

# Is the Howard Government tough on drugs?

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Surely the Howard Government is 'tough on drugs'! The Prime Minister has used this very phrase repeatedly, unambiguously and emphatically to describe his government's approach to illicit drugs. Also, Mr Howard has often described his personal attitude to illegal drugs as 'zero tolerance'. After a 6:3 majority of the Ministerial Council on Drug Strategy supported a scientific trial of prescription heroin in July 1997, Mr Howard intervened personally to stop the trial on the grounds that this research would 'send the wrong message'. The Prime Minister has subsequently rarely missed an opportunity to denounce heroin trials or any other highly visible symbols of pragmatic approaches to drugs.

Following the spirited public debate about the blocking of the heroin trial research, the Howard Government launched a new drug policy entitled 'Tough on Drugs'. The emphasis on law enforcement efforts to restrict drug supply was increased. Major Brian Watters, a zealous supporter of drug law enforcement and zero tolerance, was appointed chairman of the newly established Australian National Council on Drugs. In 1999 Mr Howard also passionately attacked proposals to establish medically supervised injecting rooms in New South Wales, Victoria and the Australian Capital Territory. Several senior ministers began to frequently support a hardline approach to illicit drugs, claiming—incorrectly—that harm minimisation was no longer the official national drug policy.

In 2001 the Prime Minister allocated \$27 million to support the development of a retractable needle and syringe. This was later reduced to \$17 million after the 2001 election. Presumably the notion was that if retractable injecting equipment with the required technical features could be identified, needle and syringe programs could be dispensed with. Four years later, little of this funding has been spent. As in previous attempts to find this Holy Grail, progress has been very limited. A round of (still unpublished) consultations confirmed a conviction

widespread among public health practitioners and drug users that this was a futile, expensive and basically ideological exercise.

These are, undoubtedly, formidable arguments that the Howard Government really is 'tough on drugs'. Of course, when it comes to the legal drugs alcohol and tobacco, responsible for 97% of drug-related deaths in Australia, it is hard to find any evidence of a 'tough on drugs' approach. But to find out what governments are really doing, as opposed to what they say they are doing, we have to look at their actions rather than just their words. Just as with drug traffickers, trying to follow the money trail is one of the best ways to establish what governments actually do about drugs.

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The Howard Government cut funding for law enforcement (including drug law enforcement) soon after coming to office in 1996. The 1996–97 federal budget included a \$22.2 million (6.9%) reduction in funding for the Australian Federal Police, while the 1997–98 budget included a 4% reduction in funding for the Australian Federal Police and the National Crime Authority. The extent to which these budget cuts affected drug law enforcement is difficult to ascertain but there is no doubt that financial support for the control of supply was reduced considerably. As part of the 'tough on drugs' policy, the Howard Government later provided a \$203

million funding enhancement for drug law enforcement. However, it is unclear how this funding was allocated or the duration of the expenditure. Although it may seem self-evident that the relative allocation of government expenditure on different responses to illicit drugs would be of considerable interest, the most recent available figures date from 1992 (Collins & Lapsley, 1996) and indicate that 84% of Commonwealth and state government expenditure was then allocated to supply control, 6% to drug treatment and 10% to prevention and research. There are no data from the Howard era to indicate whether this allocation has been changed.

Few people know of a funding enhancement to needle and syringe programs, provided through the states and territories, which commenced in 1999 and is still operating, though never announced to the public. It followed a searching review of the evidence which demonstrated that financial support for needle and syringe programs was a sound investment for public health and public finances. In a well-publicised policy initiative, the Howard Government has allocated to the states and territories more than \$200 million from 1999 to encourage diversion of drug users from the criminal justice system to drug treatment. The Howard Government has also strongly supported the adoption of harm reduction programs by Asian countries in response to the immense health, social and economic threat of HIV infection among and from injecting drug users. This could not have happened without the strong personal support of the Minister for Foreign Affairs.

The discreet increased funding for needle and syringe programs, diversion of drug users from the criminal justice system to drug treatment, and support for harm reduction in Asia are responsible, evidence-based and praiseworthy measures, but these policies are all irreconcilable with zero tolerance. The only conclusion that can be reached is that the Howard Government supports zero tolerance as a political strategy but supports harm reduction as a public policy. The major

difference between the drug policy pursued by the Howard Government and that of the Australian Labor Party (when in government and opposition) has been political marketing. The Howard Government has been conscious of the views of its constituency and the need for 'product differentiation'. Recognising the now overwhelming evidence supporting harm reduction, the Howard Government has supported policies irreconcilable with zero tolerance because to do otherwise would be to neglect its public health and financial responsibilities.

The heroin shortage that began in 2001 has been claimed as another victory for drug law enforcement, although this disregards the 80% reduction from 1996 of heroin production in Burma, source of most of the heroin reaching Australia. No Commonwealth government, including the Howard Government, wants to go down in history as responsible for the HIV epidemic that Australia does not have to have. It should be some consolation to public-health-minded members of the community that a politician who prides himself on being the most conservative prime minister Australia has ever had is the one who retained harm reduction as his government's public policy.

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# The effects of 'tough on drugs' policies

## Article summaries by Dean Murphy

### SRB 7/001

Brook, H. (2002). Governing failure: Politics, heroin, families. *International Journal of Drug Policy*, 13, 175–184.

Starting from a critique of Howard's 'Tough on Drugs' campaign, Brook takes a look at the way families have been recruited to address the use of heroin and other drugs. Then, by drawing an analogy between divorce and heroin use, she presents an alternative way to think about governing heroin use in Australia. Her contention is that there are certain similarities between the way family breakdown was managed before the Family Law Act (1975) and the way heroin use is currently managed. Before 1975 divorce was seen as an inherently harmful social evil but one which was preventable, even if only through adversarial law which allocated fault, guilt, blame and punishment. Changes to the law revealed a shift in emphasis from prevention to management. That some marriages would break down was seen as inevitable and the changes to law were intended to manage the results of that breakdown; this could be thought of as a harm reduction approach to divorce. Nowadays, marriage and divorce are seen as private, personal matters, the government of which has shifted to a self-regulatory mode. This has also led to a shift in the way divorced people are understood by others and themselves. Drug use, however, is still currently articulated as a public problem concerning law and order, public health and national morale. Heroin itself is demonised and those that are contaminated or corrupted by it are seen as objects of terror and contagion. Brook suggests that a move from public opprobrium to a more self-regulatory approach is needed in the management of illicit drug use.

### SRB 7/002

Buchanan, J., & Young, L. (2000). The war on drugs—a war on drug users? *Drugs: Education, Prevention & Policy*, 7, 409–422.

Instead of being recognised as a complex social issue, the consumption of drugs has been presented in a reductionist framework in the United Kingdom since the 1980s, argue Buchanan and Young. This has encouraged strong disapproval of drug use and drug users. The policy of prevention, prohibition and punishment has resulted in the wholesale criminalisation of major sections of society (especially those under 25 years) and locked long-term drug users into a process of stigmatisation, marginalisation and social exclusion. Buchanan and Young draw on three qualitative studies, with a total of 200 drug users, that were conducted in Merseyside between 1995 and 1998. These studies focused on what users said about the barriers they faced and what assistance they needed to recover and

reintegrate into the 'wider community'. Many drug users felt rejected and stigmatised by non-drug-users, which led to a sense of isolation and detachment. Relationships with family members other than their children tended to be rated as barely OK. Drug agencies, however, tended to focus on achieving control rather than on social reintegration. The authors present a five-phase reintegration model (chaos, ambivalence, action, control, reorientation and reintegration) which includes a wall of exclusion between the control and reorientation phases. This wall works to separate and isolate problem drug users and is supported by a drug strategy that portrays all drug users as addicts or criminals. They argue that this wall is a contributing factor to relapse.

### SRB 7/003

Bullington, B. (2004). Drug policy reform and its detractors: The United States as the elephant in the closet. *Journal of Drug Issues*, 34, 687–721.

The United States has succeeded in establishing an international drug control regime that reflects its stated prohibition model, according to Bullington in this paper on the influence of the United States in international treaties and the policies of individual countries, especially in instances where countries have attempted to develop alternative approaches that varied from the prohibitionist policy. He suggests, however, that the growth of harm reduction measures in Europe and elsewhere poses a threat to the existing control regime.

The United States has long dominated international drug policy, with a resulting emphasis on restricting organic drug substances (cannabis, coca leaf and opium) rather than synthetic drugs, and on issues of supply (production, distribution and sales) rather than features of demand such as prevention treatment and education. The paper gives four examples of United States pressure on individual nations to alter their policies or cease experiments that were seen as too liberal. The United States has long attacked the Netherlands for its approach to cannabis use. During the 1990s Switzerland's heroin trials also came under harsh attack from the United States, as did Canada's softening policy on cannabis. The proposed Australian Capital Territory heroin trial was scrapped by the federal government in 1997; the government refused to fund it or amend legislation to allow the importation of heroin for the trial. It is suggested that this action was influenced by United States threats to withdraw support for Tasmania's opium-growing industry if the trial went ahead.

Bullington concludes that, given the restrictions in place, there will not be any dramatic changes in individual countries' drug policies in the near

future but that some ‘wobble room’ has been found and so harm reduction methods will continue to be explored and refined within the existing arrangements. A more dramatic (albeit unlikely) scenario is that international drug prohibitionism could collapse under the weight of its own internal contradictions and its failure to deliver on its promises.

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#### SRB 7/004

Burris, S., Blankenship, K. M., Donoghoe, M., Sherman, S., Vernick, J. S., Case, P. et al. (2004). Addressing the ‘risk environment’ for injection drug users: The mysterious case of the missing cop. *Milbank Quarterly*, 82(1), 125–156.

Burris et al. apply an ecological analysis to risks associated with injecting drug use. They propose this analysis as a way of reframing the debate away from prohibition versus legalisation of drugs to one that focuses on the nature of policing. In particular the authors look at evidence demonstrating that criminal laws and associated law enforcement practices are significant factors in structuring the risks and practices of injecting drug users. Laws and policing practices influence the risk environment in a number of ways, from laws that make it illegal to carry injection equipment or prevent the delivery of services such as needle and syringe programs, to incarceration itself as a risk factor for disease. The authors also go on to outline a number of possible directions for research and interventions. They highlight the need for research on shaping the health of injecting drug users including research on: existing laws; management policies, procedures and training (e.g. the influence of drug tsars and racial profiling); police knowledge and attitudes towards users; and the experiences of users. In terms of interventions, targeting changes in these areas of the legal system will be as effective as, if not more effective than, helping injecting drug users cope with the risks they create.

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#### SRB 7/005

Drucker, E. (1995). Drug prohibition and public health: It’s a crime. *Australian and New Zealand Journal of Criminology*, 28, S67–73.

Hall, W. (1995). Variations in prohibition: Harm minimisation and drug wars in Australia and the United States. *Australian and New Zealand Journal of Criminology*, 28, S74–77.

Drucker’s paper is based on a presentation given in Sydney in 1994. In it he attempts to explain and justify the shift from a criminal model of illicit drug use to a public health model, primarily prompted by the advent of HIV/AIDS. Drucker notes that illicit drug injection was responsible for the rapid spread of HIV in some of the poorest communities of North and South America, Europe and South-East Asia, prompting a public health response. He argues that drug prohibition does little to discourage the trade in illicit drugs, the targeting of poor and marginalised communities as customers for these drugs, and the

demonisation of drugs and drug users. Drucker reflects on the situation in the United States and New York City, noting that poor ghetto communities in the Bronx sustain levels of HIV infection at around 10% to 20% of the adult population, are subject to vigorous anti-drug policing and prosecution, yet are neglected for HIV prevention and drug treatment services. Drucker goes on to advocate the widespread adoption of harm reduction policies (such as methadone maintenance and needle exchange) to counter the health problems associated with illicit drug use, despite the difficulty of implementing these policies in the United States.

In a short commentary on Drucker’s article, Hall observes that Australia has often been uncertain about adopting either a moralistic or therapeutic approach to illicit drug use. Noting the disastrous public health consequences of the ‘zero tolerance’ approach in the United States, Hall notes that Australia has avoided the worst consequences of the war on drugs by the adoption of a pragmatic form of ‘harm minimisation’ and by maintaining an ambivalence towards rigid prohibition. Hall suggests that the Australian policy approach was helped by bipartisan political cooperation in the 1980s and by the refusal of conservative politicians to make capital out of drug policy at the time. This allowed needle exchange and methadone programs to be rolled out across Australia. There has also been more collaboration between health and law enforcement sectors in Australia than in the United States, aiding Australian policy responses. While praising this pragmatic approach, Hall also notes the potential fragility of harm minimisation in Australia, arguing against self-congratulation and complacency.

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#### SRB 7/006

Drucker, E., & Clear, A. (1999). Harm reduction in the home of the war on drugs: Methadone and needle exchange in the USA. *Drug and Alcohol Review*, 18, 103–112.

This brief article gives an historical account of the troubled history of methadone programs and needle exchanges in the United States. Although the United States pioneered methadone treatment, it is also the ‘spiritual centre and home’ of the abstinence-based approach to drug treatment, which has undermined the credibility of methadone treatment in that country. The authors also state that the United States ‘stands almost alone in prioritising its efforts to end drug use among its citizens over stopping preventable diseases’. This means harassment and marginalisation of needle exchange programs and, since 1988, a ban on federal funding.

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#### SRB 7/007

Keane, H. (2003). Critiques of harm reduction, morality and the promise of human rights. *International Journal of Drug Policy*, 14, 227–232.

Keane reviews selected published criticisms of harm reduction which focus on its

ideological and moral elements. One of the criticisms is a challenge to harm reduction’s value neutrality. Harm itself is indeed open to interpretation, and harm reduction is not so much value neutral as promoting values that are almost universally accepted. Is it possible to have neutrality in a discourse on drugs that is dominated by morality? Another criticism is that harm reduction is too narrowly focused, and a human rights framework would seek to include ‘vulnerability reduction’ as well as the reduction of risky behaviours. The third angle from which harm reduction has been criticised is that its theory and practice are examples of ‘surveillance medicine’ and this disciplinary regime of power and knowledge that regulates individuals. Harm reduction, in this analysis, is a prescriptive moralism that impresses on citizens the duty to be healthy.

In response to these criticisms, Keane argues that the discourse of human rights may not work in the area of drug use, where rights and the reduction of harm may not always be compatible, and that, even if it does not live up to its claim, the ideal of value neutrality is perhaps an influential intervention in the heavily moralised discussion of drug use. The best way to think about harm reduction is therefore as ‘an assemblage of pragmatic practices and practical goals with varied outcomes’ in which drug use problems can be considered as technical rather than moral issues.

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#### SRB 7/008

Levine, H. G. (2003). Global drug prohibition: Its uses and crises. *International Journal of Drug Policy*, 14, 145–153.

Levine argues that since the early 1980s the previously omniscient global drug prohibition policy has faced a series of crises. The first challenge is the growth of the harm reduction movement which, in its pursuit of public health goals, has pushed drug policies in some countries from the criminalised, punitive end of the spectrum to the more tolerant, regulated end. Second is the increasingly vocal and open opposition to punitive drug policies from a number of different quarters—from scientists, lawyers, journalists and religious leaders—who point out that drug prohibition violates civil liberties and worsens health problems like the spread of HIV. Finally, global drug prohibition policies have been unable to prevent the cultivation, use and normalisation of cannabis, which remains the most widely used illegal drug in the world.

The global drug prohibition system is based on a series of treaties supervised by the United Nations. This policy has been championed by the United States but politicians, the police, the military and the media in other countries have also pursued drug prohibition, drug demonisation and anti-drug campaigns to further their own interests. However, Levine argues that this global drug prohibition is losing some of its invulnerability, evidenced by the fact that it is now becoming more visible.

## SRB 7/009

Maag, V. (2003). Decriminalisation of cannabis use in Switzerland from an international perspective—European, American and Australian experiences. *International Journal of Drug Policy*, 14, 279–281.

This brief summary of research on the experience of several countries in decriminalising the use of cannabis is based on three expert reports commissioned by the Swiss Federal Office of Public Health. At the time of writing, Switzerland was revising its Narcotics Act to decriminalise the use of cannabis products. The reports include a European comparative study, an overview of research conducted in the United States and Australia, and an historical evaluation of drug policy in Italy. The reports were unable to identify a regular relationship between drug policies and prevalence rates of cannabis use or illicit drug use in general. However, Maag concludes that decriminalisation could reduce the negative consequences for users and also bring about changes in the drug market.

## SRB 7/010

MacDonald, M., Law, M., Kaldor, J., Hales, J., & Dore, G. J. (2003). Effectiveness of needle and syringe programmes for preventing HIV transmission. *International Journal of Drug Policy*, 14, 353–357.

This analysis examined the effectiveness of needle and syringe programs in preventing HIV transmission among injecting drug users by determining change in HIV prevalence among injecting drug users in cities with and without such programs. The authors used several data sources—such as electronic journal databases, surveillance reports, websites, and indexes of relevant journals—to identify studies of HIV seroprevalence among injecting drug users and the presence or absence of programs. Ninety-nine cities across the globe were included in the analysis. HIV prevalence decreased by 18.6% per annum in cities that introduced needle and syringe programs and increased by 8.1% in cities that had never introduced programs ( $p = 0.06$ ). When analysis was restricted to cities with first HIV seroprevalence of less than 10%, the average annual change in seroprevalence was 18% lower in cities with programs ( $p = 0.03$ ). The authors conclude that, despite limitations inherent in its design, the study provides additional evidence that needle and syringe programs reduce transmission of HIV infection. The rapid spread of HIV among injecting drug users and rising rates of injecting in many countries call for scaling up of needle programs as well as other harm reduction strategies.

## SRB 7/011

Maris, C. (1999). The disasters of war: American repression versus Dutch tolerance in drug policy. *Journal of Drug Issues*, 29, 493–510.

Maris analyses Dutch drug policy—specifically the 1995 memorandum on drugs policy—in relation to John Stuart Mill's concept of the 'harm principle'. This states that the only justification for a government to exercise power or force over a citizen against his or her will is to prevent harm to others. Preventing harm to oneself is not sufficient justification. This harm principle therefore opposes moralism in which citizens are forced to act in certain ways because they are seen as morally correct. Maris believes that the Dutch policy comes closer than the United States prohibitionist policy to meeting Mill's test of producing less harm. However, the author also points out that if harm reduction is indeed the guiding principle, then drug policy should be even more tolerant. He believes the memorandum contains inconsistencies, especially in its distinction between 'soft' and 'hard' drugs (the latter being prohibited). He acknowledges, though, the pragmatic nature of drug policy with discussion of the effects of prohibitionist pressure from the United States and concerns of neighbouring states about drug trafficking and tourism. Maris believes that the Dutch policy still retains repressive elements that increase rather than decrease the harms involved and should extend the tolerant approach to 'hard' drugs as well.

## SRB 7/012

McElrath, K. (2001). Risk behaviors among injecting drug users in Northern Ireland. *Substance Use & Misuse*, 36, 2137–2157.

This paper reports on an in-depth study of 39 current or former users of heroin in Northern Ireland, conducted from late 1997 to 1999 before the implementation of needle exchange programs in that part of the United Kingdom in 2001. Perhaps not surprisingly, many injecting drug users reported great difficulty in obtaining new needles and syringes. These were most commonly available through pharmacies, although pharmacists sold them at their discretion. Fear of being exposed as a drug user in small communities was a deterrent to buying from these outlets. Fear of republican and loyalist paramilitary groups also deterred users from attempting to buy from pharmacies where their identity might be disclosed to these groups. As a result of scarcity, multiple injections with the same needle were common. Almost all the study participants had at some point shared needles with other users. Some noted that they were less likely to do so in places where needles were available such as Dublin, Glasgow and London. Older experienced injectors highlighted their use of bleach to clean injecting equipment when injecting with others. Sharing was defined by some participants in terms of their relationship to the other person. For example, sex partners did not necessarily view using their partner's needle as sharing. Most of the participants had never undertaken formal treatment for heroin use and some had not

disclosed their drug use to any health workers. Results from the study showed that risk behaviours for blood-borne viruses among injecting drug users were common in Northern Ireland. The author also claims that Northern Ireland has for the most part failed to implement harm reduction strategies.

## SRB 7/013

Weatherburn, D. (2001). Has the war on drugs failed? *Australian Journal of Forensic Sciences*, 33, 15–21.

This paper is a transcript of an address given in 2000 by Don Weatherburn, director of the NSW Bureau of Crime Statistics. Weatherburn asserts that drug law enforcement in Australia has failed to stop illegal drug use and trafficking and has created significant harm for individuals and communities. In particular, the cost of illegal drugs encourages users to turn to crime to finance their use, and aggressive policing discourages users from accessing clean injecting equipment, increasing the chance of blood-borne virus transmission. However, Weatherburn also argues that prohibition is not incompatible with harm reduction and that drug use can be treated as both a legal and public health problem. Prohibition of illegal drugs may have a deterrent effect, reinforcing social norms against illicit drug use and keeping the street prices of drugs at relatively high levels. The criminal justice system, by forcing some users into treatment, may encourage greater uptake of drug treatment than would otherwise occur. For Weatherburn this does not mean, however, that we should not continue to criticise 'tough on drugs' policy. He identifies a greater investment in treatment, better policy coordination between the criminal justice and public health systems, and a broader focus on the effects of drug use on others as well as the harms experienced by drug users themselves as ways to improve drug policy.

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