continual requests by users for loans to cover drug expenses and debts. Treatment, rehabilitation, and legal fees can mount into thousands of dollars. Families with a small business may find themselves unable to give it the necessary attention and focus, and others stop working or reduce working hours to look after the drug user or cope with their own problems. A family's ability to earn income, take holidays and save for or enjoy retirement, is thus affected. Illicit drug use presents tremendous opportunity costs to users and their families.

Impact on friends

Further:

Other siblings are often unable to have their friends visit the family home due to the unpredictability of the using member's behaviour. A mother told the committee that:

As my son's behaviour and drug use escalated fewer family and friends came to visit our home or include us in social activities in case he came. We had little respite and on reflection as I write I can see my younger children locked themselves away in their rooms, no longer eating together as a family, no longer watching TV together or talking together. We would covet brief times together away from him to share school activities, illnesses, fear, loneliness or wonder where our belongings had gone to. Sometimes we would cry together, hug and just hope everything would change. For many years nothing changed except to worsen.

Impact on workmates

Further:

In addition to the actual harm imposed on the community, the use of illicit drugs also contributes to a broad range of potential harms due to impairment associated with drug use. In 2004, of Australians aged 14 years and older who had used any illicit drugs in the last 12 months, in the same period:

- 581,000 people had driven a motor vehicle while under the influence of illicit drugs;
- 115,000 people had operated a boat or hazardous machinery; and
- 326,600 people had gone to work.

Drug use by health care and other workers has potentially fatal consequences. The committee is concerned at the potential numbers of people working under the influence of illicit drugs whilst holding positions of professional responsibility in our community.

Other drivers on the road

Further:

Illicit drug using drivers are responsible for a significant number of road traffic accidents. In 2004, of the 2.5 million Australians aged 14 years and older who had used any illicit drugs in the last 12 months, in the same period 581,000 people had driven a motor vehicle while under the influence of illicit drugs.

Recognising this, all Australian jurisdictions have examined roadside drug testing and are at different stages of implementation, with some states and territories yet to commence regular drug driver testing.

Laboratory studies have shown that cannabis compromises reaction time, attention, decision making, time and distance perception, short-term memory, hand-eye coordination, and concentration. Central nervous system stimulants, like amphetamines, ecstasy and cocaine, can impair coordination and judgement through hyperactivity, aggressiveness, overconfidence, blurred vision, hallucinations and fatigue; while narcotic analgesics such as methadone and heroin slow reflexes and blur vision. All of these effects pose significant risks to those driving under the influence, their passengers and others on the road.

Burden on public health

Finally, from the same 2007 document:

Illicit drug use causes significant illness, including mental illness, and disease, violence and crime, and devastates families. The most recent estimate of the economic cost of illicit drug use in Australia is $6.7 billion per year. This estimate does not include the significant physical and emotional trauma and social dislocation caused by illicit drugs.

The effects of illicit drug use are evident in the destructive effects of drug-related deaths, other associated health effects and the damaging impact of drug-related crime on the community.

Harm Reduction of unacceptable harms

The United Nations community will readily acknowledge that Harm Reduction programming is premised solidly on the recognition that illicit drugs cause unacceptable harms to the individual user.

The Harm Reduction industry, on the other hand, bends over backward to avoid that recognition. This raises questions as to whether the HR industry is operating in good faith for the good of the wider community, or for the 'right' of the user (there is no such right) to use.

OVOM is challenging the United Nations community to call out the the Harm Reduction industry on this glaring dissonance.

The same issues in 1912

When the initial international agreements were forged at the Hague in 1912, opium and cocaine were the chief drugs socially used with the same devastating effects on the same constellation of people around each addict.

Arthur Conan Doyle, in one of his famed Sherlock Holmes stories, portrays the impact of opium before 1912.

Between a slop-shop and a gin-shop, approached by a steep flight of steps leading down to a black gap like the mouth of a cave, I found the den of which I was in search. Ordering my cab to wait, I passed down the steps, worn hollow in the centre by the ceaseless tread of drunken feet; and by the light of a flickering oil-lamp above the door I found the latch and made my way into a long, low room, thick and heavy with the brown opium smoke, and terraced with wooden berths, like the forecastle of an emigrant ship.

Through the gloom one could dimly catch a glimpse of bodies lying in strange fantastic poses, bowed shoulders, bent knees, heads thrown back, and chins pointing upward, with here and there a dark, lack-lustre eye turned upon the newcomer. Out of the black shadows there glimmered little red circles of light, now bright, now faint, as the burning poison waxed or waned in the bowls of the metal pipes. The most lay silent, but some muttered to themselves, and others talked together in a strange, low, monotonous voice, their conversation coming in gushes, and then suddenly tailing off into silence, each mumbling out his own thoughts and paying little heed to the words of his neighbour.

The one constant between 1912 and 2024 is that illicit drugs are doing as much damage as they ever did.

The difference between then and now is that in 1912 compassion for afflicted families and friends was so high that the international community resolved to do something about the problem, and acted.

Today, the heavily monied interests promoting to governments and the media that illicit drug addiction is no real issue, and that stigmatisation of the addicted user must cease, wilfully ignore the constellation of people seriously harmed by drug abuse.

The United Nations must put aside the enormous money behind the drug liberalisation movement, and must compassionately affirm its allegiance to all who are seriously harmed by drug abuse.

CASE STUDY - AUSTRALIA

In keeping with the information presented from an Australian Parliamentary Inquiry, estimates of the real impact of drugs on the lives of families can be taken from readily available data within that country.

To be noted is that the following data only gives some understanding of the impact of drug use on families for heroin and opiate use *alone*, without attempting to gauge the impact for all other kinds of illicit drug use.

Calculating the real cost to human lives

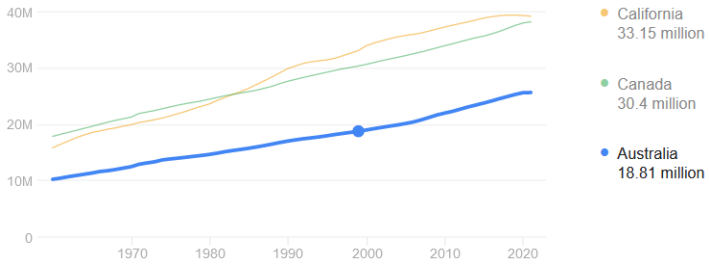
Heroin mortality statistics from 1999, the year when Australia's heroin use peaked, allow the number of dependent heorin users to be calculated, where previous estimates have shown that user numbers are 100 times greater in any given year than the recorded opiate deaths for that year. Thus there were 112,000 dependent heroin users in 1999 for the 1,116 recorded deaths.

Conservatively calculating 5 family members and friends directly affected by heroin use, it can confidently be said that 560,000 around those 112,000 users were suffering the effects of heroin addiction. This of course does not count those people on the roads or in the workplace also affected.

One in every 33 affected by heroin use

In 1999 the population of Australia was 18.81 million, thus 3%, or one in every 33 Australians were directly within the orbit of heroin addiction at that time.

18.81 million (1999)

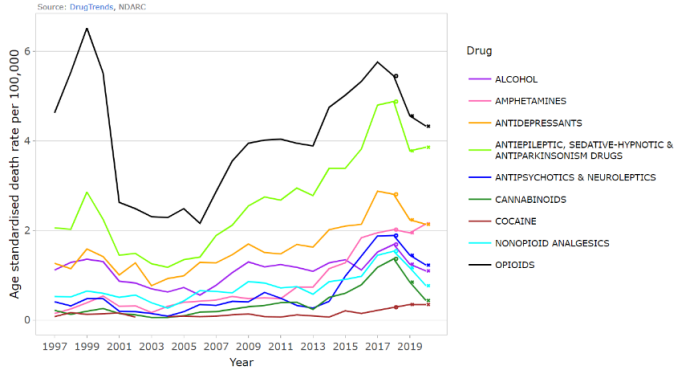


Opiate reductions liberated 75,000 families

In 1998, the Australian Federal Government introduced a drug policy titled Tough on Drugs which heavily reduced heroin use in the country. Estimates are that the dependent heroin using population reduced by two thirds as deaths from heroin plummeted from 1,116 in 1999 to an average 360 deaths from 2000 to 2007. At that time a change of government saw drug use increase once again such that deaths from opiates sharply rose to present day levels.

Clearly, the drug prevention priorities of Tough on Drugs saw 75,000 Australian families freed from the harms inflicted upon them by drug abuse.

Figure 14. Age-standardised rate per 100,000 people of drug overdose deaths for the Australian population, by drug class, 1997-2020.



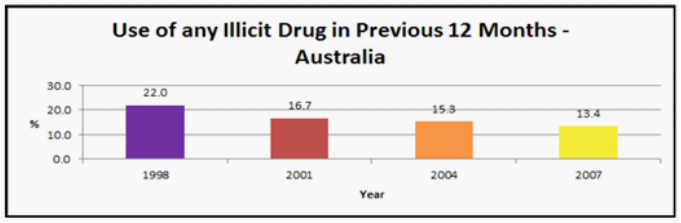
Australia's Tough on Drugs - use down 42%

Compare the results of Australia's 'Tough on Drugs' strategy between 1998 and 2007 to those of Portugal in this document (Tough on Drugs was scrapped by the new Federal government of late-2007). The Tough on Drugs approach worked within an environment of States and Territories maintaining criminal penalties for use of all illicit drugs other than cannabis.

On the below figures for Australia, drug use declined 39% during the Tough on Drugs era, but when Portugal's use is compared drug for drug with Australia, Tough on Drugs reduced the use of the particular drugs measured by Portugal by 42%. Again, this is within a criminalised regime where the threat of a criminal record has been used by drug courts to get users into rehab and treatment.

Table 2.1: Summary of recent[a] drug use, people aged 14 years or older, 1993 to 2010 (per cent)

Drug/behaviour	1993	1995	1998	2001	2004	2007	2010
Illicit drugs (excluding pharmaceuticals)							
Cannabis	12.7	13.1	17.9	12.9	11.3	9.1	10.3
Ecstasy[b]	1.2	0.9	2.4	2.9	3.4	3.5	3.0
Meth/amphetamines[c]	2.0	2.1	3.7	3.4	3.2	2.3	2.1
Cocaine	0.5	1.0	1.4	1.3	1.0	1.6	2.1
Hallucinogens	1.3	1.9	3.0	1.1	0.7	0.6	1.4
Inhalants	0.6	0.4	0.9	0.4	0.4	0.4	0.6
Heroin	0.2	0.4	0.8	0.2	0.2	0.2	0.2
Ketamine	n.a.	n.a.	n.a.	n.a.	0.3	0.2	0.2
GHB	n.a.	n.a.	n.a.	n.a.	0.1	0.1	0.1
Injectable drugs	0.5	0.5	0.8	0.6	0.4	0.5	0.4
Any illicit[d][e][g]	14.0	16.7	22.0	16.7	15.3	13.4	14.7



Australia has demonstrated that drug use can be markedly reduced if politicians just have the will.

Opiate increases afflict 104,000 new families

From the 37,000 families still affected by heroin use in the year 2007, dependent opiate use mushroomed to 5.75 per 100,000 for the 24.6 million Australians in 2017, or more than 141,000 families. This represents an increase of 104,000 families over that 10 year period.

These increases are clearly unacceptable, and the result of drug liberalisation over the intervening years since 2007.

It must be kept in mind that this number only reflects heroin use, and not all the other illicits displayed in the graph (at left).

International drug policy has lost its way

Sharp increases in drug use have occurred in many Western countries, where the US now has in excess of 107,000 overdose deaths per annum in August 2022 and rising precipitously.

Taking the attitudes of Australians, where 99% of 25,000 Australians surveyed in 2019 did not approve the regular

use of heroin, ice and speed, 98% did not approve the use of cocaine, 96% the use of ecstasy and 80% the recreational use of cannabis, it is clear that government liberalisation of drug policy is out of step with the general population's attitudes towards illicit drug use.

With so many families so severly affected by the burgeoning use of illicit drugs, it is time for the international community to once again get serious about illicit drug use.

The United Nations needs to return to the successful strategies of the initial Drug Conventions, and no longer take any money from vested interests with pro-drug-use sensibilities.

Legalisation multiplies harms

CASE STUDY - USA

The legalisation of cannabis for recreational use in the USA commenced in mid-2013 when Colorado and Washington State put changed drug policy legislation into effect.

This chapter will examine the increased use and cannabis-related hospitalisations, road deaths and suicides in Colorado, where the statistics have been closely monitored, treating them as normative for other US States and indeed for any other country that wants to replicate these policies.

2009 Colorado commercialises medical cannabis

In *2009* Colorado commercialised medicinal cannabis, making it very easy for citizens within that State to be able to obtain a prescription for cannabis, resulting in burgeoning use and harms from that year on.

The number of cardholders ballooned in 2009 from the 4,800 prior to that year to more than 41,000, with 250 medical dispensaries operative. By mid-2010 there were over 900 unlicensed cannabis dispensaries.

Colorado legalises recreational use in 2013

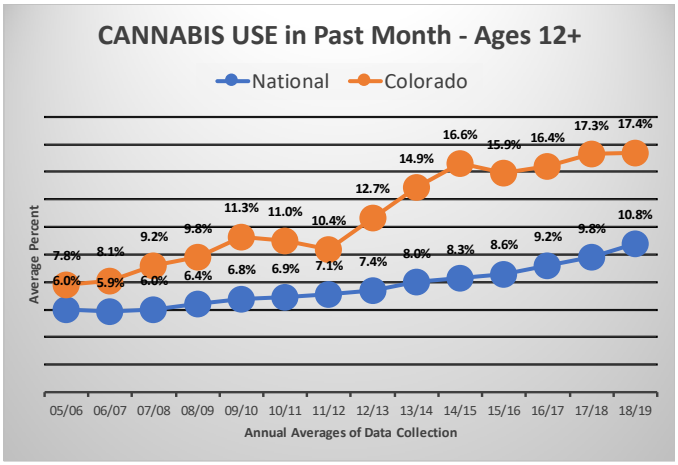
Commercialisation was a precursor to the legalisation of recreational cannabis use which effectively commenced mid-2013.

An acceleration of harm

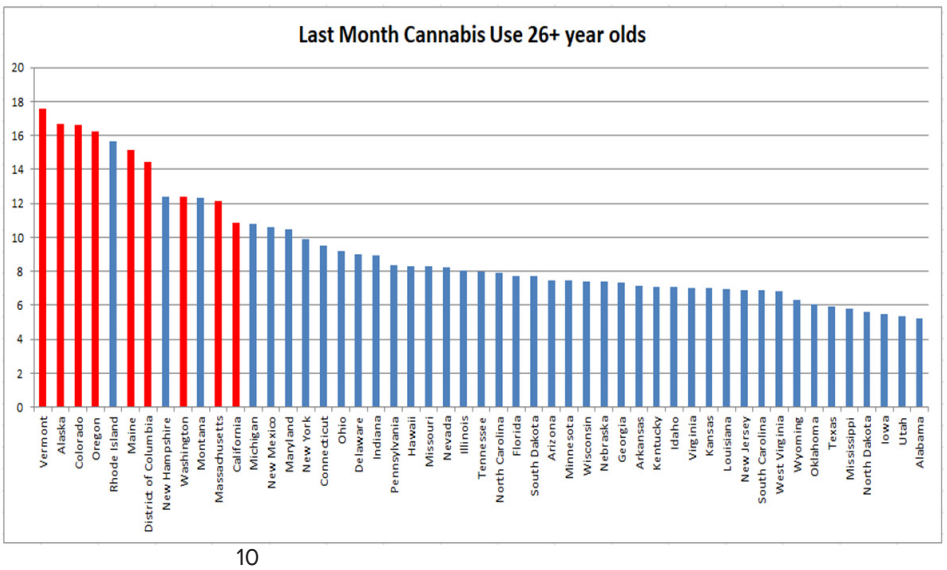
Thus significant increases in use, hospitalisations, road deaths and suicides are seen from 2009 on, and most indicators accelerating from 2013 on. This can be observed in the graphs below.

Cannabis use in past month

Use of cannabis in the month before survey indicate an acceleration in the year that Coloradans voted for the measure (2012), a trend that is seen in other jurisdictions that have liberalised drug laws (red bars on graph below). That acceleration moderated by 2016, but increases were nevertheless maintained.



Note that the very modest increases of cannabis use for the entire US - the blue trend line above - began to also accelerate as other States joined Colorado and Washington. This effect can be seen with the red-bar legalisation States in the 2016 graph below.

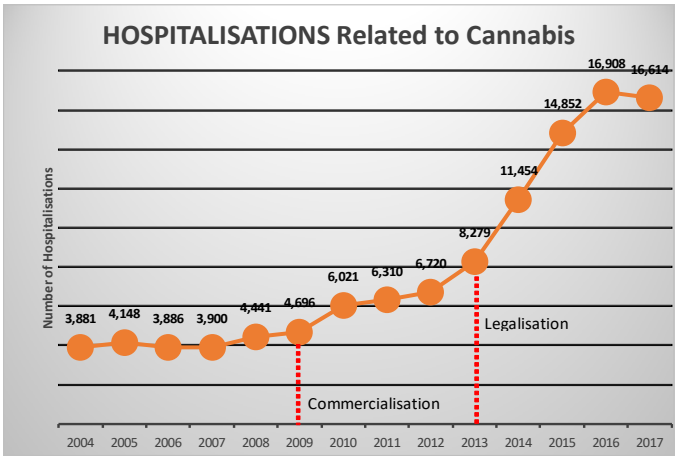


Colorado, which had previously led all other US States for cannabis use, had by 2016 slipped to number 3 as other US States Vermont and Alaska introduced recreational cannabis legalisation.

Use by adults over the age of 25 doubled in the first 2 years of legalisation, with increases in use by those 17 years or younger and by college-age adults being somewhat more modest.

Hospitalisations related to cannabis up 360%

The accelerations in use by the various age categories in Colorado were matched by increases in hospitalisations related to cannabis as per the graph below.



From commercialisation of medical cannabis in 2009 through to a peak in hospitalisations in 2016 there was a 360% increase, which represents substantial levels of harm as a result.

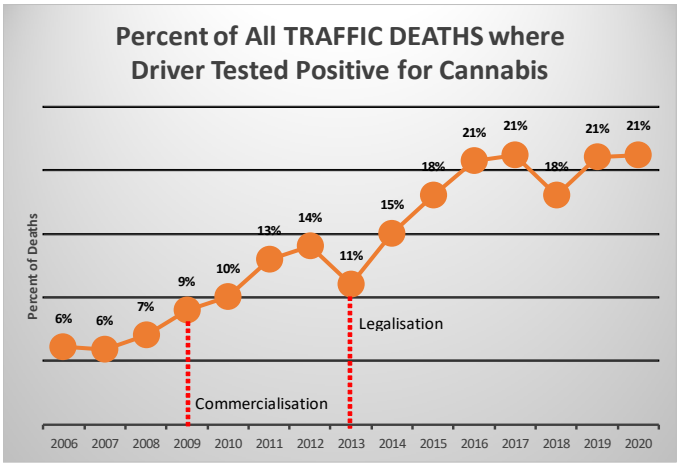
We note the above figures are not population adjusted, where population increased 16% from 2009 through 2020.

Cannabis-related traffic deaths up 230%

Traffic deaths where the driver tested positive for cannabis likewise saw very significant increases, up 230% by 2020.

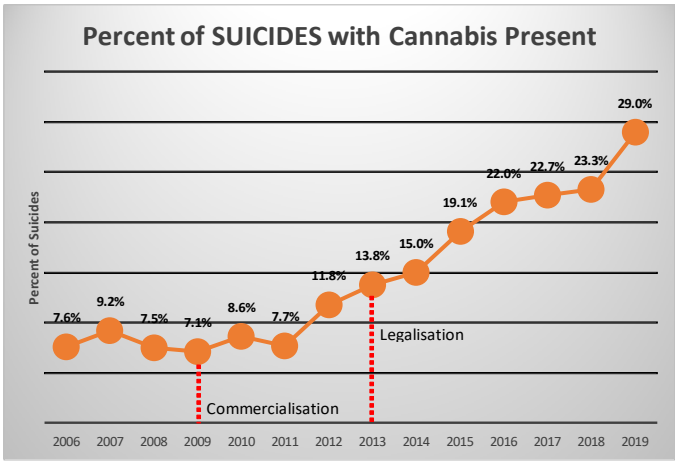
From 2013 and its introduction of legalised recreational use there was a 138% increase in traffic deaths against a 29% increase in traffic deaths overall.

This represents significant community harm.



Cannabis-related suicides up 410%

Suicides in which cannabis was present increased substantially, representing a 410% increase from commercialisation through to 2019. It must be noted that there is a very well-evidenced literature describing a relationship between cannabis and suicide.



Loose medical cannabis laws like full legalisation

US statistics show how recreational users have been able to use medical cannabis availability for self-reported 'pain' to feed their recreational use. For instance, 90% of medical cannabis patients in Arizona claim pain as their malady, while 4% use it for cancer. In Colorado, it is 94% for pain and 3% for cancer, while in Oregon 94% claim to use it for pain. Only 2% of patients across 7 US states in 2014 used cannabis for verifiable illnesses such as AIDS wasting or MS.

OVOM notes that there are no laboratory tests for pain, which makes it a prime candidate for ruse and deception due to its subjective nature and the impossibility of objectively verifying or disproving it.

There are well established profiles for patients of chronic pain across all Western countries, where patients are more predominantly women and those aged 60 and above. For instance, a 2001 study by Sydney University's Pain Management Research Centre found 54% of patients were women, with men suffering in their sixties and women in their eighties.

Yet the profile for medical cannabis pain patients in the USA is very different. A 2007 study of 4,000 medical cannabis patients in California found that their average age was 32, three quarters were male and 90% had started using cannabis while teenagers, an identical age and gender profile to that of recreational users across the US.

This discordant profile means that medical cannabis in the various states of the US has mainly amounted to a quasi-legalisation strategy for recreational use of cannabis via subterfuge and ruse.

Cannabis black market still exploded

Colorado's legislative House Bill 1221 was introduced in 2017 to address a 380% rise in arrests for black market grows between 2014 and 2016.

Decriminalisation multiplies harms

CASE STUDY - PORTUGAL

2001 - Portugal decriminalises use of all drugs

Portugal decriminalised all illicit drug use as of July 2001 and since that time drug decriminalisation/legalisation activists have inundated politicians and the media with glowing reports of Portugal's touted 'success', selectively using data with no context rather than giving the full picture.

The reality, is anything but glowing, and this chapter will use Portugal's own official data which is sent to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), as is done by all countries in the European Union. These are, of course, the same statistics used for the yearly United Nations World Drug Report drug use tables.

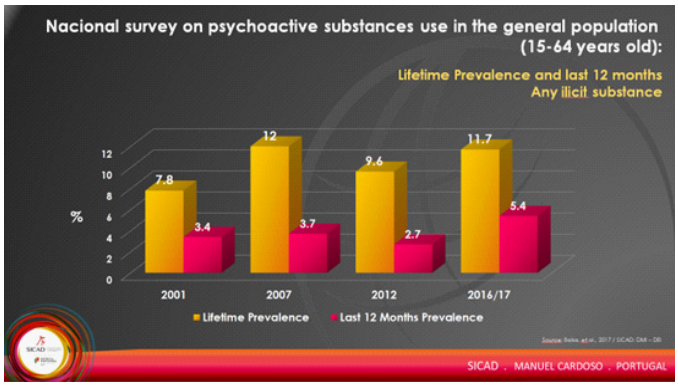
Data in this chapter is drawn from previous REITOX reports which are found on the EMCDDA website, recognising that population surveys are only done every 5 years in Portugal, with the last available survey from 2016. 2021 survey statistics are not likely to be published until 2024, given a similar lag in time to publish the 2016 statistics.

Further, the previous REITOX report format for European countries appears to no longer be available on the EMCDDA website, and relevant statistics in the last few years are best obtained from the Statistical Bulletin published on the EMCDDA website annually.

Drug use increased 59% by 2016

The EMCDDA drug use statistics for Portugal, where the percentage of adults aged 15-64 over the 12 months before survey are the most relevant, indicate increases from 3.4% in 2001 up to 5.4% in 2016, an increase of 59%.

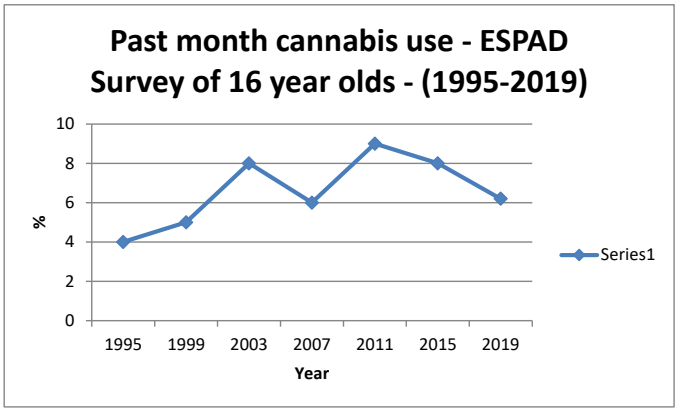
Unfortunately, the current Statistical Bulletins fail to provide comparative longitudinal data for drug use since 2001, which can be found in old REITOX reports for earlier years or on the Powerpoint graph below which was part of a presentation at a Sydney NADA Conference by Portugal's Manuel Cardoso, who is part of the management at their SICAD agency.



It is self-evident that a drug policy which commits to dissuasion of drug use has as its aim the reduction or elimination of drug use, rather than its proliferation, but the latter is clearly the case for Portugal.

Increased drug use by High School minors

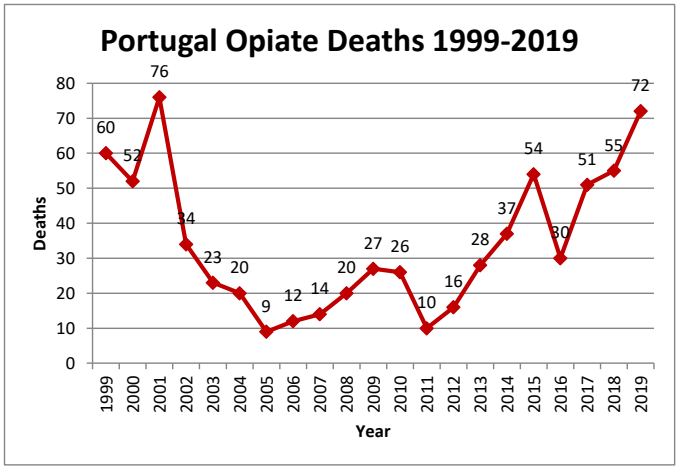
The ESPAD survey of cannabis use (last 30 days before survey) for 16 year old high-school students shows increases in use of the drug from 1999, a couple of years before decriminalisation, through to 2019. After substantial increases of 80% by 2011, and still up 60% by 2015, the 2019 figure is still 24% above the pre-decriminalisation level.



Overdose deaths as a proxy for opiate use

The EMCDDA Statistical Bulletins in previous years have displayed the drug overdose deaths for Portugal with mortality figures only available since 2002. Since 2019, though, the Statistical Bulletins have displayed mortality data for three extra years 1999-2001.

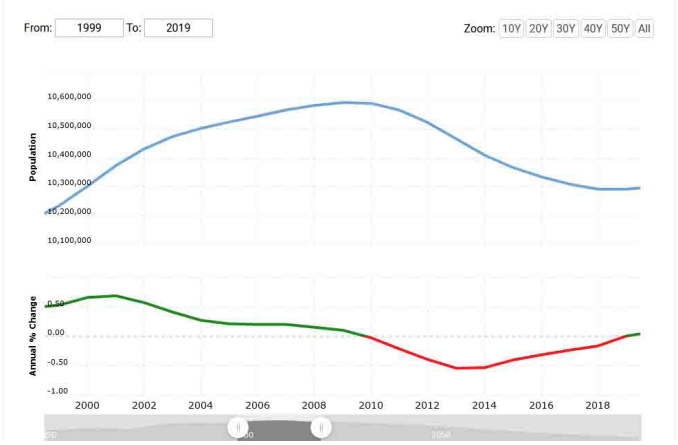
Below is a graph of their overdose mortality.



There are two things immediately evident from a glance at this graph.

1. Portugal's policy has failed to reduce opiate deaths with levels in 2019 the same as before decriminalisation, where average deaths for 1999-2001 were 63 annually
2. After drug policy successes in reducing heroin use since 1999, successes which clearly preceded the 2001 decriminalisation policy and then maintained those policies in the decriminalised environment through 2005, Portugal's drug policy regime appears to have persuaded, not dissuaded, citizens since 2005 to initiate more opiate use.

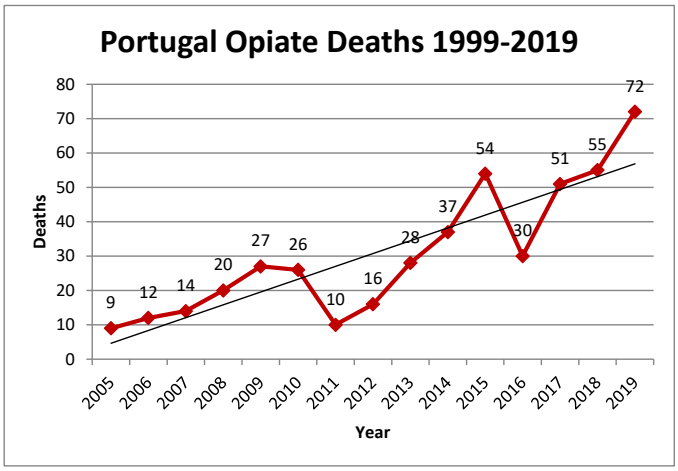
Given the caveat that Portugal's population in 2019 was almost identical to 1999, any *per capita* comparisons of overdose data are superfluous. In 1999 the population was 10,234,000 and in 2019 10,290,000 according to population websites - so roughly the same.



Portugal's increasing trend in deaths since 2005 undoubtedly reflects rising drug use, but more particularly rising opiate use moving back to the levels in the late 1990s when Portugal had the highest opiate use amongst OECD countries. It was these alarming levels that prompted Portugal to propose an alternative drug policy. Thus decriminalisation has recreated the central Portuguese dilemma of very high opiate use.

If the dictum - that high opiate overdose levels are an indicator of high opiate use - is questioned, it must be stated that drug overdose deaths do in fact closely correlate to levels of rising opiate use worldwide. Here explanation is needed.

There is a reasonably inelastic relationship between opiate use and opiate deaths, where typically 1% of drug users who inject opiates will fatally overdose each year. In fact, so solid is the correlation between the percentage change in *overdose* and the percentage change in *use* that Australia in 2000 used the correlation to estimate the number of dependent heroin users in the country for the year 1998.



Such an inelastic correlation between overdose deaths and use necessarily rejects as myth those false objections raised by the drug legalisation lobby - that overdoses are chiefly the result of varying heroin purity levels or otherwise the result of heroin being 'cut' with dangerous and deadly substances. An Australian Government Monograph demonstrated this to be wholly false, with most overdoses the result of polydrug use or alternatively opiates being used with alcohol, another depressant. This correlation is held to still hold even if opiate users in Portugal snort or smoke heroin, which yields far fewer deaths than injecting.

Compared to Australia's overdose mortality figures the most obvious factor for the lower rate of overdose deaths per million population in Portugal is that only 18% of heroin users inject heroin whereas most heroin users in Australia inject. Users who smoke or snort their opiates do not run the same risks of overdose as injectors.

Portugal high in EU wastewater drug reports

Wastewater data is collected on 104 cities throughout the European Union and published on the EMCDDA website. The study tracks particular illicit drugs which are:

- cannabis
- cocaine
- MDMA
- Amphetamine and Methamphetine

- Ketamine

It is notable that Portugal is named in the last March 2023 report as amongst the countries with highest wastewater detections for four of the five illicit drugs measured.

Directly from the report:

*The BE loads observed in wastewater indicate that **cocaine** use remains highest in western and southern European cities, in particular in cities in Belgium, the Netherlands, **Portugal** and Spain.*

*The highest mass loads of **MDMA** were found in the wastewater in cities in Belgium, Czechia, the Netherlands, Spain and **Portugal.***

*The highest mass loads of the **cannabis** metabolite THC-COOH were found in wastewater in cities in Czechia, Spain, the Netherlands and **Portugal.***

*For the first time, **ketamine** loads are being published. The highest mass loads were found in the wastewater in cities in Denmark, Italy, Spain and **Portugal.***

This data suggests that Portugal's illicit drug use may be higher than acknowledged. EMCDDA data indicates that Portugal's surveyed cannabis use is in the lowest 50% of European countries, its cocaine use in the lowest 15%, and ecstasy use in the lowest 10%. Of course, it must be recognised that wastewater analyses are limited to cities and not country areas, which may modify conclusions. However, 67% of Portugal's population lives in cities, so substantial increases in illicit drug use under decriminalisation cannot be dismissed.

Dissuasion policy not working

It is abundantly clear that both the premise and objective of Portugal's policy of dissuasion is decreased drug use. This is beyond debate. Dissuasion of drug use necessarily implies that illicit drug use is a behaviour which has negative consequences for the drug-using individual and the community that permits their drug use.

The following graph displaying numbers of users coming before dissuasion committees supports the statistics of rising drug use in Portugal under the decriminalisation regime. While it is difficult to make conclusions about the early years of dissuasion due to the policy being only newly implemented and still finding its way, the accelerating increases from 2010 to 2017 signals that illicit drug use may likewise be accelerating. No conclusions can be definitively made until the 2021 survey results are released.

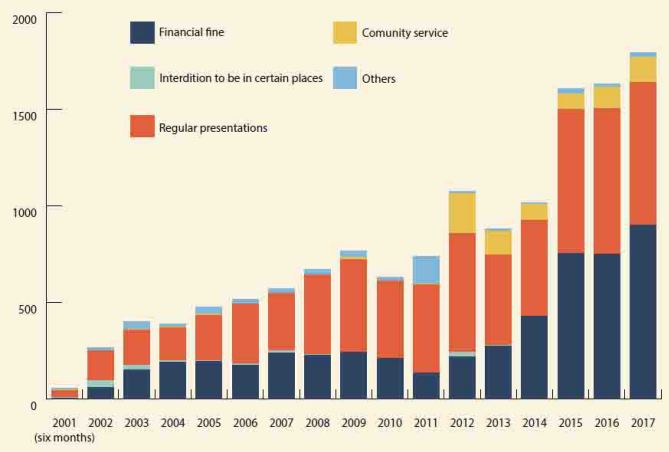
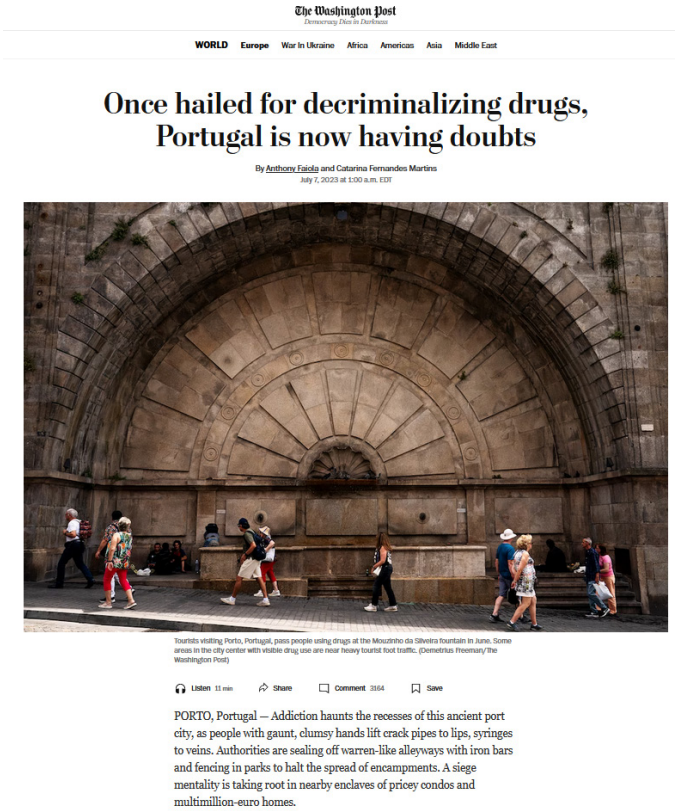


Figure 4. Type of sanction 2001-2017

Portugal fails on its own premise

Portugal has failed on its own premise of dissuasion and is now being deserted by once-faithful advocates of their policy such as the Washington Post.


The Washington Post
Democracy Dies in Darkness

WORLD Europe War In Ukraine Africa Americas Asia Middle East

Once hailed for decriminalizing drugs, Portugal is now having doubts

By Anthony Faiola and Catarina Fernandes Martins
July 7, 2023 at 1:00 a.m. EDT

Tourists visiting Porto, Portugal, pass people using drugs at the Mouzinho da Silveira fountain in June. Some areas in the city center with visible drug use are near heavy tourist foot traffic. (Demetrius Freeman/The Washington Post)

Listen 11 min Share Comment 3164 Save

PORTO, Portugal — Addiction haunts the recesses of this ancient port city, as people with gaunt, clumsy hands lift crack pipes to lips, syringes to veins. Authorities are sealing off warren-like alleyways with iron bars and fencing in parks to halt the spread of encampments. A siege mentality is taking root in nearby enclaves of pricey condos and multimillion-euro homes.

The international community needs to condemn drug decriminalisation as a policy of quasi-legalisation, where turning a blind eye to the harms of drug use will only increase those harms, at first moderately, then exponentially as is now happening in Portugal.

In 2024 each country must reaffirm their commitment to the Conventions, not to the failed policies of legalisation, decriminalisation or indeed harm reduction.

Harm reduction multiplies harm

CASE STUDY - RETURNING TO AUSTRALIA

Harm Reduction defined

The International Harm Reduction Association (IHRA) defines Harm Reduction as follows:

*Harm reduction refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, **rather than on the prevention of drug use itself**, and the focus on people who continue to use drugs.*

Australia's drug policy 1985 to now

Australia's drug policy has had three differing periods:

1985-1998	- Harm Minimisation
1998-2007	- Tough on Drugs
2007-present	- Harm Minimisation

As can be seen from the graph below the harms of heroin accelerated from 1985-1998 where harm reduction received significantly more drug policy emphasis than prevention. When Tough on Drugs was introduced in 1998, prevention took precedence over harm reduction programming, particularly in public advertising. Then in 2007, a new Federal Government scrapped the stronger prevention emphasis for one that more heavily promoted harm reduction.

In the official Australian drug-related mortality graph below, it is very evident that its Harm Reduction policy, whenever ascendent over Drug Prevention, was a tide that lifted all boats, with deaths from every illicit drug, including legal alcohol, sharply increasing. In the absence of any viable confounder, this suggests Harm Reduction policies as causal.

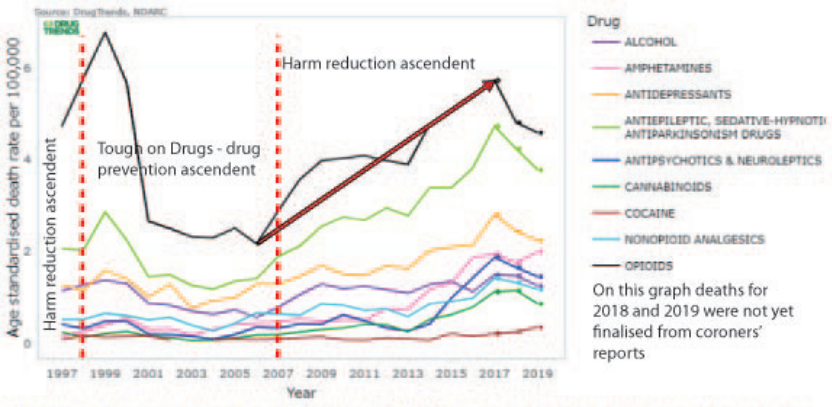
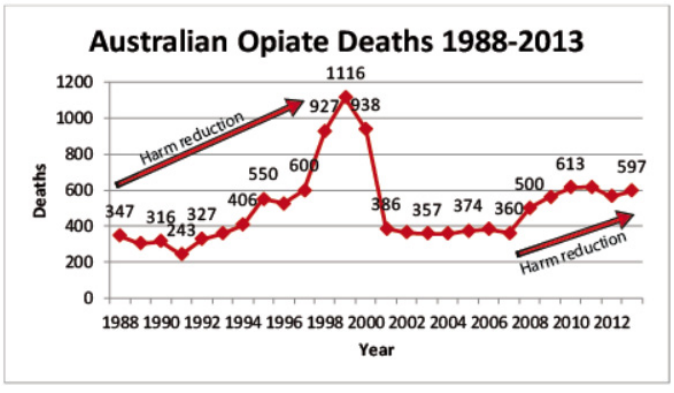


Figure 9. Age-standardised rate (per 100,000 people) of drug-induced deaths for the Australian population, by drug class, 1997-2019.

Causes of death data for 2017, 2018 and 2019 are not final and subject to further revision. The symbol 'o' indicates revised estimates and 'x' preliminary estimates. One drug-induced death may involve multiple drugs and the findings here reflect the number of drug-induced deaths involving each drug (not necessarily attributed primarily to that drug).



Harm reduction multiplied individual harm

As previously discussed in this document, harm reduction policies saw increases in Australian heroin use, peaking at 112,000 dependent users by 1999. As Tough on Drugs prevention methods were implemented, dependent user numbers had shrunk to 36,000 by 2002, a level maintained through 2007.

By 2020 harm reduction policies teamed with inadequate prevention measures, saw another 104,000 new opiate users added to the Australian population. Thus harm reduction policies TRIPLED the number of drug users and likewise tripled the gross level of harm inflicted on those individuals

and their community. Add to that the constellation of people harmed around each individual user.

The false economy of harm reduction

Taking the previous drug policy eras:

1985-1998 - opiate users number 112,000
1998-2007 - opiate users **down** to 36,000
2007-2020 - opiate users **up** numbering 141,000

In 2007 there were 36,000 opiate users susceptible because of their drug use to HCV, HIV, opiate related mortality,

Table 2.1: Summary of recent[a] drug use, people aged 14 years or older, 1993 to 2010 (per cent)

Drug/behaviour	1993	1995	1998	2001	2004	2007	2010
Illicit drugs (excluding pharmaceuticals)							
Cannabis	12.7	13.1	17.9	12.9	11.3	9.1	10.3
Ecstasy[b]	1.2	0.9	2.4	2.9	3.4	3.5	3.0
Meth/amphetamines[c]	2.0	2.1	3.7	3.4	3.2	2.3	2.1
Cocaine	0.5	1.0	1.4	1.3	1.0	1.6	2.1
Hallucinogens	1.3	1.9	3.0	1.1	0.7	0.6	1.4
Inhalants	0.6	0.4	0.9	0.4	0.4	0.4	0.6
Heroin	0.2	0.4	0.8	0.2	0.2	0.2	0.2
Ketamine	n.a.	n.a.	n.a.	n.a.	0.3	0.2	0.2
GHB	n.a.	n.a.	n.a.	n.a.	0.1	0.1	0.1
Injectable drugs	0.5	0.5	0.8	0.6	0.4	0.5	0.4
Any illicit[d][g]	14.0	16.7	22.0	16.7	15.3	13.4	14.7

criminality and poor state of health. Under the harm minimisation policies from 2007 the number suseptible to these unacceptable harms was by 2020 141,000, adding a significant burden to health care facility.

If harm reduction increases overall drug use and associated harms, then the obviously increased nett harms outweigh any supposed benefit. This leads to a situation where Harm Reduction gives with one hand and takes with two others. Thus harm reduction is a false economy that increases overall the very harms it claims to alleviate.

Disinterested in the harm inflicted on others

The afore-cited IHRA statement reflects that Harm Reduction has no interest in, or even understanding of the harm inflicted on the whole constellation of people around a given drug user. It rather pretends that the harms of illicit drugs are private, contained to the individual user alone. Looking with tunnel vision at the self-inflicted harms of the user and funneling out the harms on those around each individual, harm reduction wilfully ignores the societal impact of drug use.

1 million less families affected by cannabis

Going back to the Australian success of Tough on Drugs, 17.9% of the population was using cannabis in 1998, reducing under the prevention approach to 9.1% by 2007. There were approximately 1.1 million less cannabis users due to Tough on Drugs, and potentially 1 million less families affected.

The harms of cannabis summarised

Gone are days when cannabis could be characterised as relatively harmless. In 2024 the science on cannabis has advanced to a point where the most sensible harm reduction measure is to not use cannabis at all.

The current science drawn from multiple medical journal studies show that cannabis is:

- causal in 33 cancer types, double that of tobacco - 14
- casual in 70% of pediatric cancer types
- causal in 89 of 95 birth defects
- ageing users at age 30 by 30%
- causal in psychosis, violence, suicide
- passes mutations epigenetically on to 3 or 4 generations of a user's progeny

Harm reduction is named as such because it seeks to eliminate unacceptable harms caused by illicit drugs. All of the above are unacceptable harms. Prevention of cannabis use will shield millions from these harmful impacts.

Prevention - 1 in 4 Australians saved the grief

Given a conservative 5 people in the constellation of harm around each cannabis user, around 5 million Australians were saved the grief of the effects of cannabis use, or one in every 4 Australians by 2007 according to population figures.

By contrast, harm reduction policies had presided over an ever-increasing use of cannabis which went from 12.7% in 1993 to 17.9% in 1998. Tough on Drugs intervened while the trajectory was still steeply moving upwards. As with previous use of the similarly dangerous tobacco in the 1960s, where 70% of the male population were willing users, the upper limit for cannabis could have been significantly higher than in 1998 and many more Australians drawn into the vortex of harm.

The failure of harm reduction interventions

The current science gives a very poor accounting of the various harm reduction interventions which include:

- needle and syringe programs (NSPs)
- opioid substitution therapy (OSTs)
- supervised injection facilities

The 2009 Cochrane Collaboration review of opioid substitution therapy found that it *fails* to reduce overdose mortality, criminality and HIV - the very harms it seeks to alleviate. The world's most authoritative review of NSPs by the 2006 US Institutes of Medicine found that the evidence for NSP effectiveness with HIV was 'limited and inconclusive.'

The 2017 Cochrane Collaboration review of NSP and OST effectiveness in reducing HCV transmission made their conclusions from 17 studies judged to have a serious risk of bias, a further 7 with critical risk of bias and only 2 with a moderate risk. The findings, which were deemed positive regarding effectiveness in reducing HCV, were covered with this disclaimer, "According to Grades of Recommendation Assessment, Development and Evaluation (GRADE) criteria, the evidence on OST and combined OST/NSP is low quality, while NSP is very low."

The world's only review of supervised injection facilities that examined only studies with an acceptable rigour of quasi-experimental designs relied on a Lancet study for a positive finding regarding these facilities reducing mortality. This review failed to recognise that the Lancet study had been shown in 2012 to be either inept or fraud, using a false

baseline to manufacture a positive result.

The same reviewers failed to recognise that the only other study reporting success - on reductions in ambulance callouts - had data showing that there were greater reductions at night when that injecting room was closed, falsifying any claims to the injecting room being responsible for reductions.

A survey of the most comprehensive injecting room evaluations shows that they uniformly have overdoses 63-102 times higher in the facility than on the street, with ex-clients explaining that the high overdoses are due to experimentation with polydrug cocktails in the safety of these facilities. This is assuredly multiplying harms.

They also fail to improve public amenity without substantially increased policing, and fail to reduce blood-borne viruses. They generally have very poor referral to treatment.

Conclusion

Harm reduction fails on all metrics of efficacy, while substantially increasing drug use, increasing rather than decreasing the nett harms from illicit drug use.