REVOLVE

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ADOLESCENT DRUG USE

By David Fagg, Youth Research Officer

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A. Introduction

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For the purposes of this paper, a 'drug' is a psychoactive substance:

> *"...psychoactive drugs are those drugs that act on the central nervous system (CNS) to influence mood, thought and/or behaviour. This definition covers the major drugs of concern in Australia, including alcohol, cigarettes, cannabis, heroin and amphetamines.* [1]

Taking the definition above, everyone reading this paper is probably a drug user. The only question is which drugs we take, the effects on our body and souls, the degree of addiction to that drug, and the consequences for those around us as a result of being addicted to that drug. So, in keeping with that levelling idea, let me declare my own drug habits.

- 10 standard drinks of alcohol a week.
- 2 cups of strong coffee a day (caffeine is also a psychoactive drug)
- 800mg of carbamapezine per day to control epilepsy

The widespread nature of drug use, amongst Christians too, is what makes an issue such as this so difficult to discuss honestly. The easy option is to simply look at which drugs are illegal, then trumpet "Just Say No". But to really engage with young people's use and abuse of drugs, we need to be more honest. In addition, use of illicit drugs is being normalised amongst young people – it is no longer the domain of stereotypically "at-risk" young people. In fact, the Victorian Youth Alcohol & Drug Survey concluded that "drug-taking is more prevalent amongst those in advantaged socio-economic areas".

The use of drugs by young people is always in the news:

- petrol-sniffing in indigenous communities
- 'supervised chroming' by young people in state care
- binge-drinking at parties
- deaths from party drugs
- the apparent link between cannabis and mental illness
- the recent prevalence of crystal methamphetamine, or "ice"

chroming
inhaling spray paint fumes

The tendency in the church has been to shun drug use, whether of the licit or illicit kind. Licit drugs such as alcohol and tobacco are frowned upon, although this disapproval is becoming diluted. Illicit drugs such as cannabis or heroin are definitely out. This tendency has led to a fairly consistent condemnation of "harm-minimisation" approaches to drug use.

licit
legal

illicit
illegal

This paper will try to give some windows into young people's use of drugs, but it mainly raises more questions than answers. This is because there is little published Christian literature on drug use that goes beyond blanket condemnations. Youth For Christ Australia deals on a daily basis with young people who use drugs, and I invite all Christians who work with young people to use this Revolve as a 'discussion starter'. More conversation is needed about this issue, so that we begin to deal with substance use amongst young people from a position of honesty, rather than fear.

[1] Ryder, D et al (2001) Drug use and drug related harm

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B. When is a drug not a drug?

The readers of Revolve are mainly Christians who work with young people in some capacity. In order to deal honestly with young people's drug use, we need to uncover our own perceptions about drug use, and our prejudices about people who use different types of drugs.

Many young people will use licit drugs like alcohol and cigarettes. Far fewer will use illicit drugs such as cannabis, heroin or amphetamines. Are we more or less happy for young people to use licit drugs rather than illicit? Is this because illicit drugs are more harmful than licit ones? Are our perceptions about illicit drug-users clouded by the fact that they are engaging in criminal behaviour?

When dealing with the legality or illegality of drugs, we are dealing with public perception. The fact that a drug is legal is not a reason to consume it. The fact that a drug is illegal does not mean those who consume it are criminal or morally inferior.

Tobacco

Things have changed since 17th century Russia, when Czar Michael Federovitch ordered the execution of anyone found with tobacco. For some time in Australia, tobacco consumption was seen as perfectly fine, and even a sign of sophistication (see Figure 1). Over the past 20 years, that has changed dramatically: Tobacco advertising is severely restricted, the packaging itself is a deterrent (see Figure 2) and smoking is banned in most public spaces. Smoking has become a disgusting habit, even in the eyes of smokers!

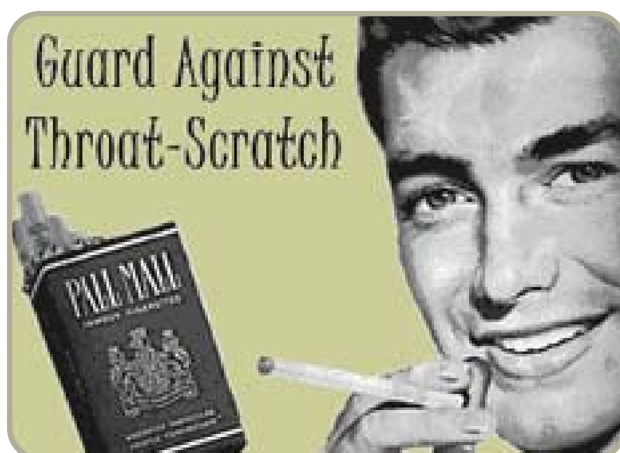

Figure 1 – Advertisement from the 1940s

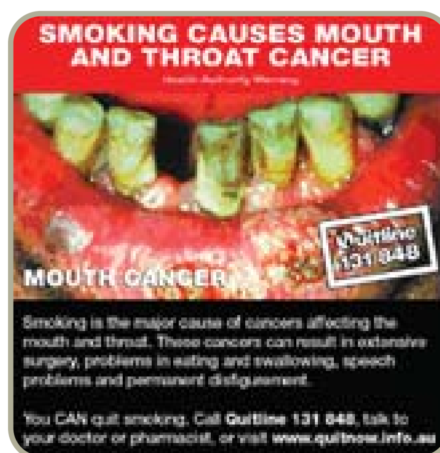

Figure 2 – Cigarette packaging from 2006

Cannabis

The stereotype of a cannabis user is the addled young male, unable to do much more than reach for his 'brekky bong'. That image, more than proven facts about its harm, has kept cannabis an illicit substance. I am aware of the connection between cannabis use and the onset of mental illness among those with a predisposition, but alcohol abuse can cause liver disease - why have we not banned it as well?

Alcohol

Alcohol consumption is still socially acceptable. But from 1993–2002, approximately 2,643 Australian young people (15-24y.o) died from alcohol-attributable injury and disease caused by high risk drinking. Surely that is enough of a reason to at least consider a restriction on its production. But alcohol is so deeply entrenched as an acceptable substance in Australia that it is likely never to have serious restraints placed upon it.

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C. Young people's use of drugs

1. Alcohol

Teenage drinking is a rite of passage to adulthood in Australian culture. Young people see adults drinking, and perceive drinking as a part of adulthood. Therefore, drinking will be a part of their perceived "growing up" activities, along with gaining employment, finding a life partner and moving out of home. However, the common media image of young people as a mob of alcohol-sodden miscreants is not borne out by the statistics. About a third drink to the detriment of their short-term health, but even those are not doing it frequently and regularly. The frequent binge-drinkers only make up 10.7% of the 14-19 y.o population.

Still, this rite of passage does come at a cost:

- From 1993–2002, 2,643 young people died from alcohol-attributable injury and disease
- Over 100,000 young people were hospitalised for alcohol-attributable injury and disease over a 9–year period (1993–2001)
- Young indigenous people are more than twice as likely as their non-indigenous counterparts to die from alcohol-attributable causes
- Young people who live in non-metropolitan areas are at greater risk of alcohol-attributable death than city youth [2]

	In Lifetime	In Last Month	In Last Week
1999	89%	49%	35%
2002	88%	49%	34%

Table 1 – Frequency of Alcohol Consumption for Australians aged 12-17 y.o [3]

So, a third of young people drink weekly, half drink monthly, and most drink yearly. It is of concern that over a third of underage people are drinking weekly. But Table 1 does not tell us how much these young people are drinking, or in what context. Are they having half a glass of beer at a family function, or are they bingeing each weekend? To find out more, let us turn to statistics on "short-term harm".

Short-term risk of alcohol-related harm

Short-term risk of harm is defined like this:

- for males, drinking up to 6 drinks on one day is considered 'low risk'
- for females, drinking up to 4 drinks on one day is considered 'low risk'.

abstainers have not drunk in last 12 months

	Aged 12-17	Aged 18-19	Aged 20-29	Aged 30-39	Total Population
Abstainers	53%	13%	10.6%	11%	16.4%
Low Risk	28%	26%	28.4%	42.7%	48.2%
Risky/High Risk	20%	62%	61%	46.3%	35.4%

Table 2 – Risk of Short Term Harm due to Alcohol Consumption, by age

This table demonstrates that the low rate of underage drinking is mainly due to its illegality. Once young people turn 18, almost two-thirds are drinking to excess, a pattern that does not change until their thirties. It strongly suggests that young people (12-17) would drink more excessively if they could easily access alcohol.

This statistics must be tempered by the observation that such high-risk drinking is not usually a frequent occurrence (ie. at least once a week). The percentage of 14-19 y.o who drank excessively more than once a week is 10.7%. For 20-29 y.o it is 14.2%.

[2] Trends in Youth Alcohol Consumption and Related Harms in Australian Jurisdictions, 1990–2002

[3] National Drug Strategy Household Survey, 2004

2. Tobacco

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The latest national survey on young smokers was conducted in 2002. That survey found that over 205,000 school students (aged 12-17 y.o) were smokers. [4] Over the period 1984 – 2002, smoking rates among young people have dropped. They dropped from 1984 to early 1990s, then rose to a peak in the mid-1990s, then dropped by 2002 to a level lower than the 1984 levels.

Smoking among Australian school students in 2002

	AGE	12	13	14	15	16	17
Smoked in last week (current smoker)	Males	6	6	12	15	20	23
	Females	5	7	15	20	24	26
Smoked on 3 or more days in the past week (committed smoker)	Males	3	3	8	9	14	15
	Females	3	4	9	13	17	19
Mean number of cigarettes per week (among smokers)	Males	13	12	22	24	35	34
	Females	10	12	18	22	33	39

Table 3 – Student smoking rates in Australia (Source: Quit Victoria)

The National Drug Strategy Household Survey (2004) found that only 2% of 12-15 y.o are daily smokers, jumping to 17% amongst 18-19 y.o. Most young people (12-19) have never smoked – 87%. However, that is defined as less than 100 cigarettes in a lifetime. It indicates that most young people, even if they try tobacco, rarely go on to be addicted.

In addition, Victorian smoking rates amongst young people went down in 2006 to their lowest level in 20 years.[5] Western Australia also experienced a drop of 7% in the smoking rate between 1999 and 2002.[6]

It seems that young people are heeding the anti-smoking message that has been relentlessly pushed through school and media. Even though many students take up smoking in their secondary school years, that rate is decreasing. I would argue that this decrease is related to the fact that less adults are smoking: if smoking is dwindling as a legal 'adult' activity, then teenagers are less likely to engage in it.

3. Illicit Drugs

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According to the 2004 NDSHS survey, only a very small number of Australian young people have ever tried illicit drugs. For the age group 12-17:

- 16.7% have ever tried an illicit drug - 278,717 people
- 12% have used them in the last 12 months - 200,276 people
- For young people aged 14-19, most have never had the opportunity to use drugs such as heroin or ecstasy

However, the NDSHS survey must be taken with a grain of salt. As a telephone interview (predominantly) it is likely that young people are likely to downplay their use of illicit drugs, as their drug use may be unknown to their parents. In addition, the NDSHS does not take into account people who are homeless, and only includes those who volunteer to be part of the survey. We can safely assume that there is a greater percentage of young people using illicit drugs than the NDSHS reports.

Notwithstanding these reservations, there is no doubt that once young people hit age 18, consumption of illicit drugs jumps dramatically:

- 5.2% of 12-15 y.o have used cannabis in the last 12 months, but that increases to 26.5% by the time they are 18 or 19.
- 0.7% used ecstasy recently at ages 12-15, but that increases by over 1200% to 8.8% at the age of 18 or 19

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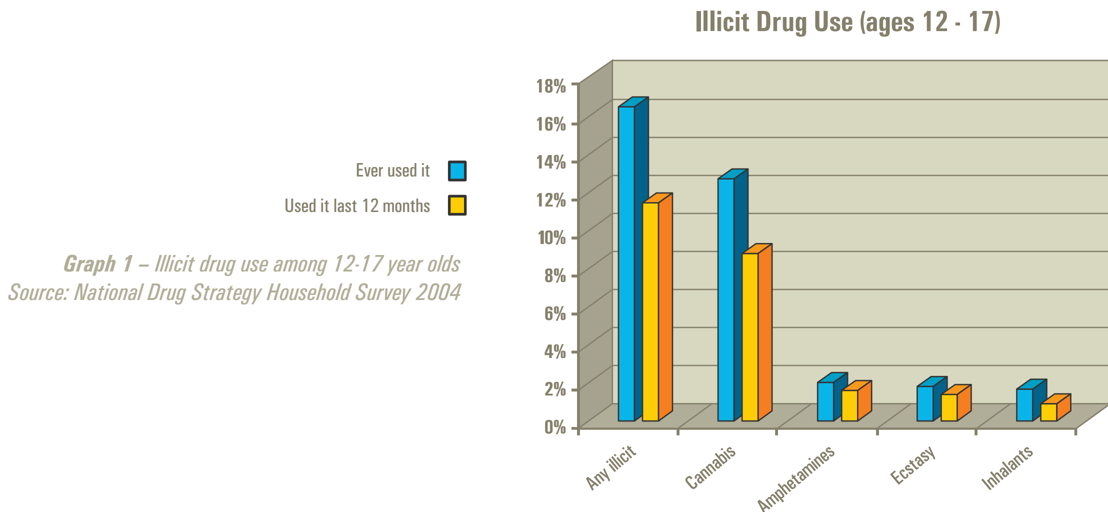
[4] http://www.quit.org.au/article.asp?ContentID=7233, accessed 14 October 2006
[5] http://www.quit.org.au/media.asp?ContentID=15629, accessed 14 October 2006
[6] http://www.youthfacts.com.au/index.php?option=displaypage&Itemid=283&op=page#smoking, accessed 14 October 2006

This trend tends to suggest that young people are only using tobacco and alcohol more because it is cheaper and more freely available. Once they achieve more independence (and hence have increased income) they choose to use illicit drugs with more frequency, while still continuing to use alcohol and tobacco.

The most common illicit drug used by 12-15 y.o is cannabis, followed by pharmaceutical drugs, followed by inhalants, followed by methamphetamines.[7] As young people age, the use of speed and ecstasy increases, but cannabis still dominates as the illicit drug of choice.

inhalants
inhaling paint, glue or fuel fumes – often called "chroming"



***Graph 1** – Illicit drug use among 12-17 year olds*
Source: National Drug Strategy Household Survey 2004

D. Why do young people take drugs?

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1. Stereotypical Approaches

There are many reasons, but let us look at 3 main ways that drug-using is usually understood by society, along with some strengths & weaknesses of each approach.

Approach	Explanation	Strengths	Weaknesses
Drug user as "sinner"	The drug user is seen as a morally inferior, or at least deficient, person. They do not have the willpower to resist drug use. The reasons for drug use are located in the individual and in the drug.	People who are very dependent have to re-evaluate the decisions they have taken. It places responsibility for change with the individual.	It ignores or minimises other reasons for the drug use, such as social networks and family background.
Drug user as "sick person" (or the 'disease theory')	The drug user is seen to have a mental and/or genetic predisposition to addiction. They cannot use any drug 'safely' because of an 'addictive personality'.	It does seem to explain why some people can use a drug and not become addicted, while others do. It also avoids the trap of seeing the drug user as morally inferior.	Can encourage drug users to think that they have no control over their behaviour. In addition, there are doubts about the scientific basis for this approach.
Drug user as "social victim"	The drug user is seen to have experienced economic, family-related or other hardship which leads them to use drugs as a coping mechanism or as an alternative method to achieve 'happiness'.	This approach takes into account the social environment from which the drug user comes, rather than just focussing on individual causes.	This approach can lead to a devaluing of individual causes, and hence a lack of empowerment on the part of the drug user.

***Table 4** – Student smoking rates in Australia (Source: Quit Victoria)*

[7] Speed

As Table 4 shows, there are both strengths and weaknesses to these three approaches to adolescent drug use. Usually, we tend to gravitate to one of these explanations. It is important to note that there are always multiple causes and factors in someone's drug use. At any one time, one or more of these may explain drug use.

2. Factors in Understanding Adolescent Drug Use

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To really understand why young people take drugs, we need to consider more than the individual user's personality. Three important factors to consider in adolescent drug use are:

1. **The drug**
   What is the drug? What is the effect of the drug on the user's physical, emotional and mental health? How addictive is the drug? How accessible is it?

2. **The user**
   What is the personality of the user? What are their attitudes? How have they been shaped by familial, social and peer influences? What do they expect to gain from drug use?

3. **The environment**
   What is the physical and social setting of the drug use? Does the young person only use the drug with friends? What events are drugs used at? How is the drug use bound up with being part of a peer group?

Usually, we tend to concentrate on the first 2 factors – understanding the effect of the drug and the personality of the user. However, the social aspect is just as important in helping young people to address their drug use.

For example, a young person may recognise the detrimental effect that constant cannabis use is having on their mind and body. Yet, if their key friendships are ones in which cannabis use is normal (or even constitutes the bonds of friendship), then how are they to stop using? Stopping cannabis use will mean the loss of friendships, causing emotional isolation that may lead to *increased* cannabis use!

To further understand this social aspect of drug use, let us look at a model of adolescent substance use – "Reputation Enhancement Theory". It is ***not*** the model for explaining adolescent drug use, but it is a useful one.

3. Reputation Enhancement Theory

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Reputation Enhancement Theory (RET)[8] has the following thesis: ***adolescents choose their behaviours in order to portray a certain image to a peer group.***

This may seem like a no-brainer; we know from experience that young people are extremely concerned about the way others perceive them, and act accordingly. But most of the time, we don't apply this reasoning to their drug use. The closest we come to it is through the use of the label "peer pressure".

RET claims that all drug use has a "social function". Often we think of drug use in individual terms – it gives the user a high, or it alleviates their emotional pain. These are important elements of drug use, but they overshadow an equally important dimension to drug use; how the drug user wishes to be seen in her social group.

> *This model [RET] views the pursuit of a desired public reputation as the key factor in determining an adolescent's involvement in substance-use behaviour.*

That is, teenagers choose to use drugs - it is not an accidental occurrence:

> *Adolescents do not enter into activities without knowing what the consequences of their actions will be. Rather, they choose to inform an audience of their actions and, through this shared knowledge, hope to attain an ideal image.*

[8] Odgers, P (1998) "Adolescent Substance Use" in *Drug use in Australia*

So, when we encounter teenage drug use, we need to ask questions about the drug and the background of the drug user. But equally, we need to discern what message this young person is trying to send to their peer group. What type of identity are they trying to form? What "ideal image" are they seeking?

It is simple to see RET in other areas of adolescent activity. Teachers see students misbehave and be disciplined. The frequency of their misbehaviour indicates that they know what the consequences of their behaviour will be – so why do they do it? To communicate an identity to their classmates – that they are willing to defy adult authority, that they are tough or aggressive, that they are independent.

It is the same with drug use. One example is that of smoking: though it gives no comparable effects to drugs like ecstasy, young people smoke in order to fit in with a particular social group. In other words, the act of smoking allows a young person to interact with a social group that would otherwise be off-limits.

Consequences of Reputation Enhancement Theory

RET has interesting consequences for addressing young people's drug use. If young people are aware of the effects of drugs, but use anyway because of considerations for their reputation, then drug education is largely ineffective. Calls for abstinence will also be fairly useless. Strategies to cope with family and social problems leading to drug use will also be inadequate. If the primary reason for drug use is to maintain an image within a peer group, then most current prevention and education strategies will be largely irrelevant.

Addressing young people's use of drugs will need to strike at the core reason they take them – their view of themselves in relation to a desirable group identity.

E. Addressing young people's use of drugs

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I am not going to detail an approach for addressing young people's use of drugs here. I am no expert on drug use. I suggest that Christians who work with young people seek out local agencies who specialise in this area, such as YSAS. But what I will do is set down a few principles that I think are important.

1. Local & Specific Solutions

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There are no solutions that work everywhere. Noel Pearson, in a 2001 speech, claimed that permissiveness about alcohol & other drugs is devastating the Aboriginal community. Pearson basically proposed a prohibition on alcohol and other drugs in some indigenous communities.[9] It could work in indigenous communities because of the role of elders in implementing such a program, as well as geographic isolation. However, a prohibitive approach would not work in other circumstances.

Therefore, it is not helpful to transfer one solution from place to place without first understanding the local situation.

2. Social Solutions

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Young people's use of drugs is mostly *social*. That is, they are introduced to drug use, whether licit or illicit, through friends or relatives. The second biggest reason for taking drugs, after 'curiosity', is 'peer pressure'. They are initiated into drug use by friends and get drugs from friends.

Therefore, approaches to drug use amongst young people must be social. That is, they must deal with the relational nature of drug use in order to have any effect. For example, if a young person has been pressured into using cannabis by their peers, they probably do not possess the self-confidence to *stop* using it, particularly as that may result in social rejection or isolation. They will need other relationships that build confidence and strength in order to risk losing drug-associated relationships.

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[9] Pearson, N (2001) On the Human Right to Misery, Mass Incarceration and Early Death, http://www.quadrant.org.au/php/article_view.php?article_id=1467, accessed 6th October 2006

3. Honesty

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We need to be honest about the different effects of different drugs. A fear-based approach is not helpful, and can be harmful. If we say to young people, "x drug is very harmful – you may have an overdose/get schizophrenia/contract HIV", we are definitely sending a strong message about our disapproval. But if the young person does try x drug, and does *not* have an overdose/get schizophrenia/contract HIV, then they are likely to discount your credibility, and continue to use x drug. They may have enjoyed the experience, in fact they probably definitely enjoyed the experience!

A far more helpful approach is to be honest about drug use. It is not un-Christian to admit that drug use can be mentally, emotionally and physically enjoyable; most of us would admit to enjoying alcohol and the effect it has on our bodies. It is possible to *not* give permission for their use *and* be honest about the drug!

Our approach to young people and drug use should not be that of legislator or teacher – those roles are already being played and young people do not respond well to them (even though they are necessary). Our role should be as "knowledgeable friend".

4. Faith & Community

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We need to talk about faith and community. Carl Jung, the renowned psychologist, once commented on "the devilish power of addiction". The only protections, he thought, were those of religious faith and the human community. Our society is shy of dealing with religious faith, and our community is fractured in many ways. Is it any wonder that young people, as well as countless others, choose to use drugs?

5. Jesus' Example: Unclean & Criminal

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We need to provide an alternative circle of acceptance, within which young people can evade the need to keep up a "delinquent reputation". The Christian community can be an alternative and non-judgemental family, modelling itself on Jesus.

Jesus constantly touched and included the 'unclean' of his day, a category of people equivalent to drug users today. He became unclean by touching lepers[10] and other 'unclean' people, and became a criminal by healing them on the Sabbath.[11] His healing touch and inclusion restored these people to a place of respect and participation in society. He healed them physically, as well as socially and spiritually.

He also named the addictions of prospective followers (family[12], money[13], status[14]), called them to renounce these and follow his example of embracing the unclean.

Therefore, we need to confront our own addictions (which may or not be substance-based) in order to faithfully reach out to the 'unclean' among us. Interesting, what do we make of Jesus' willingness to be regarded as unclean and criminal, for the sake of people's health (physically, socially, spiritually)? What might Jesus example in this respect mean for our work amongst young substance users?

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[10] Matthew 8:1-4
[11] Matthew 12:1-13
[12] Matthew 8:18-22
[13] Luke 18:18-30
[14] Mark 10:35-45

F. Harm Minimisation – what is it?

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There are 3 elements of Harm Minimisation, which is officially the Federal Government's approach to drug abuse.

1. Demand Reduction

"Demand" is an economic term that describes the desire for a particular product and how much people are willing to pay for that product. For example, there is a high demand for petrol because we need it to power our vehicles. Even though the price keeps climbing, we are willing to pay that price because we need petrol.

In the same way, there is a demand for drugs, whether illicit or licit. Demand reduction aims to decrease the desire for a drug and the willingness of people to pay for it. Demand reduction strategies are most obvious with licit drugs (such as alcohol and tobacco) because these drugs are the most widely used and abused.

Examples of Demand Reduction strategies

Media Campaigns

A current example of a demand reduction strategy is the advertising campaign being conducted around cigarette smoking – on TV, in newspapers and on cigarette packaging itself. Through graphically depicting possible physical consequences of smoking, such as mouth cancer, they aim to reduce the desire of people to take up smoking.

Education

This is the primary demand reduction strategy amongst young people regarding illicit drugs. Information is provided about the possible effects of illicit drugs, in order to help young people make informed decisions about drug use, rather than decisions based on curiosity and peer pressure.

Prevention

These strategies focus on the emotional reasons young people may take drugs in the first place, such as peer pressure and poor self-confidence. Many welfare and educational organisations see self-esteem and life-skills programs as being preventative interventions, even if they are not explicitly about drug use.

2. Supply Reduction

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Supply is another economic term. If there is a demand for a product, then there will be someone to supply it, because people want to make money! Additionally, if there is a supply of a product, then people will be more likely to buy it or use it. Simply stated, the fact that it is available increases the likelihood of people using it. Following the petrol theme, if a cheaper and environmentally friendly fuel source was widely available, people would use it.

In the same way, as there are suppliers of licit and illicit drugs, so tobacco companies, alcohol corporations and illicit drug manufacturers are all examples of suppliers. If the supply of these drugs is lessened, then the cost will go up, as so people will be less likely to use it. Of course, they will find cheaper substitutes.

Examples of Supply Reduction Strategies

Financial

One way to lessen the supply of drugs is to make it costly to produce, transport and distribute them. Seizing drugs at customs, increasing border patrols, co-operating with other governments to catch drug producers…all these increase the costs for illicit drug producers. Licit drugs have heavy taxes on them, which make it financially more risky to produce such drugs.

Legal

By imposing criminal sanctions on illicit drug production, supply can be reduced – it may be a deterrent to drug producers. Or, legal substances may have age limits imposed on them for purchase.

3. Harm Reduction

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Harm reduction aims to reduce the harm associated with administering the drug itself eg. drinking beer, smoking a cigarette, injecting ice, swallowing an ecstasy pill, inhaling paint fumes, smoking cannabis etc. Harm reduction is probably the most public and most controversial of the harm minimisation strategies. It is controversial because it can be seen to be providing public support for illegal behaviour.

Harm reduction recognises that people will use drugs regardless of social rejection or legal punishment, particularly if they are addicted, or committed to maintaining a reputation (see RET). If they desire the drug, and if they can obtain it (legally or not), they will use it. Harm reduction advocates claim that once the drug user has made a decision to use the drug, then the only avenue for support is through reducing the physical & psychological risks associated.

Harm reduction is often ridiculed for being unrealistic and an oxymoron (*ie. how can the harm of heroin use be minimised?*). Proponents of its practice are excoriated for 'encouraging' the use of dangerous drugs. The most popular targets have been so-called 'safe injecting rooms' and 'supervised chroming'.

Examples of Harm Reduction Strategies

Supervised/Legal spaces to use

One of the most harmful aspects of drug use is the fact that they are often used in unhygienic places, with medical help unavailable and with no support and information about drug use. "Safe injecting rooms" aim to provide a place that injecting drug users can inject in a clean environments so that extra diseases (such as hepatitis) are not contracted, and medical help is nearby in the case of overdose. The Berry Street agency attracted widespread derision for allowing young people to chrome (inhale paint spray can fumes) at their residential care centres. Their argument was that if young people were to chrome anyway, then their duty of care was to ensure these young people had the information about drug use, and nearby assistance if needed.

Clean equipment

Needle exchange programs are a well-established feature of most Australian urban centres. These ensure that IDUs have access to clean syringes, so that they do not need to use syringes that have already been used, and may contain blood traces from previous uses.

IDU
Injecting Drug User

Purity controls

This happens in licit drug industries currently. There are controls on the production of alcohol and tobacco so that they are relatively 'safe'. For illicit drugs, there are no such regulations – they are "self-regulating" to use corporate speak, which is to say, regulation that improves the profit of the drug seller while keeping the drug user buying from the seller. If illicit drugs were purer, then some harms associated with their use would be reduced.

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G. Information About Different Drugs

All of the possible effects of these drugs depend on a range of factors, such as the person's age and weight, degree of dependence, whether other drugs are being taken, the amount of the drug, the social environment in which it is taken. The following information is not exhaustive, and more can be obtained from DrugInfo (http://www.druginfo.adf.org.au)

	Legal Status	Short-Term Effects	Possible Long-Term Effects
Alcohol	Can be purchased over age of 18. In licensed venues, can be consumed underage under supervision of parent, with a meal.	• Relaxation, reduced concentration • Fewer inhibitions • Confusion, blurred vision • Nausea, vomiting and sleep. • Coma or death	• Cancer of the mouth, throat, oesophagus, lips, liver • Brain injury, loss of memory, confusion, hallucinations • High blood pressure, irregular pulse, enlarged heart and changes in red blood cells • Weakness and loss of muscle tissue • Sweating, flushing and bruising of the skin • Inflamed stomach lining, bleeding and stomach ulcers • Increased risk of lung infections • Severe swelling of the liver, hepatitis and cirrhosis
Tobacco	Can be purchased over age of 18.	• Raised blood pressure • Blood flow to extremities restricted • Brain and nervous system activity are stimulated for a short time and then reduced. • Dizziness, nausea, watery eyes • Appetite, taste and smell are weakened.	• Respiratory infections such as pneumonia and chronic bronchitis • Emphysema, heart attack and coronary disease • Cancer of the lung, throat, mouth, bladder, kidney, pancreas, cervix, stomach • Stomach ulcers
Cannabis Dope Choof Pot Hash Mull Ganja	Cannabis is illicit in Australia. Drug laws in Australia distinguish between those who use drugs and those who supply or traffic drugs.	• Relaxation and loss of inhibition • Increased appetite • Affected perception • Impaired coordination • Thinking and memory is impaired	• Respiratory illness • Reduced motivation • Brain function can be reduced • Hormones production can be affected **Cannabis and psychosis** • Cannabis use may be linked to a condition known as a drug-induced psychosis, or 'cannabis psychosis'. • Cannabis use may also bring forward an episode of schizophrenia or manic depressive psychosis in a vulnerable or pre-disposed individual. • Cannabis use can trigger psychotic episodes in a person who already has a mental illness.
Amphetamines Speed Goey Up Fast Louee	Illicit	• Speeding up of bodily functions • More energy and alertness • Reduced appetite • Irritability	• Chronic sleeping problems, • Anxiety and tension, high blood pressure and a rapid and irregular heartbeat. • Malnutrition • Psychosis • Reduced resistance to infections • Violence • Brain damage
Ice Crystal meth Shabu Batu Glass	Illicit	• Euphoria, alertness, confidence and libido • Restlessness, itching, picking and scratching • Tremors of the hands and fingers • Speeding up of bodily functions • Difficulty sleeping • Reduced appetite, vision and severe headaches • Abrupt shifts in thought and speech • Nervousness, panic attacks, anxiety, paranoia • Irritability, aggression, hostility • Paranoid delusions and bizarre behaviour	• High blood pressure and increased risk of heart-related complications • Malnutrition and rapid weight loss • Chronic sleeping problems • Depression, anxiety, tension and paranoia • Brain damage • Smoking ice can damage the lungs • Snorting ice can damage the lining of the nose • Injecting ice can lead to scarring, abscesses and vein damage

	Legal Status	Short-Term Effects	Possible Long-Term Effects
Ecstasy E XTC Eccy The love drug	Illicit	• Increase in heart rate, body temperature and blood pressure, sweating • Increase in confidence • Jaw clenching, teeth grinding • Feelings of well-being, feelings of closeness to others, hence the term 'love drug' • Nausea, anxiety, loss of appetite	• There is little research on the long term effects of ecstasy. Some early research indicates that ecstasy can damage some parts of the brain, leading to depression and anxiety.
Inhalants Glue Gas Sniff Huff Chroming Poppers	The products themselves are not illicit, as they are commonly used in the household. However, it is illegal for shop-owners to sell them if they believe they will be abused.	• Fewer inhibitions, excitement • Drowsiness • 'Flu-like symptoms • Sickness • Unpleasant breath • Nosebleeds and sores • Reckless behaviour	• **Health Problems:** have tremors, weight loss, tiredness, thirst. They may also have anaemia. • **Logical Thinking:** The user may be forgetful and less able to think clearly or logically. • **Irritable:** The user may be irritable, hostile, depressed or feel persecuted.

H. Christianity & Drug Use

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If you say, "Would there were no wine" because of the drunkards, then you must say, going on by degrees, "Would there were no steel," because of the murderers, "Would there were no night," because of the thieves...and "Would there were no women," because of adultery.

St John Chrysostom, Bishop of Constantinople, circa 388

The following section briefly reflects on the some issues and tensions in formulating a Christian response to drug use.

1. Free Will

The Bible sees humans as being created as free will beings. Though we are imprinted with the "image of God", we also have the ability to choose against God – in effect, choosing against a healthy and whole life. We see this ability acted out in Genesis 2, and then throughout the Bible, and it is easy to discern in the history of the world. Given this biblical precedent, forcing people to stop using drugs is problematic.

2. Against the Law

Christianity is whole-heartedly against the coercive power of the law as a motivation for living a Christ-like life. We recognise that while necessary to keep social order, legislation is not effective as a motivation for behaviour. Its highest effectiveness is as a restraint upon oppression and evil...as a protective device. Therefore, we cannot simply rely upon legislation to resolve the harm caused by drug abuse. The motivation for change must come from within a person.

3. Sanctification

Even if someone becomes a Christian, it does not follow that they will immediately engage in behaviour that is healthy and whole; some behaviours will change and others will remain. The process of becoming more and more like Christ ("sanctification") is slow and not always steadily progressive. Therefore, we cannot simply rely upon evangelism to tackle drug addiction.

4. Desire

Christianity has a profound concern with desire, which is the central issue in drug addiction. Christianity locates the true fulfilment of our desires in Jesus. Our lives consist of following desires which are destined not to be fulfilled.
Desire for the experience given by drugs is but one desire – material possessions, emotional belonging, achievement, recognition...all these are more socially acceptable, but often harmful, desires. We need to work to address all types of harmful desires that affect young people.

5. Compassion & Free Will

God is a compassionate God, who hates to see people hurting themselves and others. Christ is centrally concerned with the health of people, as individuals, and in relation with God and others. It is therefore not good enough to simply allow any people unrestrained access to harmful substances, on the basis of 'free will'.

We must wrestle with the tension between what an individual thinks is good for them, and what we have come to believe is good for them, based on biblical reflection and what is known about drug addiction. However, we should never coerce someone to take on beliefs or course of action; Christianity is a faith of persuasion, voluntarism and modelling. Therefore we must continue to love people, and continue to encourage them to live in a healthy way, but always keeping in mind that they may choose not to.

6. Christianity & Culture

Christians must be aware of how our faith is conditioned by the culture around us. Most of us would oppose cannabis use on religious grounds – that is, because of our faith, we are against it. To put it another way, we don't think it's Christian to smoke cannabis. But why not? Is it just because it is illegal? We speed in our cars. Is it because of the loss of control? Alcohol also does this, even in small amounts. Is it because there is a link with mental illness? Alcohol or tobacco use can also lead to illness. Or is it because of the stereotype of a 'pothead', completely befuddled and unable to do more than pick up his bong? If that is so, it is an illogical opposition.

Just because there are alcoholics doesn't mean that we ban the drinking of alcohol. In order to honestly deal with drug abuse, we need to examine the assumptions we have about different types of drugs and those who use them.

7. Christianity & Harm Minimisation

Given that many young people will continue to abuse different substances even when they know the harmful consequences, what is the Christ-like thing to do? Leave the user to their fate? They may die, leaving no opportunity for healing. Lock them up in a forced detoxification? This could have detrimental health effects and is not likely to take away the desire to use.

Obviously, it is Christian to work for demand reduction (decreasing the desire for a drug) and supply reduction (decreasing its accessibility). But when those have failed, perhaps we should consider the possibility that harm reduction is a Christ-like response.

8. Is Prohibition a Christian option?

Prohibition will never eradicate drug abuse, or any other harmful practice. Banning a substance, such as alcohol or tobacco or illicit drugs, will not bring about the cessation of its use. That was tried in America in the Prohibition era; it simply drove the market for alcohol underground, and denied the government the opportunity to regulate its production and consumption. In addition, prohibition on a drug can cause other harms: illicit drugs vary widely in purity and therefore can cause overdoses, and illicit drug use is usually performed in unhygienic environments, leading to increased chance of disease.

Hear Paul Dillon from the National Drug and Alcohol Research Centre:

> *"We've seen from experience that if something is banned, people find other ways to do it which are much more harmful."* [15]

Does that mean that we should legalise all currently illicit substances? The difficulty in getting hold of a drug will restrict the prevalence of its use. Blanket prohibition, therefore, is not a solution on its own. Neither is blanket acceptance of any drug's availability. The point of legislation is to "restrain evil". If a law against a harmful drug is in fact reducing its use and the harms associated, then it is a good thing. But if a law is having very little impact on drug abuse, and may be actually contributing harm, we need to reform it.

Prohibition may need to be exercised in particular places and with particular communities, but it is a fairly ineffective solution on a broad scale.

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[15] *Herald-Sun*, 20 July 2006, p.23

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