Australia's illicit drug problem: Challenges and opportunities for law enforcement

Submission from the Department of Health and Aged Care
to the Parliamentary Joint Committee on Law Enforcement Inquiry

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Introduction

The Department of Health and Aged Care (the Department) welcomes the opportunity to make a submission to the Joint Committee on Law Enforcement's inquiry into *Australia's illicit drug problem: Challenges and opportunities for law enforcement*.

The Department is responsible for administering a broad range of policies, programs and regulatory activities aimed at preventing or reducing the harms associated with illicit drugs in Australia. The Department works cooperatively with law enforcement and other Commonwealth agencies, the states and territories, service providers and the broader community to provide a coordinated and health-focused response to this issue.

The Department's activities are guided by the priorities outlined in Australia's *National Drug Strategy 2017-2026* (National Drug Strategy) and in line with the three pillars of harm minimisation (harm reduction, demand reduction and supply reduction). Key responsibilities for the Department include:

- Development and oversight of national policy frameworks including the National Drug Strategy and its associated sub-strategies, and the National Preventive Health Strategy, which includes specific targets for reducing the prevalence of illicit drug use by Australians.
- Administering the Australian Government's Drug and Alcohol Program, which will provide funding of more than $870 million over four years (from 1 July 2022) to deliver treatment and support services; national prevention and early intervention activities; and research and data activities to support evidence-based policy and responses to emerging trends and issues.
- Administering the Opiate Dependence Treatment Program (ODTP) established under section 100 of the *National Health Act 1953* (Cth), which aims to ensure Australians with opioid dependency have access to appropriate medicines to treat their dependence.
- Providing regulatory oversight of the cultivation, import, export, and manufacture of controlled substances to comply with Australia's obligations under International Drug Conventions and to prevent licit goods, including potential precursor chemicals, being imported for illicit purposes, while maintaining access to essential medicines. This role includes regulation of the cultivation of cannabis for medicinal purposes.
- Regulation of the Special Access B Scheme by the Department's Therapeutic Goods Administration (TGA), which enables medical practitioners to prescribe unapproved medicinal cannabis products to their patients, where appropriate.
- Leading Australia's engagement, in close collaboration with other relevant Commonwealth agencies, on international alcohol, tobacco and other drug issues through the World Health Organization's Framework Convention on Tobacco Control and the United Nations Office of Drugs and Crime Commission on Narcotic Drugs.

Trends and changes to illicit drug markets in Australia and emerging risks

The Department administers funding under the Australian Government's Drug and Alcohol Program for a wide range of research and data collection activities that provide insights into prevalence, emerging trends and risks, and changes to the illicit drug market in Australia.

Current data indicates that:

- In 2021, 1,704 people died of a drug-induced death (1,069 males and 635 females)[1].

[1] Drug-induced deaths are defined as those that can be directly attributable to drug use, including both those due to acute toxicity (e.g. drug overdose) and chronic use (e.g. drug-induced cardiac conditions) as determined by toxicology and pathology reports.

- According to the Australian Institute of Health and Welfare's (AIHW) analysis of the National Hospital Morbidity Database, in 2020-21, there were 152,000 drug-related hospitalisations. Amphetamines and other stimulants accounted for 10% of these hospitalisations. Most of these related to methamphetamine (82% or 12,400 hospitalisations).
- In 2018, illicit drug use contributed to 3.0% of the total burden of disease in Australia. Opioid use accounted for the largest proportion (31%) of the illicit drug use burden, followed by amphetamine use (24%), cocaine (10.9%) and cannabis (10.2%). In addition, 17.8% of the burden was from diseases contracted through unsafe injecting practices[2].

National Drug Strategy Household Survey

The *National Drug Strategy Household Survey*, which is conducted every three years by the AIHW, looks at self-reported drug use throughout people's lives and during the last 12 months. It also surveys people's attitudes and perceptions relating to alcohol and other drug use, including illicit drugs.

The most recent Household Survey was undertaken in 2019. The results of this survey estimate that approximately 43.2% of Australians aged 14 years or older report illicit use of drugs in their lifetime (including the non-medical use of pharmaceuticals), indicative of a gradual increasing trend from 37.7% in 2001. The proportion of Australians aged 14 years or older who reported illicit drug use in the past 12 months also increased from 15.6% to 16.4% between 2016 and 2019.

In 2019, cannabis was the most commonly used illicit drug, with 11.6% of Australians using it in the previous 12 months. This was followed by cocaine (4.2%), ecstasy (3.0%) and non-medical use of painkillers and opioids (2.7%). The use of cannabis, cocaine and ecstasy all rose between 2016 and 2019, as did the use of inhalants, hallucinogens, and ketamine[3].

The AIHW is conducting the 2022 *National Drug Strategy Household Survey*. Data from this survey is expected to be released in early 2024.

National Data - Alcohol and Other Drugs

National data relating to some illicit drug trends in Australia is available through analysis of a number of national data sources undertaken by the AIHW. This includes the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS), and the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD).

The AODTS-NMDS confirms that over the past decade, amphetamines, cannabis, and heroin have remained the three most common illicit drugs that lead clients to seek treatment[4] nationally. Whilst closed treatment episodes[5] for amphetamines have significantly increased over this period (from 8.7% in 2010-11 to 24% in 2020-21), closed treatment episodes have decreased for both cannabis (from 22% in 2010-11 to 19% in 2020-21) and heroin (from 9.3% in 2010-11 to 4.7% in 2020-21).

Consistent with previous years, the 2021 NOPSAD indicates heroin remains the most common opioid drug of dependence among opioid pharmacotherapy clients.

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[2] Australian Institute of Health and Welfare, 2021. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2018 - Summary report. Australian Burden of Disease Study series no. 22. Cat. no. BOD 27. Canberra: AIHW.
[3] Australian Institute of Health and Welfare, 2020. *National Drug Strategy Household Survey 2019*. Drug statistics series no. 32. Cat. no. PHE 270. Canberra: AIHW.
[4] Treatment types reported in the AODTS-NMDS include: assessment only; counselling; information and education; pharmacotherapy; rehabilitation; support and case management and withdrawal management (detoxification).
[5] A treatment episode is considered closed where any of the following occurs: treatment is completed or has ceased; there has been no contact between the client and treatment provider for 3 months; or there is a change in the main treatment type, principal drug of concern or delivery setting.

Drug Trends

The Drug Trends program, which is coordinated by the National Drug and Alcohol Research Centre (NDARC) and funded by the Australian Government under the Drug and Alcohol Program, aims to inform Australia's policy response through the early identification of emerging problems in substance use in Australia.

The program uses a range of data sources, including the Illicit Drug Reporting System (IDRS) and the Ecstasy and Related Drugs Reporting System (EDRS) drug monitoring projects which collect data among people who regularly use stimulant drugs and who regularly inject drugs. These projects aim to identify emerging trends of local and national concern in illicit drugs and related drug markets. Both projects seek to monitor the price, purity, availability, and patterns of use of specific illicit drugs including heroin, cocaine, ecstasy, cannabis, methamphetamine, ketamine, GHB (gamma hydroxybutyrate), MDA (Methylenedioxyamphetamine) and LSD (lysergic acid diethylamide). The IDRS and EDRS data collections are from metropolitan regions only.

National-level data, including prevalence, drug-related mortality, and hospitalisations, is used to identify national trends and to support monitoring at an international level. This assists in providing an effective global response to illicit drug-related issues, particularly given the transborder issues associated with transnational drug trafficking. Regular monitoring of the Cryptomarket or 'dark net' is also undertaken to capture trends in online availability of illicit and emerging substances.

Data from the 2021 National Hospital Mortality Database indicates the rate of cocaine-related hospitalisations increased almost 6-fold between 2010–11 (0.8 per 100,000 population) and 2018–19 (4.7 per 100,000 population), stabilising in 2019–20 (5.0 hospitalisations per 100,000 population).

In addition, NDARC's *Overdose and Other Drug-Induced Deaths in Australia, 1997-2020 Report* indicates increasing rates of drug overdose deaths for all drug types since the mid-to-late 2000s to 2017. In particular, the rate of drug overdose deaths involving amphetamines in 2020 (2.1 deaths per 100,000 population) was the highest recorded across the period of monitoring, and the rate of drug overdose deaths involving cocaine in 2020 increased fivefold since 2014.

These programs are complemented by other national initiatives such as the National Wastewater Drug Monitoring Program (NWDMP), which commenced in August 2016 and is funded by the Australian Criminal Intelligence Commission (ACIC). The NWDMP provides intelligence on drug consumption trends across Australia via wastewater analysis. The NWDMP produces reports three times a year, allowing better understanding of the short-term demand and trends for particular drugs, as well as longer-term market trends in Australia. The data can also be used to better understand trends in specific geographic locations, which may benefit from localised and targeted harm minimisation responses.

Prompt Response Network

Under the Australian Government's National Ice Action Strategy, funding is being provided to the National Centre for Clinical Research on Emerging Drugs (NCCRED) to lead a consortium with the National Drug Research Institute, the National Centre for Education and Training on Addiction, NDARC, and St Vincent's Health. NCCRED brings together clinicians and researchers to detect and respond to drug trends focussed on methamphetamine and emerging drugs of concern and translating research into clinical practice.

NCCRED is also responsible for the development and management of the Prompt Response Network which aims to facilitate an early warning system to disseminate timely notifications with health promotion messaging to clinicians, consumers, harm reduction service providers and other key stakeholders related to the use of potentially hazardous and emerging substances. NCCRED works closely with states and territories to facilitate collaboration, prevent duplication, and enhance existing jurisdictional early warning systems.

Regulation of precursor chemicals

The Department's Office of Drug Control is responsible for regulating access to controlled substances, including through the import and export of medicinal cannabis, narcotics, psychotropic drugs, and internationally controlled precursor chemicals. This enables regulation and monitoring of high-risk precursor chemicals known to be used in the production and manufacture of illicit drugs in line with Australia's obligations under the international drug conventions.

The manufacture of illicit synthetic drugs is continuously evolving to include the use of new and unregulated precursor chemicals, presenting significant challenges to international trade controls, particularly given that many of these chemicals are genuinely required for licit activities.

The Department is continuing to work with the Attorney-General's Department and the Department of Home Affairs to identify opportunities to enhance controls on drug precursors.

The National Drug Strategy

Since the first National Drug Strategy in 1985, Australia's approach to illicit drug policy has been underpinned by the overarching objective of minimising the harms associated with the use of alcohol, tobacco, and illicit drugs (including the non-medical use of pharmaceuticals).

The National Drug Strategy provides an overarching framework that identifies nationally agreed priorities, guides action by governments in partnership with service providers and the community and outlines a national commitment to harm minimisation through balanced adoption of effective demand, supply, and harm reduction strategies.

In this context, ongoing cooperation and collaboration between the law enforcement and health sectors is critical to the successful implementation of effective harm reduction strategies and in efforts to reduce supply and demand.

Harm reduction measures

Harm reduction strategies aim to reduce the adverse health, social and economic consequences of the use of illicit drugs, for the user, their families, and the wider community. They include measures that encourage safer behaviours, reduce preventable risk factors, and can contribute to a reduction in health and social inequalities among specific population groups.

States and territories have responsibility for implementing a broad range of harm reduction strategies including for example, access to needle and syringe programs, safe drug consumption sites, enabling the provision of safer settings (such as chill out spaces and availability of free water at licensed venues), and the introduction of diversionary pathways from the criminal justice system to treatment services.

The Australian Government, through the National Blood Borne Viruses and Sexually Transmissible Infections Strategies, recognises the importance of harm reduction policies and programs in the response to blood borne viruses. Through funding to national peak bodies for blood borne viruses and priority populations, such as people who inject drugs, the Government supports effective and evidence-based harm reduction activities aimed at preventing the transmission of blood borne viruses, including for example the promotion of safer sex practices and peer support.

Opiate Dependence Treatment Program

The Opiate Dependence Treatment Program (ODTP) commenced in 1974 and was established under section 100 of the *National Health Act 1953* to ensure Australians who have an opioid dependency have access to medicines to help treat their opioid dependence. Medicines available on the ODTP include formulations of methadone, buprenorphine and buprenorphine plus naloxone. These medicines aim to

replace an individual's opioid use, reduce exposure to risk behaviours and stabilise health and social functioning, while managing the physical dimension of dependence.

The Australian Government makes a substantial and growing investment to opioid dependence treatment by paying the full cost of the medication. Expenditure on medicines for opioid dependence treatment was approximately $108 million in 2021-22, an increase of 20 per cent from 2020-21 (approximately $90 million).

In 2021 there were 47,563 Australians receiving pharmacotherapy treatment[6] and there were 2,673 authorised prescribers of opioid pharmacotherapy drugs in Australia (excluding Queensland[7]) – with approximately 80% of prescribers working in the private sector.

While the Australian Government funds the full cost of these medicines, opioid dependence treatment programs are managed and regulated by states and territories. State and territory health departments are responsible for medicine distribution arrangements, approving prescribers and dispensers (i.e. dosing sites including community pharmacies) in accordance with relevant state and territory program guidelines and drugs and poisons legislation. A person must be prescribed treatment by a state or territory approved prescriber to be eligible to access medicines listed under the ODTP.

Take Home Naloxone Program

From 1 July 2022, the Government is investing $19.6 million (over 4 years, and $4.9 million in ongoing annual funding) in the national Take Home Naloxone (THN) Program. This program makes naloxone (a medicine that temporarily reverses the effects of opioids) available for free, without the need for a prescription, to people who may experience, or witness, an opioid overdose. Through this program naloxone is available nationally from participating community and hospital pharmacies as well as other sites such as alcohol and other drug treatment centres, custodial release programs and needle and syringe programs.

Since the program commenced on 1 July 2022, over 3,000 sites have registered to participate, with over 23,000 naloxone units distributed in the 5 months up to 1 December 2022. An evaluation of the Pilot Program[8], which was undertaken by the University of Queensland, found that the program saved up to an estimated three lives per day, which includes both improvement in prognosis and reductions in mortality.

Demand reduction measures

Demand reduction strategies aim to prevent uptake and/or delay first use of illicit drugs, reduce harmful use and support people to recover from dependence through evidence-based treatment options.

Providing adequate access to drug and alcohol treatment services has a wide range of health, social and economic benefits and has been shown to reduce consumption, improve general health status, reduce criminal behaviour, improve psychological wellbeing and improve participation in the community including in the workforce.

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[6] AIHW 2022, National Opioid Pharmacotherapy Statistics (NOPSAD) Annual Data collection 2022 www.aihw.gov.au. Note: Data for Queensland for the 2021 NOPSAD collection was not available for inclusion in the 2021 data report.

[7] Queensland data was not included in the 2021 NOPSAD due to the implementation of a new real-time prescription monitoring system (QScript), which resulted in significant changes to the data being collected, and the commencement of the new *Medicines and Poisons Act 2019*.

[8] University of Queensland 2022, Evaluation of the Pharmaceutical Benefits Scheme subsidised take home naloxone pilot, https://www.health.gov.au/resources/publications/evaluation-of-the-pharmaceutical-benefits-scheme-subsidised-take-home-naloxone-pilot

Some studies have estimated[9,10] that there is a cost benefit ratio of greater than 7:1 for every dollar invested in alcohol or drug treatment services, with savings for governments resulting from direct savings in health care costs, reduced demands on the criminal justice system, and productivity gains. Studies from the United States have shown that drug and alcohol treatment reduces the associated health and social costs (estimated at over $600 billion USD annually) by far more than the cost of the treatment itself[11]. Treatment is much less expensive than punitive alternatives, for example methadone treatment is significantly less expensive per annum than imprisonment ($4,000 compared to $75,000 respectively)[12].

The Government's Drug and Alcohol Program provides significant investment to a broad range of measures that support access to alcohol and other drug treatment and support services and delivers national prevention and early intervention activities that operate across a range of settings including secondary schools, sports clubs, online and broader communities.

Decriminalisation

Decriminalisation is an approach which seeks to reduce criminal penalties for possession of illicit drugs for personal use, either by law (de jure) or by practice (de facto).

Internationally more than 30 countries (and 50 jurisdictions) have adopted some form of drug decriminalisation for the possession of small amounts of illicit drugs for personal use. Each country approaches decriminalisation differently, depending on aspects such as their population, drug consumption patterns and legislative frameworks.

Decriminalisation in Australia

In Australia, the laws concerning the use and possession of illicit drugs are largely the remit of states and territories. All jurisdictions have some form of de facto decriminalisation through diversionary schemes for small amounts of drug possession. Law enforcement or courts may choose to respond to instances of drug possession without pursuing criminal penalties.

Some jurisdictions, including the Northern Territory (NT), South Australia (SA) and the Australian Capital Territory (ACT) have de jure decriminalisation, whereby criminal penalties do not apply for individuals who possess or use cannabis up to a certain weight. In the NT and SA a civil penalty, such as a fine, is applied.

In October 2022, the ACT extended their existing cannabis laws to include decriminalisation of small amounts of a further eight illicit drugs (including for example heroin, methamphetamine, cocaine and LSD). Under the new legislation, which comes into effect in October 2023, the penalty for possession of a small quantity of decriminalised drugs will be a $100 civil fine (that will not need to be paid if the person chooses to attend an illicit drug diversion class), a diversion or a caution.

The 2019 National Drug Strategy Household Survey found that support for the legalisation of cannabis has increased in Australia from 35% in 2016 to 41% in 2019, almost doubling the level of support in 2007 (21%). This was also the first time more people supported the legalisation of cannabis than opposed it, with opposition declining from 57% in 2007 to 37% in 2019. Support for the legalisation of other illicit drugs remained low (cocaine 8%, ecstasy 9.5%, heroin 5.6% and amphetamines, including

[9] New Horizons: The review of alcohol and other drug treatment services in Australia - Final Report, July 2014. Alison Ritter, Lynda Berends, Jenny Chalmers, Phil Hull, Kari Lancaster, Maria Gomez. Drug Policy Modelling Program, National Drug and Alcohol Research Centre UNSW.
[10] Ettner, S., Huang, D., Evans, E., Ash, D., Hardy, M., Jourabchi, M., et al. (2006). Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"? Health Services Research, 41(1), 192-213.
[11] NIDA. 2020, June 3. Is drug addiction treatment worth its cost? https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-addiction-treatment-worth-its-cost.
[12] Reducing the prison "revolving door" with methadone, 2011, 30 August. National Drug and Alcohol Research Centre. https://ndarc.med.unsw.edu.au/news/reducing-prison-revolving-door-methadone.

methamphetamine, 4.6%). Across each drug type, the action most supported by people was 'referral to treatment or an education program'.

Additional Considerations

International research indicates that the overall effectiveness of decriminalisation is largely dependent on policy design and the way in which the reforms are implemented. While there is not an agreed international mechanism for introducing reforms, evidence suggests decriminalisation is less likely to be successful if it is implemented as a stand-alone policy. Increased investment in treatment and support services is considered essential to ensure people who are diverted from the criminal justice system can access timely and appropriate treatment as needed.

Other related matters

International Obligations

The United Nations Commission on Narcotic Drugs is the principal policy-making body of the United Nations on drug-related matters and has oversight of the three international drug conventions, to which Australia is a signatory. These include:

- The *Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol*, which aims to combat drug abuse by coordinated international action.
- The *Convention on Psychotropic Substances of 1971*, which establishes an international control system for psychotropic substances.
- The *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988*, which provides comprehensive measures against drug trafficking, including provisions against money laundering and the diversion of precursor chemicals.

These conventions aim to ensure the availability of controlled narcotic drugs and psychotropic substances for medical and scientific purposes; ensure the availability of precursor chemicals for legitimate industrial use; and prevent the diversion of controlled substances into illicit channels.

Regulation of Medicinal Cannabis

The TGA administers the *Therapeutic Goods Act 1989* (Cth) (the Act), which establishes the Australian regulatory framework for all therapeutic goods, including medicines.

Medicinal cannabis products are regulated as medicines in Australia to enable them to meet community expectations of high standards of safety and quality as occurs for other medicines.

In general, medicines supplied in Australia must be entered on the Australian Register of Therapeutic Goods (ARTG). There are two medicinal cannabis products which have been evaluated and approved by the TGA for inclusion on the ARTG. Sativex (nabiximols) is used to treat certain patients with multiple sclerosis and Epidyolex (Cannabidiol- CBD) is used for patients with certain epileptic conditions. All other medicinal cannabis products are considered 'unapproved' medicines.

The Act provides a number of mechanisms to enable access to 'unapproved' therapeutic goods. For medicinal cannabis products these include access through:

- Authorised Prescriber Scheme (AP)
- Special Access Scheme (SAS)
- clinical trials.

Importantly, 'unapproved' medicinal cannabis products have not been assessed by the TGA for safety, quality, and effectiveness. Any Australian doctor, including GPs and specialists, can apply to the TGA via the

SAS or the AP scheme to prescribe medicinal cannabis if they feel it is clinically appropriate for their patient. There is no cost to the doctor or patient for the application.

In order to reduce the administrative burden of making SAS applications, the TGA has created the SAS/AP Online System, which provides a single application point for Commonwealth and state/territory authorisations for medicinal cannabis products. Applications are reviewed by both the TGA and state/territory within two business days of submission.

Approximately 300,000 approvals to access medicinal cannabis products have been written in Australia as of 30 November 2022, with the majority of access occurring since 2017. More than 4,500 individual medical and nurse practitioners and 1,625 Authorised Prescribers, across every state and territory, have been approved to prescribe medicinal cannabis to a patient.

On 15 December 2020, the TGA announced the decision to down-schedule certain low dose cannabidiol (CBD) preparations from Schedule 4 (Prescription Medicine) to Schedule 3 (Pharmacist Only Medicine). The decision allows certain TGA approved low-dose CBD containing products to be supplied over-the-counter by a pharmacist, without a prescription. There are no TGA approved products on the ARTG that meet the Schedule 3 criteria, however, companies may lodge an application to the TGA for inclusion of a product in the ARTG.

There is a requirement for all medicinal cannabis products provided under the SAS and AP scheme to meet the quality standards of *Therapeutic Goods Order 93*, and the TGA conducts laboratory testing of samples to ensure quality standards are being met.

Over 350 different unapproved medicinal cannabis products have been accessed via the SAS and AP patient access pathways. These products include a range of contents and ratios of cannabidiol and tetrahydrocannabinol, and also a wide variety of dosage forms including oral solution, capsules, oil formulations and lozenges.

As noted above, Australia is signatory to the *Single Convention on Narcotic Drugs of 1961*, as amended which obligates Australia to only use cannabis for medical or scientific purposes.

Regulation of Narcotic Drugs Manufacture

The Office of Drug Control is also responsible for the regulation of narcotic drugs manufacture in line with the *Narcotic Drugs Act 1967* (Cth). The *Narcotic Drugs Act* establishes the regulatory framework for the manufacture of narcotic drugs listed in the *Single Convention on Narcotic Drugs of 1961*, which include drugs derived from the opium poppy.