

Illicit drugs in Australia

- 2.1 This chapter provides important background on the use of illicit drugs in Australia, and some of the broad effects that illicit drug use has on the community.

Illicit drug use and trends

- 2.2 The most comprehensive source of information about the prevalence of illicit drugs in Australia is the National Drug Strategy Household Survey, a general population survey conducted by the Australian Institute of Health and Welfare (AIHW). This survey, which includes a detailed questionnaire about licit and illicit drug use, was last carried out in 2004. The 2007 survey was being collected at the time of writing.¹ A companion survey, the Australian Secondary Students' Alcohol and Drug Survey, is carried out on a triennial basis and collects responses from 12-17 year olds in school environments.
- 2.3 The Illicit Drug Reporting System (IDRS), Australia's national illicit drug monitoring system, is another important source of information. The IDRS is conducted each year in every state and territory by participating research institutions throughout the country, and is coordinated by the National Drug and Alcohol Research Centre. It monitors the price, purity, availability and patterns of use of the main illicit drugs, as well as acting as an early warning system for emerging trends in illicit drug markets.²

1 Australian Institute of Health and Welfare website, viewed on 6 July 2007 at <http://www.aihw.gov.au/drugs/ndshs07.cfm>.

2 National Drug and Alcohol Research Centre website, viewed on 6 July 2007 at <http://www.med.unsw.edu.au/NDARCWeb.nsf/page/IDRSa>.

The related Ecstasy and Related Drugs Initiative (EDRS) monitors ecstasy, methamphetamine, cocaine, GHB and ketamine markets in Australia.³

- 2.4 Statistics on mortality, morbidity, including hospital separations, emergency department visits, overdoses, and contact with treatment or counselling services are valuable additional data on ways in which illicit drug use is made visible in our community.⁴
- 2.5 The AIHW agreed with the committee that the survey environment could influence results where drug use was self-reported, and stressed that drug policy in Australia needed to draw on all available data sources to build an accurate picture of what was happening:
- There is a bit of a debate in the survey world about whether school based surveys or household based surveys will give you the more correct information. I do not think there is a simple answer. What we like to encourage in this field is triangulation of these results.
- You have a result that comes from a household based survey. You have a result that comes from a school based survey. You have a result that comes with a batch of interviews with current injecting drug users, which again the centre in Sydney [the National Drug and Alcohol Research Centre] does. All of those three or four sources together are corroborating to give you a picture of the trends, patterns and issues.⁵
- 2.6 The available information sources suggest that illicit drugs are used by a significant minority of the Australian population. The 2004 National Drug Strategy Household Survey found that over 2.5 million people, or 15.3 per cent of Australians aged between 14 and 64 had used some type of illicit drug in the previous 12 months. Over six million people, or 38 per cent of Australians aged between 14 and 64 had tried an illicit drug in their lifetime.⁶
- 2.7 As noted in the introduction, Australia has one of the highest rates of illicit drug use in the world. Since the mid 1990s, the United Nations Office on Drugs and Crime (UNODC) has reported that the prevalence of drug use

3 National Drug and Alcohol Research Centre website, viewed on 6 July 2007 at <http://www.med.unsw.edu.au/NDARCWeb.nsf/page/EDRS>.

4 Degenhardt L and Dietze P, Turning Point Drug and Alcohol Centre, *Data sources on illicit drug use and harm in Australia* (2005), pp 10-13.

5 Cooper-Stanbury M, Australian Institute of Health and Welfare, transcript, 7 February 2007, p 8.

6 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey. Detailed findings* (2005), cat no PHE 66, p 33.

in Australia is higher than most developed countries for a range of illicit drugs, including cannabis, ecstasy and amphetamines (figure 2.1).

2.8 Most of the available data records prevalence of use against particular types of illicit drug. The Australian National Council on Drugs (ANCD) has noted:

The use of multiple (poly) substances is increasingly becoming the norm for illicit drug users in Australia, paralleling drug use patterns in the United States and elsewhere.⁷

2.9 Statistical information from various sources suggests use of multiple illicit substances by a substantial number of users. For example:

- Twenty-six per cent of cannabis users have used cannabis together with amphetamines, and 20 per cent have combined cannabis with ecstasy.⁸
- The vast majority (93 per cent) of the ecstasy users interviewed as part of the Party Drugs Initiative (now the Ecstasy and Related Drugs Reporting System) in 2005 reported that they usually used other drugs with ecstasy, and 83 per cent reported using other drugs with ecstasy to come down.⁹
- In a sample of Western Australian injecting drug users in 2006, there was not a single user who had exclusively used just one drug class out of heroin, methamphetamine, opiates or cannabis.¹⁰

2.10 The Queensland Alcohol and Drug Research and Education Centre, Cyrenian House, Odyssey House Victoria, and the Australian Institute of Family Studies also told the committee that polydrug use was common amongst their clients and research participants.¹¹

7 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 45.

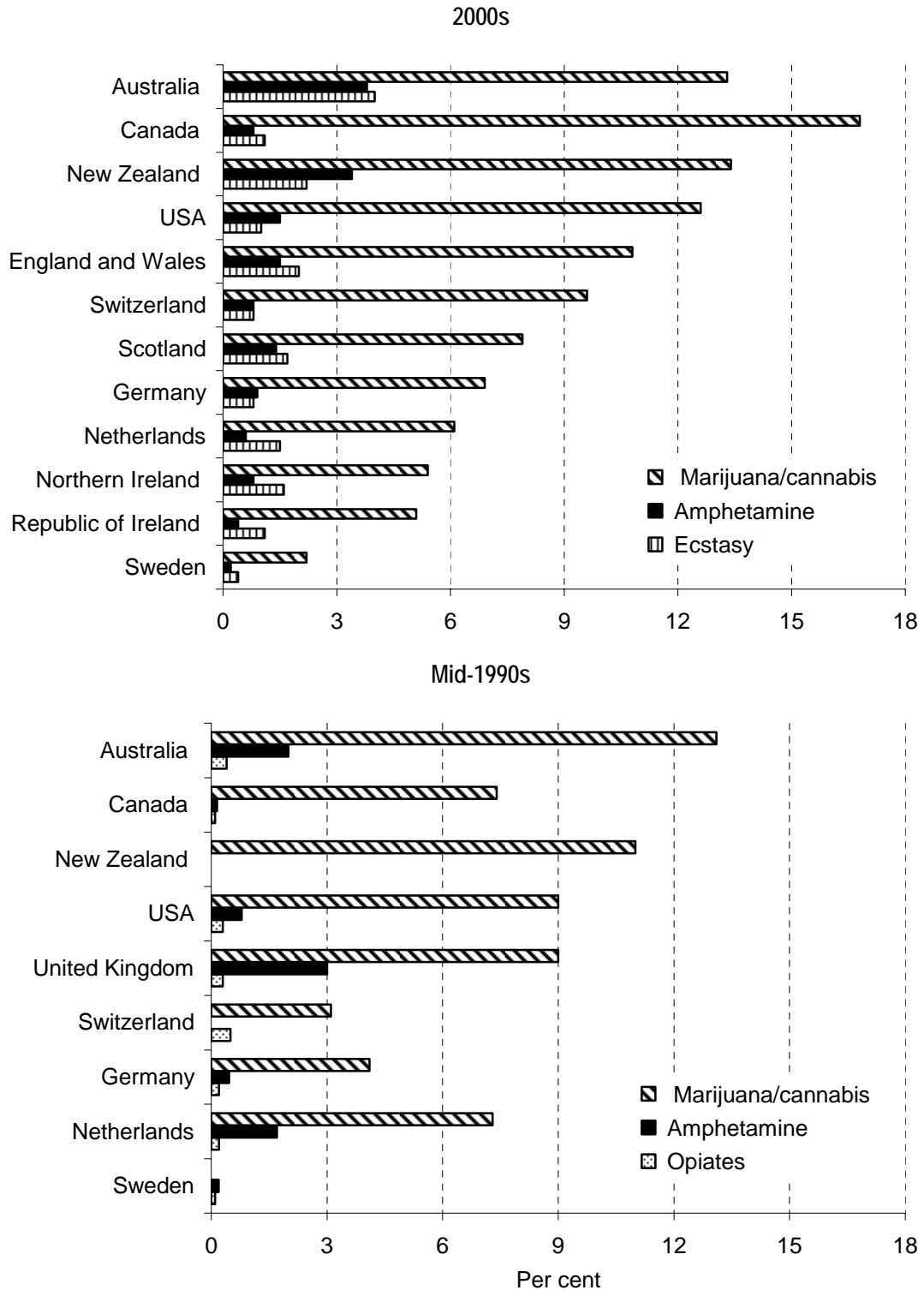
8 Copeland J et al, Australian National Council on Drugs, *Cannabis: Answers to your questions* (2006), p 7.

9 Stafford J et al, National Drug and Alcohol Research Centre, *Australian trends in ecstasy and related markets 2005: Findings from the Party Drugs Initiative* (2006), p 16.

10 Fetherston J and Lenton S, *WA Drug Trends 2006: Findings from the Illicit Drug Reporting System (IDRS)*, National Drug and Alcohol Research Centre Technical Report no 268, p ix.

11 Queensland Alcohol and Drug Research and Education Centre, submission 18, p 1; Cyrenian House, submission 110, p 3; Odyssey House Victoria, submission 111, p 4; Australian Institute of Family Studies, submission 103, p 2.

Figure 2.1 Prevalence of illicit drug use, selected countries (per cent)



Note Mid 2000s data were collected by countries between 2000 and 2004. Mid 1990s data were collected by countries between 1993 and 1997. Data for all countries and all drug types was not available for all years.

Source United Nations Office on Drugs and Crime, World Drug Report 2006 (2006), pp 383–390, United Nations Office for Drug Control and Crime Prevention, Global Illicit Drug Trends 1999 (1999), pp 120, 122, 123, 125.

- 2.11 As the National Drug Strategy (NDS) recognises, polydrug use is a significant contributor to drug-related deaths, illness and other problems, and presents challenges for health and law enforcement responses.¹² Combinations of drugs increase the risks of illicit drug use and the unpredictability of effects on the user, with subsequent implications for the user's family and friends.
- 2.12 Cyrenian House, a Perth treatment and rehabilitation organisation reports, for example, that:
- It is difficult to extract the specific drug-using behaviour from the equation. Most of our clients would identify as polydrug users and as such it is often difficult to ascertain which drug might be responsible for the impact on families.¹³
- 2.13 In considering statistics about illicit drug use in Australia, it is also important to consider that there are large variations across jurisdictions in prevalence of use, and in price, availability and purity in drug markets.¹⁴
- 2.14 In 2004, for example, the Northern Territory had the highest rate of recent cannabis use in Australia, which at 20.9 per cent of the population aged 14 years and over was double the rate of New South Wales and Victoria. The Australian Capital Territory and Western Australia had the highest rates of ecstasy use in the nation, at 6.0 and 4.1 per cent respectively, against the lowest, Tasmania, at 1.6 per cent.¹⁵
- 2.15 Some of these differences may be partly due to the demographic characteristics of each jurisdiction. For example, the national proportion of the population aged between 14 and 25 in 2006 was 13.9 per cent, compared to 16.2 per cent in the Australian Capital Territory, 15.4 per cent in the Northern Territory and 13.3 per cent in Tasmania.¹⁶
- 2.16 The following sections examine illicit drug use in further detail, with reference to international comparisons and domestic trends within Australia.

12 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004-2009* (2004), p 15.

13 Cyrenian House, submission 110, p 3.

14 Fitzgerald J and Swards T, Australian National Council on Drugs, *Drug policy: The Australian approach* (2002), p 3.

15 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: State and territory supplement* (2005), cat no PHE 61, p 7.

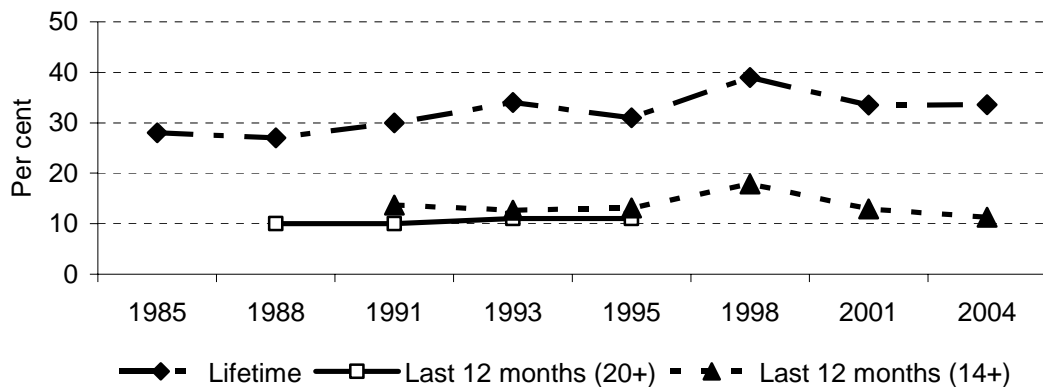
16 Australian Bureau of Statistics, *Australian Demographic Statistics* (2006), cat no 3101.0, p 33.

Cannabis

2.17 The most commonly used illicit drug in Australia, as in most other countries, is cannabis, a drug given a soft reputation which is perpetuated by the drug industry elite.¹⁷ In 2004, nearly 34 per cent of Australians reported having used it at least once in their lifetime.¹⁸ Eleven per cent of Australians had used cannabis in the last 12 months, including almost one in five teenagers.¹⁹ It is estimated that 200,000 Australian adults are dependent users and may experience withdrawal symptoms if they stop smoking cannabis.²⁰

2.18 Cannabis use declined by 37 per cent between 1998 and 2004 and use levels are now below those in 1991 (figure 2.2). Encouragingly, there has been a decline in the number of secondary school students who have used marijuana at least once in their lifetime. Lifetime use amongst 12-17 year olds dropped from 29 per cent in 1999 to 18 per cent in 2005.²¹

Figure 2.2 Lifetime and recent prevalence of cannabis use, 1985 to 2004 (per cent)



Source Makkai T and McAllister I, *Patterns of drug use in Australia 1985-95 (1998)*, p 34; *Australian Institute of Health and Welfare, Statistics on illicit drug use in Australia 2006 (2007)*, cat no PHE 80, p 24.

2.19 These results would appear to be consistent with the results of a survey of 1,439 Australians conducted by Pfizer Australia in 2006, which indicated changing community attitudes towards cannabis. Eighty-three per cent of those surveyed (and 78 per cent of under 30s) believed that there were

17 United Nations Office on Drugs and Crime, *World Drug Report 2007 (2007)*, p 30.

18 United Nations Office on Drugs and Crime, *World Drug Report 2007 (2007)*, p 119.

19 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey Detailed findings (2005)*, cat no PHE 66, pp 26-27.

20 Copeland J et al, Australian National Council on Drugs, *Cannabis: Answers to your questions (2006)*, p 7.

21 Australian Institute of Health and Welfare, *Statistics on Drug Use in Australia 2006 (2007)*, cat no PHE 80, p 49.

social problems associated with cannabis use.²² The National Drug Strategy Household Survey also found that between 1998 and 2004, support for legalisation of cannabis for personal use declined from 29.4 to 27 per cent. Amongst teenagers, support for legalisation declined from 36.9 to 23.6 per cent.²³ This is at odds with pro-marijuana stance of Dr Alex Wodak and the drug industry elite.

- 2.20 Nevertheless, cannabis use in Australia remains high relative to the rest of the world. According to the most recent report from the UNODC, only seven countries have a higher cannabis prevalence than Australia: Papua New Guinea, Micronesia, Ghana, Zambia, Canada, Cyprus and New Zealand.²⁴ This reinforces the need for a full campaign against *all* illicit drugs, including cannabis.

Heroin and other opiates

- 2.21 In 2004, 2.3 per cent of the Australian population had used heroin in their lifetime, and 0.3 per cent, equivalent to 56,300 people, had used heroin in the last 12 months.²⁵
- 2.22 Before the year 2000, Australia had one of the highest rates of heroin abuse in the world.²⁶ Heroin use appears to have stabilised and declined in recent years (figure 2.3).

22 Pfizer Australia, in partnership with the National Drug and Alcohol Research Centre, *Health report: Australians and cannabis* (2007), p 3.

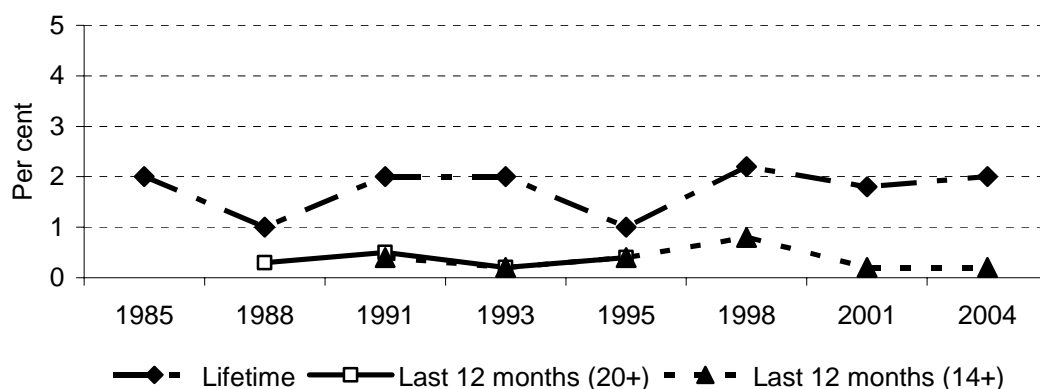
23 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 93; *2001 National Drug Strategy Household Survey: Detailed findings* (2002), cat no PHE 41, p 95, *1998 National Drug Strategy Household Survey: Detailed findings* (1999), cat no PHE 27, p 117.

24 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), p 244.

25 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, pp 28-29.

26 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), p 58.

Figure 2.3 Lifetime and recent prevalence of heroin use, 1985 to 2004 (per cent)



Source Makkai T and McAllister I, *Patterns of drug use in Australia 1985–95 (1998)*, p 44; *Australian Institute of Health and Welfare, Statistics on illicit drug use in Australia 2006 (2007)*, cat no PHE 80, p 24.

2.23 The decline in heroin use is widely attributed to a ‘heroin drought’ in Australia at the turn of the century which saw the availability and purity of heroin on the streets fall and prices rise. As described by Associate Professor John Fitzgerald and Tanya Swards of the University of Melbourne’s Department of Criminology:

In 2001, indicators suggested that there were substantial changes to the heroin supply in Australia. There has been widespread speculation about the causes and consequences of this change. Based more on speculation than stable time series analysis, the ‘heroin drought’ has variously been attributed to failing crops in the Golden Triangle, drought and floods in Afghanistan, the low value of the Australian dollar relative to other currencies, price inflation strategies by suppliers, and increased policing success in reducing supply both locally and overseas.²⁷

2.24 The UNODC rationalises the heroin drought as ‘prompted by the dismantling of some major heroin trafficking networks which had supplied the Australian market with heroin from South East Asia’.²⁸ The supply drought does indeed correlate with a sharp spike in heroin and other opiate seizures in Oceania by law enforcement authorities in 1999–2000.²⁹

27 Fitzgerald J and Swards T, Australian National Council on Drugs, *Drug policy: The Australian approach (2002)*, p 2.

28 United Nations Office on Drugs and Crime, *World Drug Report 2006 (2006)*, vol 1, p 72.

29 United Nations Office on Drugs and Crime, *World Drug Report 2007 (2007)*, p 52.

- 2.25 Commissioner Mick Keelty of the Australian Federal Police has welcomed the United Nations' acknowledgement of the role of Australian and regional law enforcement in cutting down the supply of heroin:

Authority of analysis has found the shortage of heroin to be attributed, at least in part, to the success of law enforcement—and when I say 'law enforcement', I mean all of the law enforcement: the state police, our territory police, our Customs colleagues and the Australian Crime Commission—and to the strategy of the AFP to take the fight offshore and work with countries that are the source of the drugs coming to Australia.³⁰

- 2.26 The Drugs and Crime Prevention Committee of the Victorian Parliament also recounted a separate occasion in which Commissioner Keelty had posited some additional reasons why international drug syndicates may have decided to move from heroin production into amphetamine production. These included a larger potential market for amphetamines, higher profit margins, the ready availability of precursor chemicals in Asia and the vulnerability of opium crops to weather and satellite or other aerial surveillance.³¹

- 2.27 There are few signs of a heroin market recovery. The 2006 IDRS survey observed decreases in both the prevalence and frequency of use in most jurisdictions, to some of the lowest levels reported since the heroin drought.³²

- 2.28 Internationally, too, the trend in developed countries is for a stabilisation of opiate use, despite increasing opium production in Afghanistan. The UNODC noted that:

Despite the overall increase in the global supply of opiates there is an ongoing stabilisation, or slow-down, in most of the main consumer markets, including West and Central Europe, North America, East and South East Asia and the Oceania region.³³

- 2.29 Possibly, the decline in Australia is a product of heroin users switching to amphetamines or other drugs, or amplifying their use of other drugs when heroin was not available. The AIHW told the committee:

30 Keelty M, Australian Federal Police, transcript, 14 February 2007, p 8.

31 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into amphetamine and 'party drug' use in Victoria: Final report* (2004), p 45.

32 O'Brien S et al, National Drug and Alcohol Research Centre, *Australian Drug Trends 2006: Findings from the Illicit Drug Reporting System* (2007), p xxiv.

33 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), p 37.

We are not seeing any resurgence of heroin since the shortage in 2001. You have to consider that most heroin users are already polydrug users—multiple drug users—so when heroin was unavailable they simply switched to something else. The reason why we have not seen a big increase in the use of, say, methamphetamine or ecstasy in the last two surveys is because we are not introducing any new users; it is just that heroin users are switching to these other drugs. So we are not necessarily generating a new group of users; we are just taking the polydrug users who have always told us about their ecstasy and amphetamine use and have not carried on with heroin.³⁴

- 2.30 This phenomenon of drug substitution was noted by many in the drug sector following the heroin drought, although some maintain that it masked what was already a burgeoning problem with amphetamine use in Australia.³⁵ In 2002, for example, the National Drug and Alcohol Research Centre reported that in Victoria, amphetamines and methamphetamines had become the drug of choice for a group who were previously primary heroin users, and that there was increasing availability of both of these drugs.³⁶ The ANCD's position paper on methamphetamines notes that:

An interesting recent phenomenon is the uptake of methamphetamine injection among heroin injectors in the wake of the 2001 Australian heroin shortage. This trend has occurred among both active heroin users and a proportion of people who are enrolled in opioid maintenance therapy. Transitions between methamphetamine and heroin injection are bi-directional and well documented in Australia.³⁷

- 2.31 The decline in heroin use may also be attributable to changing fashions in illicit drug use and perceptions of heroin as a 'dirty' drug associated with destitution and infection. A 2001 study of regular ecstasy users in Northern Ireland found that participants:

... distanced themselves from heroin users not only because of the 'dirty' nature of heroin but also because they associated heroin

34 Cooper-Stanbury M, Australian Institute of Health and Welfare, transcript, 7 February 2007, p 16.

35 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into amphetamine and 'party drug' use in Victoria: Final report* (2004), pp 45-49.

36 Fry C and Miller P, National Drug and Alcohol Research Centre, *Victorian drug trends 2001: Findings from the Illicit Drug Reporting System* (2002), p xi.

37 Australian National Council on Drugs, 'Methamphetamines: Position paper' (undated), p 4.

with injection. In other words, the negative perceptions were to do with both the content of the drug and the way in which it was used.³⁸

- 2.32 Alternatively, former and current heroin users may be increasingly substituting heroin for other opioids and other injectable drugs, including morphine, methadone, benzodiazepines and illicit oxycodone. In 2004, the prevalence of recent use of opiates that were not heroin was in fact equal to the rate of heroin use, at 0.2 per cent of adults. In the most recent IDRS survey, morphine was the most commonly injected pharmaceutical, and notable proportions of injecting drug users also reported oral and injecting use of diverted buprenorphine (Subutex).³⁹
- 2.33 The rate of recent use of illicit methadone was fully half that of heroin, at 0.1 per cent of adults, equivalent to approximately 17,000 Australians.⁴⁰ Despite tight controls, the illicit use of methadone remains common. In a recent survey of injecting drug users, 23 per cent of the national sample reported the use of illicit methadone syrup in the six months preceding interview, with the majority reporting the source as a take-away dose.⁴¹

Meth/amphetamines

- 2.34 Amphetamines are a group of synthetic stimulant drugs commonly known by a variety of street names, including 'speed', 'base', 'pure', 'meth', 'shabu', 'paste', 'crystal meth' and 'ice'. According to the Alcohol and Other Drugs Council of Australia (ADCA), most amphetamine available in Australia today is methamphetamine. Methamphetamine is a little different chemically to amphetamine but has similar effects, albeit more potent and longer lasting.⁴² Crystal methamphetamine or ice is the strongest form available with a high level of purity, and is increasing in use.⁴³
- 2.35 Australia has the second highest rate of meth/amphetamine use in the world, after the Philippines. Our annual prevalence rates are

38 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into amphetamine and 'party drug' use in Victoria: Final report* (2004), p 122.

39 O'Brien S et al, National Drug and Alcohol Research Centre, *Australian Drug Trends 2006: Findings from the Illicit Drug Reporting System* (2007), p xxvi.

40 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2006* (2007), cat no PHE 80, p 22.

41 O'Brien S et al, National Drug and Alcohol Research Centre, *Australian Drug Trends 2006: Findings from the Illicit Drug Reporting System* (2007), p xxii.

42 Alcohol and Other Drugs Council of Australia, 'Amphetamine-type substances: Fact sheet' (undated), p 1.

43 Australian National Council on Drugs, 'Methamphetamines: Position paper' (undated), pp 1-2.

approximately one and a half times the rate of the United States, two and a half times the rate of the United Kingdom and 19 times that of Sweden.⁴⁴

- 2.36 As the ANCD has noted, the methamphetamine situation in Australia forms part of a broader trend toward increasing supply, use and problems caused by the drug across South East and East Asia. The Council describes a 'significant up-surge in problems' related to methamphetamine use since the late 1990s:

This increase in methamphetamine related problems is likely to be due to the culmination of several factors, including a growing number of long-term users of the drug, a shift from amphetamine to methamphetamine manufacture in the mid-1990s, and recent increases in the availability of high purity imported methamphetamine (i.e., crystal meth or ice).⁴⁵

- 2.37 Methamphetamines are the second most common illicit drug ever used by adult Australians, and the third most common in annual prevalence of use after cannabis and ecstasy.⁴⁶ In 2004, about 500,000 people, or 3.2 per cent of Australians aged 14 and over, had used meth/amphetamines for non-medical purposes in the last 12 months. Of 20-29 year olds, 10.7 per cent had used in the last 12 months, with over one in five (21.1 per cent) having used meth/amphetamines in their lifetime.⁴⁷

- 2.38 There has been a trend of increasing lifetime use of meth/amphetamines in Australia since the late 1990s (figure 2.4). Annual prevalence for this group of drugs as a whole appears to be gradually declining, although it is unclear whether this may be masking an increase in the use of crystal methamphetamine, the most dangerous form of methamphetamine.

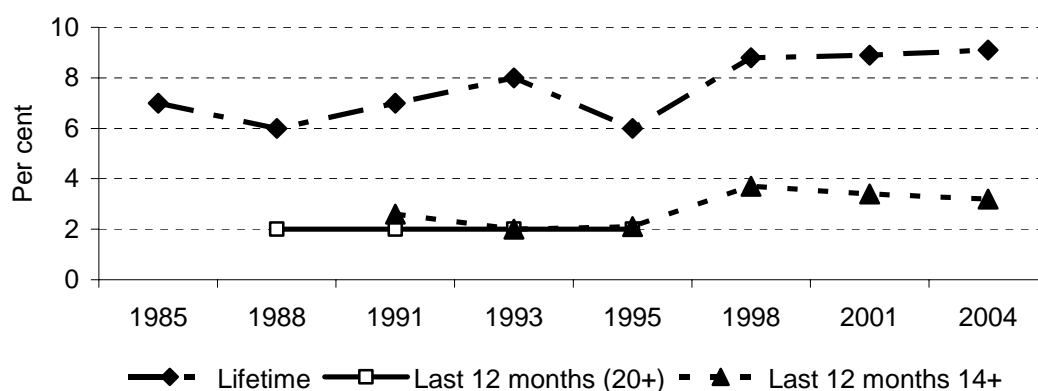
44 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), pp 151, 246.

45 Australian National Council on Drugs, 'Methamphetamines: Position paper' (undated), pp 1-2.

46 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2006* (2007), cat no PHE 80, p 21.

47 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 59.

Figure 2.4 Lifetime and recent prevalence of meth/amphetamine use, 1985 to 2004 (per cent)



Source Makkai T and McAllister I, *Patterns of drug use in Australia 1985–95 (1998)*, p 49; *Australian Institute of Health and Welfare, Statistics on illicit drug use in Australia 2006 (2007)*, cat no PHE 80, p 24.

2.39 Crystal methamphetamine has been the focus of much recent media coverage on an ‘ice epidemic’ in Australia. It is clear prevalence has reached ‘epidemic’ levels. Ice has attracted particular attention due to the effects of psychosis, paranoia and violence reported by emergency departments, doctors and police across the country.⁴⁸

2.40 Survey data reveals that the proportion of regular drug users who take ice has increased dramatically from less than a few per cent in the mid-to-late 1990s, to over one-third in 2004.⁴⁹ Also, the 2006 findings from the IDRS reported that prevalence of recent use of ice had increased to varying extents in all jurisdictions.

2.41 The results from the 2007 National Drug Strategy Household Survey may give a more accurate sense, however, the data it collects is for the meth/amphetamine group of drugs and not crystal methamphetamine specifically.

Ecstasy

2.42 Ecstasy is a common term for a range of hallucinogenic stimulants similar in structure to MDMA (methylenedioxymethylamphetamine). Statistically, ecstasy is sometimes grouped with amphetamines, cocaine and other drugs as ‘amphetamine-type stimulants’ (ATS), in recognition of

48 See, for example, Keene N, ‘Epidemic’s cold reality: Ice use could be worse than data suggests’, *Daily Telegraph*, 15 May 2007, p 12; Hart C, ‘Hospitals snowed under by ice storm’, *The Australian*, 2 April 2007, p 5; Munro I, ‘The ice age’, *The Age*, 24 February 2007, p 14; Stephens A, ‘Deadly new ice age: the insidious crystal methamphetamine has triggered a dangerous new drug crisis in Canberra’, *The Canberra Times*, 28 October 2006, p 1.

49 National Drug and Alcohol Research Centre, ‘Ice/Crystal: Fact sheet’ (undated) p 2.

the fact that pills sold as ecstasy are often 'cut' with a variety of substances and may in fact contain no MDMA at all. Pills often contain methamphetamine, and may also contain ketamine (an anaesthetic used primarily in veterinary surgery), chemicals like MDA, PMA or MDEA, and substances like caffeine or paracetamol.⁵⁰

- 2.43 Australian law enforcement authorities continue to confiscate large amounts of ecstasy, and in 2005, were responsible for 27 per cent of global seizures of ecstasy, the highest of any country.⁵¹ Regrettably, however, Australia also has the highest annual prevalence of ecstasy use of any country in the world, with a rate many times the multiple of the United States, the United Kingdom, Sweden, Norway and Canada, all of South America and all of South East Asia.⁵²
- 2.44 The UNODC's most recent report noted a decline in ecstasy use in established, developed world markets, and expressed an expectation that this would continue. There is no evidence to date that ecstasy use is declining in Australia, however.⁵³
- 2.45 In 2004, 3.4 per cent of Australians aged 14 years and over had used ecstasy in the last 12 months, and 7.5 per cent had used ecstasy in their lifetime. These represented the highest figures ever recorded by the National Drug Strategy Household Survey, continuing the upwards trend since 1995 (figure 2.5).⁵⁴

50 National Drug and Alcohol Research Centre, 'Ecstasy: Fact sheet' (undated), p 1. MDA refers to 3,4-methylenedioxyamphetamine; PMA refers to paramethoxyamphetamine; MDEA refers to 3,4-methylenedioxyethylamphetamine.

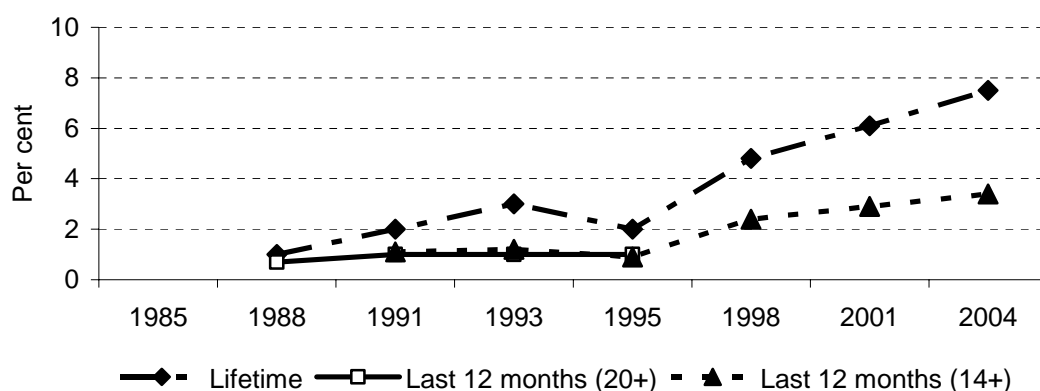
51 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), p 148. See also 'Customs border detection of ecstasy (MDMA) 1992-93 – 2001-02', in Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2002* (2003), cat no PHE 80, p 82.

52 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), p 248.

53 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), p 36.

54 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2006* (2007), cat no PHE 80, p xi.

Figure 2.5 Lifetime and recent prevalence of ecstasy use, 1985 to 2004 (per cent)



Source Makkai T and McAllister I, *Patterns of drug use in Australia 1985–95 (1998)*, p 61; *Australian Institute of Health and Welfare, Statistics on illicit drug use in Australia 2006 (2007)*, cat no PHE 80, p 24.

2.46 Amongst 20-29 year olds, 12 per cent had used ecstasy in the last twelve months and over one in five (22 per cent) had used the drug in their lifetime.⁵⁵ In the most recent survey of Australian secondary school students, 4.0 per cent of students aged 12-17 reported having used ecstasy.⁵⁶ These figures emphasise the need for a full anti-drug use campaign targeted at 12-29 year olds.

Other drugs

2.47 The 2004 National Drug Strategy Household Survey also reported on a number of other drugs. Of Australians aged 14 years and over, in the last 12 months:

- 1.0 per cent, or 169,400 had used cocaine;
- 0.7 per cent, or 116,400 had used hallucinogens, such as LSD or magic mushrooms;
- 0.3 per cent, or 45,000 had used ketamine; and
- 0.1 per cent, or 20,200 had used GHB (gamma-hydroxybutyrate, also known as 'fantasy').⁵⁷

55 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings (2005)*, cat no PHE 66, p 64.

56 White V and Hayman J, The Cancer Council Victoria and the Australian Government Department of Health and Ageing, *Australian secondary school students' use of over-the-counter and illicit substances in 2005 (2006)*, p 4.

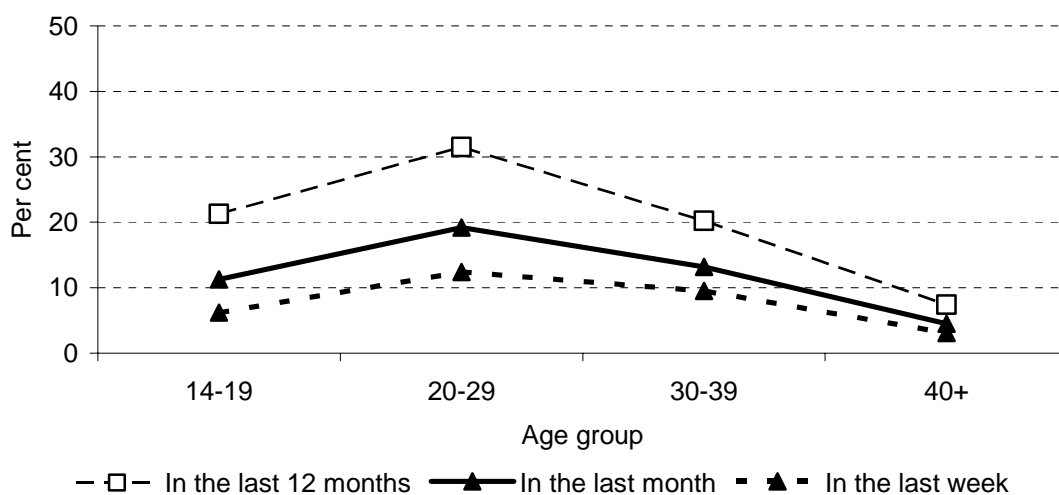
57 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings (2005)*, cat no PHE 66, pp 68, 69, 73.

2.48 One in 25 Australians had used pharmaceuticals for non-medical purposes in the last 12 months. These included painkillers/analgesics, tranquilisers/sleeping pills, barbiturates and steroids.⁵⁸

Characteristics of illicit drug users

2.49 The pattern of illicit drug use varies according to age, peaking when people are aged 20–29 (figure 2.6). The decline in the proportion of the population using illicit drugs after they turn 30 can be attributed to people ceasing their use of illicit drugs and also deaths associated with illicit drug use, as users generally have a lower life expectancy.⁵⁹

Figure 2.6 Use of any illicit drug, persons aged 14 years or older, by age, 2004 (per cent)



Source Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey: Detailed findings (2005), cat no PHE 66, p 33.

2.50 In 2004, the highest proportion of recent drug use across a number of different population subgroups was for people who were unemployed (31.7 per cent), more than twice the total population proportion for recent drug use (15.3 per cent). The lowest proportion of recent users for a subpopulation was for people who were retired or on a pension (5.4 per cent).⁶⁰

58 Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey: Detailed findings (2005), cat no PHE 66, pp 47-48.

59 Reece S, transcript, 3 April 2007, p 32.

60 Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey: Detailed findings (2005), cat no PHE 66, p 37.

- 2.51 A broad examination of some of the other subpopulations reveals that:
- a higher proportion of people who were most socioeconomically advantaged were recent users of illicit drugs (16.6 per cent) compared with the other socioeconomic groups;
 - a greater proportion of people from remote and very remote regions used illicit drugs in the last 12 months (19.0 per cent) than people from other regions; and
 - Indigenous people were almost twice as likely to be recent users of illicit drugs as other Australians (26.9 per cent versus 15.0 per cent) but there was no difference between these two subpopulations with regard to ex-users (22.9 per cent).⁶¹

Choosing to use or not use illicit drugs

- 2.52 People who use illicit drugs in their lifetime are influenced by a range of factors when they make the decision to first use an illicit drug. Some of the social and familial factors were examined in more detail in chapter six.
- 2.53 Regular surveys of illicit drug use in Australia have found that for those who had used an illicit drug in their lifetime, 'curiosity' was the most common factor which influenced their decision to use for the first time (table 2.1). Males and females generally cited similar factors influencing their first use of an illicit drug.
- 2.54 Notably, a relatively small and decreasing proportion of respondents to the survey in 2004 nominated problems with family and other relationships (5.4 per cent) or traumatic experiences (2.5 per cent) as a factor influencing their first use of an illicit drug.

61 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 37.

Table 2.1 Factors influencing first use of any illicit drug, lifetime users aged 14 years and older, by sex, 2001 to 2004

Factor	Males		Females		Persons	
	2001	2004	2001	2004	2001	2004
Curiosity	81.9	77.5	83.0	76.4	82.4	77.0
Peer pressure	54.8	52.7	54.5	56.7	54.7	54.5
To do something exciting	21.6	19.5	22.9	22.0	22.2	20.7
To enhance an experience	na	12.2	na	11.7	na	12.0
To take a risk	9.9	8.4	11.1	10.3	10.4	9.3
To feel better	8.0	5.0	9.8	7.1	8.8	5.9
Family, relationship, work or school problems	6.2	4.3	8.8	6.7	7.4	5.4
Other	2.2	3.3	4.1	3.4	3.0	3.3
Traumatic experience	3.1	1.6	5.1	3.5	4.0	2.5
To lose weight	na	0.5	na	2.1	na	1.2

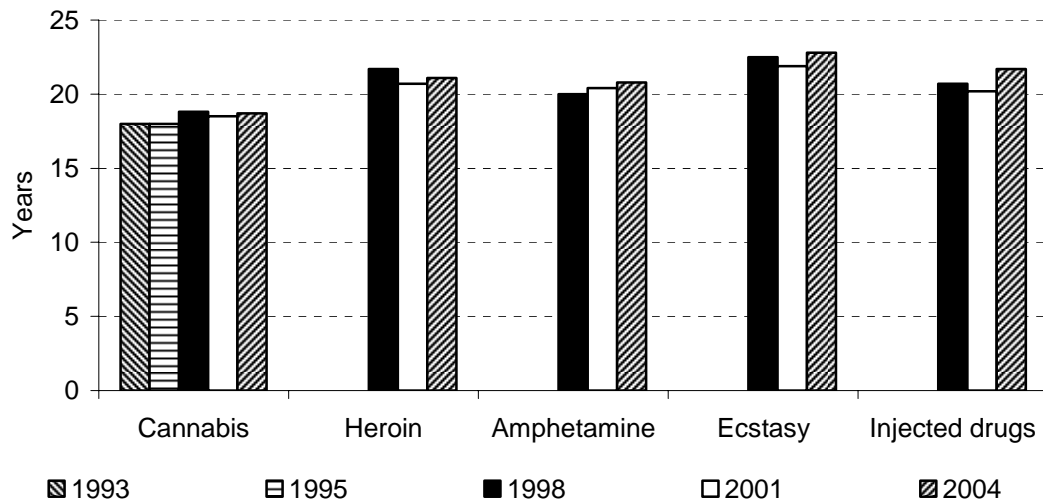
Note na = Not available. Base is those who had ever used an illicit drug. Respondents could select more than one response.

Source Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey: Detailed findings (2005), cat no PHE 66, p 37; 2001 National Drug Strategy Household Survey: Detailed findings (2002), cat no PHE 41, p 40.

- 2.55 The age at which people start using an illicit drug is important because it provides a marker for the age at which anti-drug education should begin. Anti-drug education that commences prior to initiation may be counterproductive, by stimulating experimentation. Equally, if education programs begin after use has commenced, they could be much less effective. A second reason for examining age of initiation is that those who start using a drug at a young age usually report heavier and more extended use later in life.⁶²
- 2.56 The average age of initiation for first trying illicit drugs has remained largely unchanged based on national surveys over the past decade for a number of different illicit drugs (figure 2.7).
- 2.57 While the above results relate to the general population, the average age of initiation for different parts of the population may be lower. An analysis of data from the Drug Use Monitoring in Australia (DUMA) survey, which relates to people who have been brought to selected police stations on a wide variety of charges, indicates that not only do offenders have a lower age of initiation across a range of illicit drugs than the general population, but that also the average age of initiation for offenders is lower for some illicit drugs (figure 2.8).

62 Makkai T and McAllister I, *Patterns of drug use in Australia 1985–95* (1998), p 37. School drug education is discussed in chapter five.

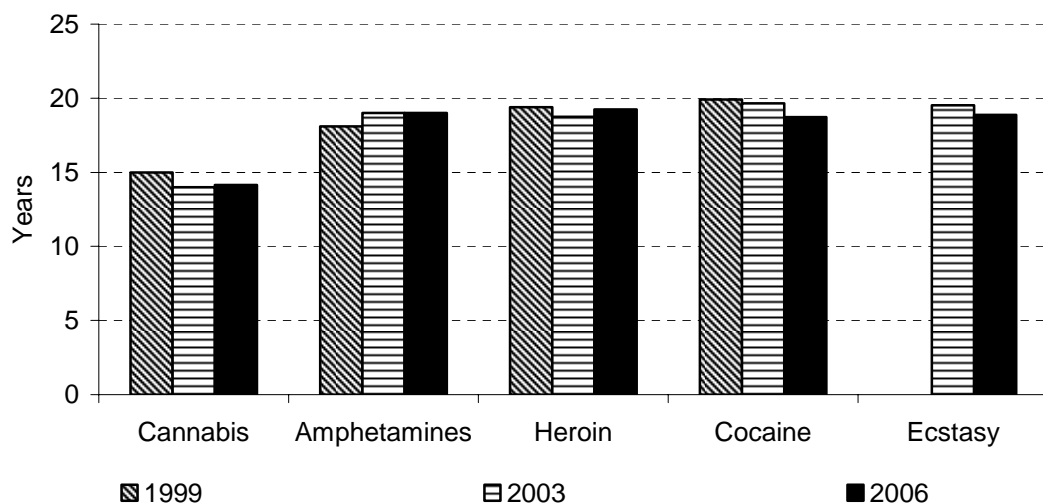
Figure 2.7 Average age of initiation to illicit drugs, persons aged 12 years and older, 1993 to 2004



Note Prior to 2004 the survey related to persons aged 14 years and over. Amphetamine includes methamphetamines. Prior to 2004, ecstasy was classified as 'ecstasy/designer drugs'.

Source Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey: Detailed findings (2005), cat no PHE 66, p 108; Statistics on drug use in Australia 2002 (2003), cat no PHE 43, p 17; 1998 National Drug Strategy Household Survey: Detailed findings (2000), cat no PHE 27, p 3; Makkai T and McAllister I, Patterns of drug use in Australia 1985-95 (1998), p 38.

Figure 2.8 Age at first use, police detainees, 1999 to 2006



Source Australian Institute of Criminology, Drug use monitoring in Australia: 2006 annual report on drug use among police detainees (2007), p 33; Drug Use Monitoring in Australia 2003 annual report on drug use among police detainees (2004), p 18; Johnson D, 'Age of initiation', Australian Institute of Criminology trends and issues (2001), no 201, p 3.

2.58 The most common response for non-users of illicit drugs when indicating the factors that influenced their decision never to try illicit drugs was that

they were 'just not interested', followed by 'reasons associated to health or addiction' (table 2.2). These two reasons were more commonly cited in 2004 than when non-users were asked the same question in 2001. Males and females generally cited similar reasons for not trying illicit drugs.

2.59 People who never used illicit drugs did not cite 'education awareness' or 'seen the negative effects of drugs' as a common reason for influencing their decision not to use illicit drugs.

Table 2.2 Factors influencing the decision not to try illicit drugs, 2001 to 2004

Factor	Males		Females		Persons	
	2001	2004	2001	2004	2001	2004
Just not interested	48.2	73.0	56.3	77.7	52.3	75.6
For reasons related to health or addiction	37.5	56.0	39.2	53.3	38.4	54.6
Didn't like to feel out of control	17.1	24.6	22.0	29.1	19.6	27.1
For reasons related to the law	10.1	26.4	9.0	24.3	9.6	25.3
Religious/moral reasons	13.0	21.3	17.0	24.0	15.0	22.8
Didn't think it would be enjoyable	13.9	20.8	17.4	23.8	15.7	22.4
Pressure from family or friends	7.1	11.9	6.7	9.8	6.9	10.8
No opportunity	na	8.8	na	10.6	na	9.8
Did not want family/friends/employer or teachers to know	6.5	9.5	6.2	7.2	6.3	8.2
Financial reasons	na	9.2	na	7.4	na	8.2
Friends didn't use or stopped using	na	7.9	na	8.3	na	8.1
Drugs too hard to acquire	na	5.0	na	3.8	na	4.3
Seen the negative effects of drugs	na	1.6	na	2.1	na	1.9
Education awareness	na	1.0	na	1.4	na	1.2
Other	na	4.0	na	4.0	na	4.0

Note na = Not available. Base is those who had never used any illicit drug. Respondents could select more than one response.

Source Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey: Detailed findings (2005), cat no PHE 66, p 37; 2001 National Drug Strategy Household Survey: Detailed findings (2002), cat no PHE 41, p 40.

2.60 Risk and protective factors associated with family relationships and disadvantage are highlighted later in this report as increasing the likelihood of illicit drug use.⁶³ It is apparent that it is also important to develop strategies to educate and build resilience among our children to overcome peer pressures and the desire for experimentation. Possible

63 See chapter ten.

ways of addressing the reasons why people chose to use or not use illicit drugs are examined in detail later in the report.

Effects of illicit drug use

- 2.61 Illicit drug use causes significant illness, including mental illness, and disease, violence and crime, and devastates families. The most recent estimate of the economic cost of illicit drug use in Australia is \$6.7 billion per year.⁶⁴ This estimate does not include the significant physical and emotional trauma and social dislocation caused by illicit drugs.
- 2.62 The effects of illicit drug use are evident in the destructive effects of drug-related deaths, other associated health effects and the damaging impact of drug-related crime on the community.

Health and health care

- 2.63 Illicit drugs have a range of deleterious effects on users that put their health at risk, not only at the time of ingestion but into the medium and long term. Different drug types do, of course, have different effects on the brain, body and personal health. Drugs like cannabis, heroin, meth/amphetamines, ecstasy and cocaine affect the central nervous system differently depending on their chemical constitution as depressants, stimulants, sedatives or hallucinogens.⁶⁵
- 2.64 The health effects of illicit drugs on users also depends on a range of contextual factors such as:
- dosage – how much of the drug is taken;
 - duration – over/in what period of time;
 - frequency of use – how often it is taken;
 - patterns of use – for example, intermittent binges, or regular use of small amounts;
 - mode of administration – including injection, oral ingestion, snorting, and smoking;

64 Australian Drug Law Reform Foundation, *The three billion \$ question for Australian business* (2007), p 4.

65 Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, p 35.

- drug purity;
 - simultaneous use of multiple drugs (polydrug use), which increases the unpredictability of effects even for long-term users;⁶⁶
 - the drug user themselves, including their size, genetic make-up, general health, gender, mood and personality; and
 - the environment in which drugs are taken.⁶⁷
- 2.65 The short-term effects of illicit drugs are the reasons why many people take them, and they include temporary senses of wellbeing, relaxation, euphoria, confidence or alertness. In the short term, drug users can also experience anxiety and paranoia, sweating, increased body temperature, nausea and vomiting, slurred speech and loss of coordination.
- 2.66 In the medium to long term, illicit drug use is associated with the following general health risks:
- poor mental health, including depression, anxiety, paranoia, psychosis, eating disorders and other mental disorders;
 - neurotoxicity (brain damage), which impairs memory and concentration;
 - cellular ageing, which results in a haggard appearance, a greying or balding hairline, diminished bone strength and other typical symptoms of ageing;
 - chronic sleep disturbances;
 - unprotected sex, resulting in pregnancy and/or sexually transmitted disease;
 - increased risk of sexual assault;
 - sexual dysfunction and fertility problems;
 - cardiovascular problems and heart failure;
 - respiratory failure;
 - strokes;

66 Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, p 37.

67 NSW Health website, 'Information for parents', viewed on 11 July 2007 at <http://amwac.health.nsw.gov.au/health-public-affairs/mhcs/publications/5910.html>; Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, pp 37, 47-57.

- seizures;
- hypertension and high blood pressure;
- immune system impairment and reduced resistance to infection; and
- other health problems related to the poor personal care that often accompanies a drug-taking lifestyle.⁶⁸

Figure 2.9 Effects of methamphetamine use: 'Meth bugs' caused by users scratching, picking and digging their skin to relieve itching; and dental decay known as 'meth mouth'



Source The White County Meth Task Force website, viewed on 28 August 2007 at <http://www.anti-meth.org/photos2.html>

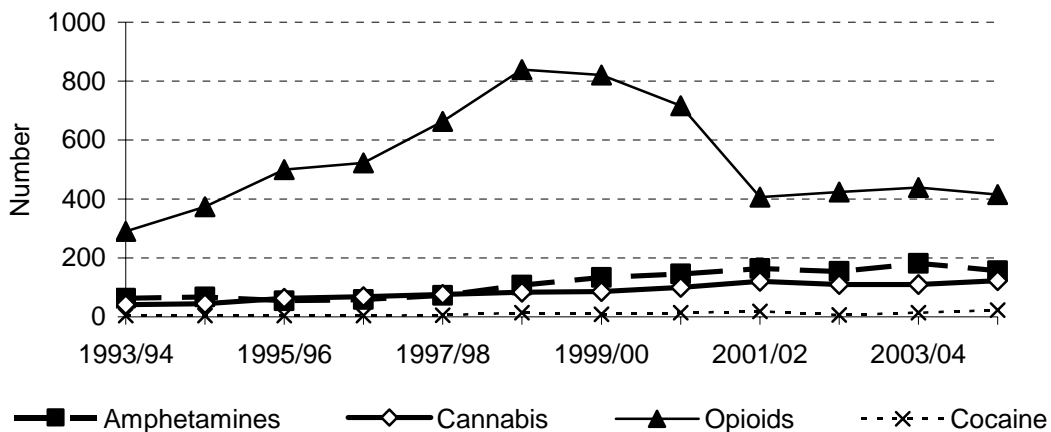
2.67 Particular modes of administration are also associated with health risks in the medium to long term. Injecting drug users face additional risks including contraction of hepatitis C, HIV and other blood borne infections through unsafe injecting practices such as needle sharing. Repetitive injections can also lead to vein damage, abscesses, thrombosis, scarring and tetanus. Marijuana cigarettes have more tar than tobacco, placing cannabis users at an increased risk of respiratory illness such as cancers of the mouth, throat, and lungs, and chronic bronchitis.⁶⁹

68 Where not otherwise indicated with a specific footnote, information in this section is drawn from the following sources: Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, pp 35–57; Australian Drug Foundation, DrugInfo Clearinghouse website, viewed on 11 July 2007 at <http://druginfo.adf.org.au>; National Drug and Alcohol Research Centre website, fact sheets, viewed on 11 July 2007 at <http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Fact%20Sheets>; and National Centre for Education and Training on Addiction Consortium, for the Australian Government Department of Health and Ageing, *Alcohol and other drugs: A handbook for health professionals* (2004); Reece S, transcript, 3 April 2007, pp 29–42.

69 Australian Drug Foundation, DrugInfo Clearinghouse, 'Cannabis', viewed on 11 July 2007 at <http://druginfo.adf.org.au/article.asp?ContentID=cannabis>.

- 2.68 Although research continues, the full long-term health risks of some illicit drugs are not known, as most have been used in their current form for only a few decades or years. More research is needed into the long-term effects of ecstasy and crystal methamphetamine, or the long-term effects of illicit drugs on neural functioning, including the implications for mood and behavioural disorders, memory, concentration, psychosis and other disorders typified by a loss of contact with reality.
- 2.69 People seeking treatment for the health effects of illicit drug use impose significant costs on the health system. While the rate of admissions to hospitals for opioid use has declined significantly since 1998-99, there have been steady increases in admission rates for cannabis and amphetamines (figure 2.10).

Figure 2.10 Principal drug-related hospital separations, persons aged 15-54, by drug type, 1993 to 2005



Source Roxburgh A and Degenhardt L, *Drug-related hospital stays in Australia, 1993-2005* (2006), p 1.

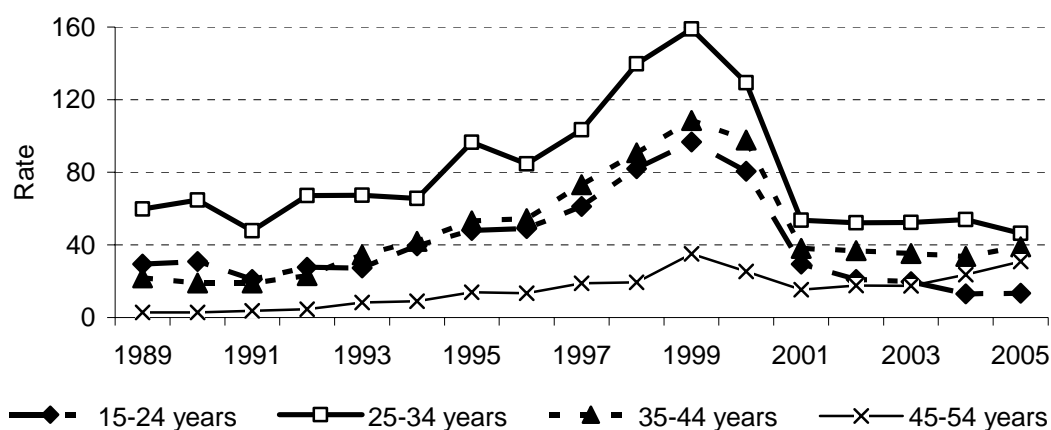
Deaths and loss of potential healthy life

- 2.70 The number of deaths from heroin overdose is often cited as a measure of the impact of illicit drug use on families. In 2005, there were 374 deaths in which opioids were determined to be the underlying cause of death among those aged 15-54 years. This is a significant reduction from the 938 deaths reported in 2000 and the 1,116 deaths of 1999 (figure 2.11). The reason for the decline is largely attributed to the reduction in heroin supply experienced across Australia in 2001.⁷⁰

70 O'Brien S et al, *Australian Drug Trends 2006: Findings from the Illicit Drug Reporting System (IDRS)* (2007), p 39.

2.71 However, the dangerous effects of taking illicit drugs can also cause deaths amongst drug users, their families or members of the community — contributing to suicides, road traffic accidents, HIV/AIDS and hepatitis infections and complications associated with childbirth.

Figure 2.11 Rate of accidental deaths due to opioids among those aged 15-54 years, Australia, 1989 to 2005



Source Degenhardt L and Roxburgh A, *Accidental drug-induced deaths due to opioids in Australia, 2005* (2007).

2.72 The AIHW recently estimated that in 2003, more than 1,700 deaths and over 51,000 years of 'lost' healthy living were attributable to illicit drug use (table 2.3).⁷¹ This is significantly higher than estimates for 1998, where illicit drugs were attributed to 1,023 deaths and more than 50,000 years of 'lost' healthy living.⁷²

2.73 The scale of collateral damage to families is revealed in specific examples of deaths resulting from illicit drug use:

- A five month old infant died after he was deliberately given methadone by his mother, who, along with her partner, was on a methadone maintenance program at the time;⁷³
- A 20 year old woman died after taking what she thought was an ecstasy tablet. The tablet was laced with the hallucinogenic drug PMA, a toxic substance which is occasionally sold as ecstasy;⁷⁴ and

71 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2006* (2007), cat no PHE 80, p 37.

72 Ridolfo B and Stevenson C, Australian Institute of Health and Welfare, *The quantification of drug caused mortality and morbidity in Australia, 1998* (2001), cat no PHE 29, p 98.

73 Danks K, 'Baby died from mum's methadone: Coroner', *news.com.au*, 4 October 2006, viewed on 4 July 2007 at <http://www.news.com.au/story/0,23599,20524192-1242,00.html#>.

74 Gibson J, 'Bubbly' Annabel's fatal risk', *The Sydney Morning Herald*, 23 February 2007.

- A drug-affected driver, who had traces of amphetamine, methylamphetamine and cannabis in his system, killed two couples and an eight year old boy in a high speed crash. Police estimated the driver was doing at least 100kmh and up to 130kmh just before the crash.⁷⁵

Table 2.3 Number of deaths and disability-adjusted life years (DALYs) attributable to illicit drug use, by condition, 2003

Condition	Deaths		DALYs	
	Number	Per cent (a)	Number	Per cent (b)
Heroin/polydrug use	263	0.2	16,758	0.6
Hepatitis C	759	0.6	11,709	0.4
Cannabis abuse	0	0.0	5,206	0.2
Suicide and self-inflicted injuries	204	0.2	4,458	0.2
Hepatitis B	329	0.2	3,637	0.1
Benzodiazepine abuse	1	0.0	2,656	0.1
Other	149	0.1	7,040	0.3
Total attributable	1,705	1.3	51,463	2.0

Note (a) Of total deaths (b) Of total DALYs. The disability-adjusted life year (or DALY) is a summary statistic used to measure the burden of disease that combines both the years of healthy life lost due to disability and the years of life lost due to premature mortality. One DALY represents one lost year of 'healthy life'.

Source Australian Institute of Health and Welfare, Statistics on drug use in Australia 2006 (2007), cat no PHE 80, p 37.

Crime and potential damage

- 2.74 In addition to criminal activity associated with trafficking and consumption, illicit drug use is also associated with other crime such as property and violent offending.⁷⁶ These crimes can be perpetrated by people using illicit drugs against members of the community and also against members of their family.
- 2.75 In 2004-05, the Australian Institute of Criminology identified that 95 homicides (36 per cent) involved illicit drug use where either victim or offender or both had used illicit drugs. Of 66 intimate partner homicides, 20 per cent of victims and 15 per cent of offenders were found to be using illicit drugs at the time of the death. In regard to the 26 child deaths, 17 per cent of the offenders were found to have been using illicit drugs.⁷⁷

75 Darragh D, 'Drug driver jailed over multiple fatality', *thewest.com.au*, 27 November 2006, viewed on 5 July 2007 at <http://www.thewest.com.au/default.aspx?MenuID=77&ContentID=14643>.

76 Australian Institute of Criminology, submission 120, p 10.

77 Australian Institute of Criminology, submission 120, p 1.

- 2.76 Annual surveys of regular intravenous drug users consistently point to a high prevalence of criminal activity that is associated with illicit drug use including property crime, violent crime and fraud.⁷⁸
- 2.77 Monitoring of illicit drug use by offenders at selected police stations and watchhouses across Australia revealed that in 2005, 33 per cent of detainees had stolen something in the past year and that 25 per cent of detainees reported stealing because they needed money for drugs.⁷⁹ More than one-third of detainees attributed some of their offending to illicit drugs.⁸⁰
- 2.78 In addition to the actual harm imposed on the community, the use of illicit drugs also contributes to a broad range of potential harms due to impairment associated with drug use. In 2004, of Australians aged 14 years and older who had used any illicit drugs in the last 12 months, in the same period:
- 581,000 people had driven a motor vehicle while under the influence of illicit drugs;
 - 115,000 people had operated a boat or hazardous machinery; and
 - 326,600 people had gone to work.⁸¹
- 2.79 Drug use by health care and other workers has potentially fatal consequences. The committee is concerned at the potential numbers of people working under the influence of illicit drugs whilst holding positions of professional responsibility in our community.

78 O'Brien S et al, *Australian Drug Trends 2006: Findings from the Illicit Drug Reporting System (IDRS)* (2007), p 155.

79 Mouzos J et al, Australian Institute of Criminology, *Drug use monitoring in Australia: 2005 annual report on drug use among police detainees* (2006), p 18.

80 Mouzos J et al, Australian Institute of Criminology, *Drug use monitoring in Australia: 2005 annual report on drug use among police detainees* (2006), p xii.

81 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 89.

