2

Alcohol and drug harm in Australia

Introduction

2.1 Drugs are part and parcel of everyday life and have been so for thousands of years. Scenes of alcoholic fermentation appear on Mesopotamian pottery dating from 4,200 BC.[1] The opium poppy, domesticated about 8,000 BC and first written about in 3,100 BC, was included in 700 different concoctions described by Theban physicians in 1,552 BC.[2]

2.2 Many licit drugs can be used to great benefit. However, abuse and misuse of drugs can also lead to damaging effects including death, and this is what makes managing their use so difficult. Drugs can variously relieve symptoms of illness and pain; in addition they may also cause sleep or induce euphoria; and change visual, auditory and other perceptions. The use of some drugs also leads to dependency and sometimes psychotic disturbance. Taken in large quantities, they cause serious physical damage to the body.

2.3 Attitudes to the use of drugs have varied over time. In many societies, their use has been generally accepted and they have become central elements in religious ceremonies. At other times and in other places they have been controlled by the authorities, sometimes to the extent of being totally prohibited. Over the last few centuries, the pendulum has swung between more and less tolerance of drug consumption as societies have experienced the relative benefits and drawbacks of drug use. Personal,

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1 *World Book 2002*, World Book Inc, Chicago, 2002, vol 1, p 337.

2 Davenport-Hines R, *The pursuit of oblivion: A social history of drugs*, Phoenix Press, London, 2002, p 8.

community, political and economic concerns have at different times and to different extents driven attitudes and practices in relation to drug use.

Experiences of harm

2.4 The harm caused by licit and illicit drug abuse has an impact at every level of society from the individual person to the global community. A snapshot of how drug use affected one user and her family is reflected in comments by her mother to the former committee:

> … my youngest daughter, Sarah, has battled drug addiction for eight years. There is no drug she has not used, and she has singularly fragmented a strong family unit.
>
> We have struggled to keep faith in Sarah, to love and protect her, to support her, to keep having hope. It has not been easy and, in truth, it has torn the family to its heart. She is nearly 20 years old now; of high intellect. She is articulate and talented and yet she prostituted herself on every level to support a heroin habit almost to the point of death, which at the time, was acceptable to her in oblivion. But that has now become an intolerable memory and a burden almost too heavy to bear. We no longer grieve for 'what if?' or 'if only'. There are no easy solutions, but in this prolonged journey of supporting them in their illness it becomes even harder to help them bridge the gap between the world they have made their own and ours ...[3]

2.5 The disruption to a family's life that is caused by addiction is mirrored in the upsets experienced in the communities where drug users live.

2.6 Crime associated with drug use is also deeply concerning, adding to unease in the community. Families and Friends for Drug Law Reform (ACT) said:

> Crime and other dysfunctional activity largely contributed to by illicit drugs is a corrosive influence on the fabric of our society. Old people are set against the young; children against parents; drug users needing treatment against the rest of the community. Users themselves who are drawn overwhelmingly from the young are exposed to a criminal world that is beyond the protection of the law. Our justified insecurity it [*sic*] fanned by a security and insurance industry. Our fears encourage us to withdraw inside our home made secure by bars and alarm system. In lots of little ways

3 Stratton P, transcript, 21/2/01, pp 614-615.

> we "take precautions" and withdraw just that bit more from neighbourhood and community involvement. The glue that holds us together as a community is loosened.[4]

2.7 At a national level, the impact is visible in economic losses due to harm, diminished productivity, and damage to property. In addition, the services that governments put in place to address crime, trauma and ill health are costly.

Prevalence and costs

2.8 The 2001 National Drug Strategy (NDS) Household Survey of 26,744 Australians estimated that 14.7 per cent of Australians aged 14 years and over had not used any alcohol, tobacco or illicit drugs in the previous 12 months. Among the other 85 per cent of Australians, alcohol was the most widely used substance; four in five had consumed alcohol. Comparable figures for tobacco and illicit drugs were much lower. Fewer than one in four Australians had smoked and almost one in six had used illicit drugs.[5]

2.9 The most commonly used illicit drug in 2001 was cannabis, which had been used in the previous year by 12.9 per cent of the people surveyed. Other illicit drugs were much less frequently consumed; the next most common after cannabis were amphetamines, pain killers / analgesics, and ecstasy / designer drugs, taken respectively by 3.4 per cent, 3.1 per cent and 2.9 per cent of people.[6]

2.10 As shown in Table 2.1, the consumption of several substances in 2001 had fallen since the last survey in 1998, among them tobacco, the use of which fell from 24.9 per cent to 23.2 per cent. The decline in the use of illicit drugs was statistically significant, down from having been used by 22.0 per cent of Australians in 1998 to 16.9 per cent in 2001. The consumption of alcohol had increased from 80.7 per cent to 82.4 per cent of Australians.[7]

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4 Families and Friends for Drug Law Reform (ACT), sub 77, Inquiry into Crime in the Community, House of Representatives Standing Committee on Legal and Constitutional Affairs, pp 21-22.

5 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, Drug statistics series no 9, AIHW, Canberra, May 2002, pp xiii-xiv, 3.

6 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 3.

7 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 3.

Table 2.1 Summary of drugs recently[(a)] used: proportion of the population aged 14 years and over, Australia, 1998-2001

Drug/behaviour	1998	2001
	(per cent)	
Tobacco	24.9	23.2
Alcohol	80.7	82.4
Illicits		
Marijuana/cannabis	17.9	12.9 #
Pain-killers/analgesics[(b)]	5.2	3.1 #
Tranquillisers/sleeping pills[(b)]	3.0	1.1 #
Steriods[(b)]	0.2	0.2
Barbiturates[(b)]	0.3	0.2
Inhalants	0.9	0.4 #
Heroin	0.8	0.2 #
Methadone[(c)]	0.2	0.1
Other opiates[(b)]	n/a	0.3
Amphetamines[(b)]	3.7	3.4
Cocaine	1.4	1.3
Hallucinogens	3.0	1.1 #
Ecstasy/designer drugs	2.4	2.9
Injected drugs	0.8	0.6
Any *illicit*	22.0	16.9 #
None of the above	14.2	14.7

(a) Used in the last 12 months. For tobacco 'recent use' means daily, weekly and less than weekly smokers.
(b) For non-medical purposes.
(c) Non-maintenance.
2001 result significantly different from 1998 result (2-tailed $\alpha = 0.05$).

Source: Derived from Australian Institute of Health and Welfare, 2001 National Drug Household Survey: First results, Drug statistics series no 9, AIHW, Canberra, May 2002, p 3.

2.11 20-29 year olds are a particular cause of concern as they have been shown to smoke more tobacco, use more illicit drugs, and put themselves at greater risk of long-term alcohol-related harm than any other age group. Furthermore, 15.1 per cent of teenagers (14-19 year olds) smoked tobacco daily in 2001, more than a quarter (27.7 per cent) had used illicit drugs, and 11.7 per cent drank so much alcohol that they put themselves at risk or high risk of long term harm.[8] Indigenous people, for example, have reported smoking at twice the rate of non-Indigenous Australians (49.9 per cent and 22.8 per cent respectively).[9]

8 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 12, 18, 21.

9 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, Drug statistics series no 11, AIHW, Canberra, December 2002, p 24.

2.12 The Commonwealth Department of Health and Ageing said that although drinking alcohol was less common among Indigenous than among non-Indigenous Australians, those who drank alcohol were more likely to do so at hazardous levels. Volatile substance misuse, such as petrol sniffing, was very prevalent in some Indigenous communities.[10]

2.13 The most recent available estimates for Australia of the social costs of abusing legal and illicit drugs have been reported by Collins and Lapsley, based on information from 1998-99 (Table 2.2). They showed that the total cost was $34.4 billion. Of this cost 61.2 per cent was due to tobacco; alcohol contributed 22.0 per cent of the costs and illicit drugs 17.6 per cent.[11] These costs included estimates of losses caused by death, pain and suffering (the intangible costs), as well as tangible costs such as police and hospital costs.[12]

Table 2.2 Social costs of drug use, 1998-99

	Alcohol $m	Tobacco $m	Illicit Drugs $m	All Drugs $m
Tangible	5,541.3	7,586.7	5,107.0	18,340.8
Intangible	2,019.0	13,476.3	968.8	16,099.0
Total	7,560.3	21,063.0	6,075.8	34,439.8
Proportion of total	**22.0%**	**61.2%**	**17.6%**	**100.0%**

Note: The sum of the individual costs of all drugs differs from the "All Drugs" total as a result of adjustment for the effects of interaction on the aggregation of the individual aetiological fractions, and because the "All Drugs" total includes some crime costs attributed jointly to alcohol and illicit drugs.

Source: Collins DJ & Lapsley HM, Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, p 59.

2.14 The highest tangible costs associated with the misuse of drugs were borne in the home ($7.6 billion), followed by the workplace ($5.5 billion); costs relating to crime ($4.3 billion), road accidents ($2.3 billion) and health care ($1.4 billion) were progressively smaller (Table 2.3).[13] The government sector bore a proportion of the tangible cost of drug abuse (24.4 per cent of

10 Commonwealth Department of Health and Ageing, sub 238, p 10.

11 Collins DJ & Lapsley HM, *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998-9*, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, p ix.

12 How these costs compare with those made in previous estimates is not clear as the methods used to calculate these and earlier estimates differ.

13 Collins DJ & Lapsley HM, p x.

alcohol-attributable costs, 11.3 per cent for tobacco and 33.3 per cent for illicit drugs). By contrast, business carried a higher proportion of the costs (38.6 per cent for alcohol, 29.8 per cent for tobacco and 57.2 per cent for illicit drugs).[14]

Table 2.3 Selected tangible drug abuse costs, 1998-99

	Alcohol $m	Tobacco $m	Illicit Drugs $m	Alcohol & Illicit Drugs Combined[(c)] $m	Total $m
Crime	1,235.3	-	2,500.4	582.3	4,318.0
Health (net)	225.0	1,094.9	59.2	-	1,379.1
Production in the workplace[(a)]	1,949.9	2,519.5	991.2	-	5,460.7
Production in the home [(b)]	402.6	6,880.0	344.8	-	7,627.5
Road accidents	1,875.5	-	425.4	-	2,300.9
Fires	-	52.1	-	-	52.1

(a) Drug abuse can have an important impact upon the productivity of the paid workforce in three ways:

(a) Reduction in the size of the available workforce as a result of drug-attributable deaths and illnesses causing premature retirement;

(b) Increased workforce absenteeism resulting from drug-attributable sickness or injury;

(c) Reduced on-the-job productivity as a result of drug-attributable morbidity.

(b) Estimates of the value of production losses in the household sector are based upon ABS estimates of unpaid work in the publication *Unpaid Work and the Australian Economy 1997.* The definition of unpaid work used in an earlier ABS study is as follows:

'Household production consists of those unpaid activities which are carried on, by and for the members, which activities might be replaced by market goods or paid services, if circumstances such as income, market conditions and personal inclinations permit the service being delegated to someone outside the household group.'

A household activity is considered as unpaid work in an economic unit other than the household itself could have supplied the latter with an equivalent service. The ABS estimates take account of domestic activities, childcare, purchasing of goods and services, and volunteer and community work.

(c) Some component of crime costs is causally attributable jointly to alcohol and illicit drugs. It is not possible to indicate what proportion of these joint costs is attributable to either alcohol or illicit drugs individually.

Source: Collins DJ & Lapsley HM, Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998/9, Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, 2002, pp x, 27, 29, 47.

The National Drug Strategy

2.15 Fitzgerald and Sewards history of significant events at a national level of Australia's drug policy revealed, Australia's response to drug problems

14 Collins DJ & Lapsley HM, pp 62-63.

has been based, in part[15], on the recommendations of the 1977 report of the Senate Standing Committee on Social Welfare. That committee recommended a pragmatic approach to limiting the adverse effects of drug abuse. It emphasised the importance of balancing efforts to reduce the demand for drugs with measures to restrict the supply of drugs. It also stressed the desirability of viewing drug abuse as primarily a social and medical problem rather than a legal one.[16]

2.16 Fitzgerald and Sewards reported that in 1985 following completion of an Australian commission of inquiry and a royal commission, a Special Premiers Conference was held to discuss a national coordinated approach to drug problems. This led to the establishment of the Ministerial Council on Drug Strategy and the National Campaign Against Drug Abuse (NCADA).[17] The NCADA's overall aim was minimising the harmful effects of drugs on Australian society. The approach was to be national and cooperative across jurisdictional boundaries and comprehensive in addressing problems related both to legal and illegal drugs, supply control and demand reduction strategies were to be integrated, and reliable data were to be collected to enable program monitoring and evaluation.[18]

2.17 These same principles underpin the current NDS which started in 1999. In summary those principles, as set out in the National Drug Strategic Framework 1998-99 to 2002-03, are:

- harm minimisation, a term used to refer to policies and programs aimed at reducing drug-related harm;
- a coordinated, integrated response to reducing drug-related harm in Australia in association with related areas of law enforcement, criminal justice, health and education rests with government agencies at all levels, the community-based sector, business and industry, research institutions, local communities and individuals;
- a partnership approach with a close working relationship between the Commonwealth, state and territory and local governments, affected communities (including drug users and those affected by drug related harm), business and industry, professional workers, and research institutions;

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15 For a history of significant events on drug policy at the national level see: Fitzgerald JL & Sewards T, *Drug policy:The Australian approach,* ANCD research paper 5, Australian National Council on Drugs, Canberra, 2002, pp 5-6.

16 Senate Standing Committee on Social Welfare, *Drug problems in Australia - an intoxicated society?*, Commonwealth Government Printer, Canberra, 1977, pp 1-2.

17 Fitzgerald JL & Sewards T, p 6.

18 Intergovernmental Committee on Drugs, sub 50, p 5.

- a balanced approach which seeks a balance between supply-reduction, demand-reduction and harm-reduction strategies emphasising the need for integration of drug law enforcement and crime prevention into all health and other strategies aimed at reducing drug-related harm. It also seeks a balance between strategies to reduce harm caused by licit and illicit drugs. Achieving a balance between other components of the NDS is more difficult and complex, for example, involving among other things allocating resources between prevention, treatment, training and research or meeting the needs of special populations and other groups. Better allocation of resources would be facilitated by increased emphasis on coordination of research, monitoring, evaluation and reporting;
- an evidenced-based practice where all supply-reduction, demand-reduction and harm-reduction strategies should reflect evidence-based practice, which is based on rigorous research and evaluation, including assessment of the cost-effectiveness of interventions; and
- social justice – strategies for tackling drug-related harm not only must target the particular drug or drug causing problems but must also develop with regard to the broader context of the needs of and problems facing the affected community.[19]

2.18 As a result of these principles, the mission for the National Drug Strategic Framework 1998-99 to 2002-03 is:

> To improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society.[20]

2.19 The objectives of the National Drug Strategic Framework 1998–99 to 2002–03 are:

- to increase community understanding of drug-related harm;
- to strengthen existing partnerships and build new partnerships to reduce drug-related harm;
- to develop and strengthen links with other related strategies;
- to reduce the supply and use of illicit drugs in the community;
- to prevent the uptake of harmful drug use;
- to reduce drug-related harm for individuals, families and communities;
- to reduce the level of risk behaviour associated with drug use;

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19 *National Drug Strategic Framework 1998-99 to 2002-03: Building partnerships: A strategy to reduce the harm caused by drugs in our community*, Ministerial Council on Drug Strategy, Canberra, November 1998, pp 15-18.

20 *National Drug Strategic Framework 1998-99 to 2002-03*, p 19.

- to reduce the risks to the community of criminal drug offences and other drug-related crime, violence and anti-social behaviour;
- to reduce the personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the harmful use of drugs;
- to increase access to a greater range of high-quality prevention and treatment services;
- to promote evidence-based practice through research and professional education and training;
- to develop mechanisms for the cooperative development, transfer and use of research among interested parties.[21]

2.20 The NDS operates under the direction of the Ministerial Council on Drug Strategy with the assistance of the consultative and advisory groups shown in Figure 2.1.[22]

2.21 The National Drug Strategic Framework 1998–99 to 2002–03 stresses that the effectiveness of the framework depends on cooperation within a wide range of sectors of Australian society, that is, across the three levels of government, families and communities, community-based organisations, and business and industry.[23]

2.22 In relation to families and communities the framework notes that they have a vital role in the development of attitudes to and values concerning drug use.[24]

2.23 The framework highlights the significant role that individuals and community-based organisations have under the NDS and summarises that role as: the provision of counselling, support, and treatment and care; the provision of education, information and support to prevent and reduce drug-related harm; contributing to the development, delivery and evaluation of policies and programs; and advocating for specific policies or programs.[25]

2.24 In relation to business and industry the framework points out that both employers and employees are responsible for occupational health and safety and some industries such as the pharmaceutical, alcohol beverage and hospitality industries have a responsibility to promote safe and responsible use of their products.[26]

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21 *National Drug Strategic Framework 1998-99 to 2002-03*, p 19.

22 Intergovernmental Committee on Drugs, sub 50, pp 9, 22.

23 *National Drug Strategic Framework 1998-99 to 2002-03*, pp 37-42.

24 *National Drug Strategic Framework 1998-99 to 2002-03*, p 37.

25 *National Drug Strategic Framework 1998-99 to 2002-03*, pp 37-38.

26 *National Drug Strategic Framework 1998-99 to 2002-03*, p 38.

INSERT FIGURE 2.1

2.25 Under the NDS, the Commonwealth government has a dual role. It is responsible for providing national leadership in Australia's response to reducing drug-related harm, and it has responsibility for implementing its own policies and programs to contribute to the reduction of drug-related harm. The Department of Health and Ageing is the Commonwealth agency with overall responsibility for coordination of the NDS and related programs. Activities undertaken or administered by the Commonwealth Department of Health and Ageing can be categorised as:

- funding to state and territory governments and peak bodies under the NDS;
- prevention and early intervention;
- national responses to HIV / AIDS, hepatitis C and related diseases;
- treatment, including diversion to treatment;
- education and promotion of best practice;
- research, monitoring and evaluation;
- addressing the needs of specific populations;
- registration, availability and quality use of pharmaceutical products; and
- international activities. [27]

2.26 It is important to note, however, that a range of other Commonwealth government agencies have responsibility for policies and programs that may impact on the demand for, or supply of, tobacco, alcohol, and other drugs. These include:

- Commonwealth Department of Education, Science and Training - responsible for the development and implementation of the National School Drug Education Strategy;
- Commonwealth Attorney-General's Department - monitors adherence to international drug treaties and develops and implements policy in the area of crime prevention, money laundering, extradition and mutual assistance;
- Australian Customs Service – enforces the Commonwealth governments controls on illicit drugs and controlled substances;
- Australian Federal Police – primary responsibility for investigating offences associated with the importation of illicit drugs into Australia and for disrupting the international supply of illicit drugs;
- Australian Crime Commission – undertakes criminal intelligence collection and analysis, sets national criminal intelligence priorities,

27 Commonwealth Department of Health and Aged Care, sub 145, pp viii-x, 92.

conducts intelligence led investigations of national significance and exercises coercive powers to assist in intelligence operations and investigations;[28] and

- Australian Institute of Criminology.

2.27 It is difficult to estimate the overall funding by the Commonwealth for the NDS but since 1997 the Commonwealth government has allocated more than $1 billion for the National Illicit Drug Strategy[29].

2.28 State and territory governments provide leadership within their respective jurisdictions. They are responsible for policy development, implementation and evaluation and for the delivery of police, health and education services to reduce drug-related harm in the manner best suited to meet local circumstances. Other activities for which state and territory Governments are responsible under the NDS include:

- developing and implementing their own drug strategies from the perspective of law enforcement and population health and based on local priorities;
- controlling the supply of illicit drugs through both specialist drug law enforcement units and general duties police officers;
- enforcing the regulation of pharmaceutical drugs;
- enforcing laws regulating the consumption and availability of alcohol and developing and enforcing legislation relating to tobacco;
- implementing harm reduction strategies to prevent drink driving;
- providing public sector health services or funding community based organisations to provide drug prevention and treatment programs;
- regulating and administering the delivery of methadone services and needle and syringe programs;
- developing effective and comprehensive professional education and training, research and evaluation strategies, in close cooperation with other jurisdictions so as to achieve consistency;
- assessing measures that allow police to exercise discretion in diverting drug users away from the criminal justice system into appropriate treatment options; and
- establishing an appropriate public policy framework to deal with drug use and drug-related harm in areas such as housing,

28 Commonwealth Department of Health and Aged Care, sub 145, pp 85-86; Australian Crime Commission, viewed 6/8/03, <http://www.crimecommission.gov.au/index.html>

29 Commonwealth Department of Health and Ageing, sub 291, p 2.

> school-based drug education, criminal justice and juvenile justice and liquor licensing.[30]

2.29 The NDS was originally planned to run from 1998-99 to 2002-03. It has, however, been extended by one year to 2003-04 and will be evaluated in 2003 before the next stage of the strategy is developed.[31] More detailed strategies and action plans have been developed to address specific aspects of substance abuse, including illicit drugs, alcohol, tobacco, and school-based drug education. The plans specify priorities for reducing harm, strategies for taking action and performance indicators.[32] The National Drug Prevention Agenda is also being prepared.[33] Details on these policies are presented in later subject specific chapters.

2.30 Pragmatic and balanced is how the Australian approach to drug policy has been described in a recent overview by Fitzgerald and Sewards.[34] According to Fitzgerald and Sewards, an important feature of Australia's drug policy making has been 'the deliberate avoidance of electoral politics and public conflict by attempting to maintain consensus and accommodation through an extensive network of consultative machinery'.[35] The achievements of these policies are considerable. Falling tobacco and illicit drug use, the containment of HIV infections and extensive availability of treatment are among Australia's successes.

2.31 Notwithstanding these successes, much still remains to be done. Simply in economic terms, much expense could be avoided if more effective anti-drug policies and programs were introduced. Collins and Lapsley estimated that 62.1 per cent of total alcohol costs ($3,928.6 million) and 44.9 per cent of total tobacco costs ($9,467.2 million) were avoidable.[36] The challenge for governments is to put effective policies in place. This committee intends that this report will contribute significantly to this process.

The international context

2.32 While Australia is an island, it is not unique in the way drugs are used, abused and responded to. Patterns of drug use in Australia bear

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30 Commonwealth Department of Health and Aged Care, sub 145, pp 89-90.
31 Commonwealth Department of Health and Ageing, sub 238, p 14.
32 Commonwealth Department of Health and Aged Care, sub 145, p 77.
33 Commonwealth Department of Health and Ageing, sub 238, pp 14-18.
34 Fitzgerald JL & Sewards T, p vi.
35 Fitzgerald JL & Sewards T, p 26.
36 Collins DJ & Lapsley HM, p 61.

resemblances to and are influenced by what is happening overseas. Overseas events also affect how Australian governments, communities and individuals respond to the impact of drugs.

2.33 As one of the world's 'western' countries, Australia's pattern of drug use is likely to approximate most closely that of other similar nations. Close comparisons between countries is difficult, however, because of the differences in the way in which countries collect and present their national drug-related data.

2.34 The *2002 annual report on the state of the drugs problem in the European Union and Norway* commented that, after the sharp rises in drug use in the 1980s and early 1990s, 'the general picture seems now more similar to a stable "endemic" situation, with constant recruitment and exit rates'. The report's author, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), noted stability in cannabis use, problem drug use, HIV prevalence, and drug-related deaths. There is, however, considerable variation between countries. Prices of most drugs seem generally stable or decreasing, and cannabis remained the most widely used illicit drug across Europe.[37]

2.35 The 2001 US National Household Survey on Drug Abuse reported a significant increase from year 2000 in the recent use of cannabis, cocaine and the non-medical use of pain relievers and tranquillisers by Americans 12 years and older. The use of ecstasy tripled between 1998 and 2000. There were, however, no significant changes between 2000 and 2001 in heavy and binge drinking and tobacco use.[38]

2.36 The US survey also revealed ethnic and geographical differences in the US, with illicit drug use being highest amongst American Indians, Alaskan Natives and blacks, and higher in urban than in rural areas.[39]

2.37 The policies and programs in place in western countries vary in their emphasis on supply control as opposed to demand reduction and in how restrictive they are in tolerating substance use. Their approaches to drug problems reflect the nature of their experience with drugs and their cultural traditions. The US, for example, relies more heavily on law

37 European Monitoring Centre for Drugs and Drug Addiction, *2002 annual report on the state of the drugs problem in the European Union and Norway*, Office for Official Publications of the European Communities, Luxembourg, 2002, pp 5, 11, viewed 30/4/03, <http://annualreport.emcdda.eu.int/pdfs/2002_0458_EN.pdf>.

38 US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *2001 National Household Survey on Drug Abuse: Highlights*, pp 1, 3, viewed 28/4/03, <http://www.samhsa.gov/oas/nhsda/2k1nhsda/vol1/highlights.htm>.

39 US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, p 1.

enforcement to address drug problems than Australia and many European countries, and the approaches taken by European countries range from the more liberal in the Netherlands to more restricted in Sweden.

2.38 Evidence is accumulating that indicate how far supply control measures can be expected to impact on reducing drug abuse. For example, the 2002 report by the US Office of National Drug Control Policy on that nation's drug control strategy indicated significant progress in reducing the crime and violent consequences of drug trafficking, but progress towards demand reduction, prevention and reducing the quantity of illicit drugs available were described as 'off track' in reaching strategy targets.[40] At a recent United Nations' meeting, progress was reported on addressing the world's drug problems, including a new emphasis on prevention, advocacy and treatment as a UN operational priority. This new priority balances an earlier emphasis on supply control.[41]

2.39 The EMCDDA reported growing consensus among European countries about the measures to address some of the principal problems and evidence on their effectiveness.

> For example, the value of low-threshold services and the importance of access to sterile injecting equipment to reduce bloodborne infections are widely acknowledged. The protective effect of methadone maintenance on mortality and morbidity, the additional value of voluntary drug-free treatment and the role of medically-assisted treatment in reducing illegal drug consumption, risky behaviour and crime are now broadly recognised.
>
> The widespread recognition of the value of these measures is a contributing factor, perhaps, to the relative convergence of public policy in the areas of prevention and treatment in the European Union …[42]

2.40 The EMCDDA also noted prominent developments in the legislative area with moves:

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40 Office of National Drug Control Policy, *2002 final report on the 1998 National Drug Control Strategy: Performance measures of effectiveness*, ONDCP, no place, February 2002, pp ix-x, viewed 1/10/02, <http://www.whitehousedrugpolicy.gov/publications/policy/02pme/pmepdf/PME.pdf>.

41 United Nations Office on Drugs and Crime, *'Encouraging progress towards still distant goals': Progress report by the Executive Director as a contribution to the mid-term review of UNGASS [United Nations General Assembly Special Session]*, UNODC, 8 April 2003, p 9, viewed 30/4/03, <http://www.unodc.org/pdf/document_2003-04-08_2.pdf>.

42 European Monitoring Centre for Drugs and Drug Addiction, p 5.

> … to target substances regardless of their legal status, to widen the distinction between drug users and drug-law offenders, to reduce or remove penalties for personal use or possession of cannabis and to strengthen the legal framework for substitution treatment …[43]

The UK government, for example, planned to introduce legislation by July 2003 to downgrade the classification of cannabis, following recommendations from its Advisory Council for the Misuse of Drugs and the House of Commons Select Committee on Home Affairs. *The Government reply to the third report from the Home Affairs Committee session 2001-02 HC 318 The Government's drug policy: Is it working?* stated:

> The Government has taken into consideration this recommendation and the advice of the Advisory Committee for the Misuse of Drugs and intends to bring forward proposals to Parliament to reclassify cannabis from Class B to Class C under the Misuse of Drugs Act 1971 by July 2003. Reclassification will not mean cannabis is made legal. It is illegal and will remain illegal. [44]

However, by June 2003 the Home Office announced that the changes to the cannabis laws would not come into effect until January 2004 at the earliest. Difficulties in the passage of legislation were experienced.[45]

2.41 Australia's geographic position close to Asia means that it is impacted by drug use, production and policies in those countries. The United Nations Office for Drug Control and Crime Prevention noted that in 2000 opiate and cannabis abuse decreased in South East Asia but there were increases in the abuse of amphetamines and ecstasy, especially amphetamines.[46] Along with other countries, Australia has taken measures to increase international cooperation in reducing drug supplies. Fighting the diversion of chemical products and precursors into illicit drug production, international customs and police cooperation, and international tracking of financial transactions have grown in recent years.[47]

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43 European Monitoring Centre for Drugs and Drug Addiction, p 5.

44 *The* [United Kingdom] g*overnment reply to the third report from the Home Affairs Committee: The government's drugs policy: Is it working*, July 2002, pp 2-3, 12-13, viewed 14/5/03, <http://www.official-documents.co.uk/document/cm55/5573/5573.pdf>.

45 Travis A, Downgrading of cannabis put off till next year: Change to penalties depends on passage of crime bill, *The Guardian*, 23/6/03.

46 United Nations Office for Drug Control and Crime Prevention, *Global illicit drug trends 2002*, ODCCP Studies on Drugs and Crime: Statistics, UNODCCPP, New York, 2002, p 7, viewed 30/4/03, <http://www.unodc.org/pdf/report_2002-06-26_1/report_2002-06-26_1.pdf>.

47 Commonwealth Attorney-General's Department, sub 149, pp 20-21 and sub 259, p 12; European Monitoring Centre for Drugs and Drug Addiction, p 10.