

VicHealth Position Paper: Illicit Drugs

Preamble

VicHealth makes significant investment in action to reduce the harms from tobacco and alcohol and has separate policy positions in relation to these two drug issues. This position statement only refers to illicit drugs, an area that VicHealth does not prioritise for action but supports preventative measures through its other work.

VicHealth works with a range of partner organisations to deliver innovative responses to the complex social, economic and environmental forces that influence the health of all Victorians. VicHealth's primary focus is innovation, through building and sharing health promotion knowledge and working across many sectors to broaden the benefit of health promotion strategies.

VicHealth notes the following:

1. There is continuing **widespread community concern** about the use of illicit drugs, particularly among young people.¹
2. There are **many firmly held and divergent views** on issues associated with illicit drugs. Problems that arise from illicit drug use are complex and difficult to resolve and require multi-faceted systems responses.²
3. **Abstaining from illicit drugs** avoids the harm sometimes associated with their use. As not everyone will abstain from illicit drug use it is necessary to respond to the harms associated with drug use.
4. **Prevalence and patterns of illicit drug use.** There are few comprehensive, up-to-date reviews on the prevalence of illicit drug use. Estimates of rates and patterns of drug use vary according to the age, size and other characteristics of the population surveyed as well as methods of survey. The Australian Institute of Health and Welfare estimates that in 2004 there were over six million Australians aged 14 years or older (38.1%) who had used an illicit drug in their lifetime and more than 2.5 million (15.3%) who had used an illicit drug in the last 12 months.¹ Of those who had used drugs within the last 12 months:
 - Marijuana/cannabis was the most widely used illicit drug with 11.3% of Australians aged 14 and over reporting having used it within the last year, followed by pain killers/ analgesics used for non-medical purposes (5.5%), ecstasy (3.4%), meth/amphetamines (speed) (3.2%) and injected drugs (1.9%)¹. Only three in a thousand Australians aged over 14 (0.3%) reported using opioids (e.g. heroin and opium) in the last 12 months.¹
 - Recent drug use was more frequently reported in Australians who were male (18.2%), aged between 20-29 years (31.5%), unemployed (31.7%), socio-economically disadvantaged (16.6%), living in remote regions (19%) and Indigenous Australians (26.9%).¹

Of Victorians aged 14 years and over, 14.3% had used illicit drugs in the last 12 months, most frequently marijuana/ cannabis (9.8%), pain killers/ analgesics used for non-medical purposes (3.3%), ecstasy (3.1%), meth/amphetamines (speed) (2.8%) and cocaine (1.2%).³

In 2004, one in fourteen (7.2%) Australians aged 12-15 years had used an illicit drug. The most frequently reported illicit drug used (5.2%) was marijuana/ cannabis.¹ The only class of illicit drug use more frequently reported by this age group was the use of inhalants (1.1% compared to 0.4% of adults aged 20 years and over).¹

A 2004 telephone survey of Victorians aged 16–24 years reported that 50% had used illicit drugs in their lifetime and 30% had recently used them.⁴ These high rates of drug use in part reflect the age group surveyed. The survey was consistent with other surveys in reporting cannabis as the most frequent and widely used illicit drug by young Victorians (48% life time and 27% recent use). The study findings suggested that the use of illicit drugs peaks at around 20–21 years of age.⁴

5. **Market forces influence drug use patterns.** The promotion, availability, purity and cost of drugs influence patterns of drug use, which vary according to the interaction of these factors. Findings from the Illicit Drug Reporting System for 2005 suggest that in Victoria heroin is very easy to access and availability is stable, purity levels are low and relatively stable, and the price is stable to increasing.⁵ Although the price and availability of drugs in Victoria is dynamic and subject to change, surveillance of Victorian injecting drugs users in 2005 suggests that heroin is their drug of choice (68%), the drug they inject most often (69%) and the last drug they injected (68%).⁶ The global market in illicit drugs controlled through organised crime further impedes action on availability, price and purity.
6. There are **different types of drug use**: experimental use, recreational use, situational use (e.g the use of amphetamines by long haul truck drivers), intensive use ("bingeing") and dependent use, where a person becomes dependent on a drug after prolonged or heavy use.⁷ Most drug users are experimental and recreational drug users, with only a relatively small proportion becoming dependent drug users. Harms associated with drug use can occur at all levels of use.⁷
7. The **harms associated with illicit drug use** are usefully understood as those experienced by individual users themselves, and those experienced by third parties or by society collectively. Drug related harms impact on a number of dimensions - health, economic, and social. Major areas include illness and disease, injury, economic costs and workplace concerns, violence and crime, and families and relationships. It is useful to understand different patterns of harm in the context of different patterns of drug use (see **Appendix 1**).⁸

In particular it is useful to consider that injecting drug use as a mode of administration may be a more important indicator of risk and harm than the particular drug used. Injecting drug use is associated with a high risk of health complications (e.g. blood borne infection and thrombosis), overdose and dependence.⁸ Drug users may also vary the drug they are using due to market forces and many drug users use more than one drug ('poly-drug use' which is in itself associated with high levels of risk and harm), but seldom go from injecting to non-injecting use.⁸

8. It is also useful to understand the overall significance of harm from illicit drugs in the context of that associated with licit drugs: deaths, years of life lost and hospital separations related to illicit drug use is much lower than that related to the harmful effects of alcohol and tobacco (see **Appendix 2**).⁸ For example in Victoria in 2001 the disease burden attributable to illicit drugs was 1.5% of the total disability adjusted life years compared to tobacco (8.2%).⁹
9. The **number of drug related deaths** in Victoria directly attributable to heroin use peaked over 1999-2000 (359 and 331 deaths respectively), underwent a dramatic decrease in 2001 (50 deaths) and has since remained between 50 and 120 deaths per year (see Appendix 3).¹⁰ The overall reduction in mortality has been attributed to market forces and the reduced availability of heroin on the streets, along with the increasing popularity of amphetamine type stimulants in Victoria.¹⁰

10. The **social costs of illicit drug use** in Australia in 1998-99, including costs associated with crime, health, production in the workplace and at home and accidents such as road accidents and fires, was estimated to be \$6.075 billion.¹¹ Most economic appraisals of interventions to reduce illicit drug problems concentrate on the cost of drug misuse. There is evidence that needle and syringe exchange programs in Australia are cost effective in preventing harm.¹²

11. **Antecedents and risk factors for illicit drug use.** There are a range of health risk behaviours with common social determinants and shared risk and protective factors, one of which is illicit drug use.^{2,13} Social disadvantage and material deprivation are clearly linked to health damaging behaviours including tobacco use, alcohol abuse and illicit drug use.^{2,13} Although these macro level influences exist, a range of modifiable risk and protective factors may mediate the relationship between social disadvantage and drug use and drug-related harm, along with other outcomes. Social disadvantage, social isolation and marginalisation are strong predictors for drug use and contexts that facilitate social bonding, such as strong family attachments, and or belonging to social, sporting or other interest groups, are known protective factors.

Risk factors associated with drug use in young people include personality and peer influences (e.g. aggressive or problem behaviours, association with friends who are using drugs, family influences (e.g. family conflict, family impoverishment and family history of drug abuse), school influences (e.g. academic failure, lack of attachment or commitment to school and persistent problem behaviours in school) and community influences (e.g. drug laws and regulations, community attitudes, living in a neighbourhood which is poor or has high crime levels, and availability of drugs in the community).¹⁴

Protective factors which may reduce risk of drug use in young people include attachment to family, parental harmony, having a sense of belonging and fitting in at school, positive experiences and achievements at school, having someone outside the family who believes in them, contributing to their school and community, and feeling loved and respected.^{2,13,15}

12. There are a **range of prevention interventions** to reduce drug-related harm. Primary prevention initiatives aim to prevent the onset of drug use among non-drug or novice drug users. Secondary prevention strategies aim to reduce problems among current drug users at an early stage (e.g. targeted information dissemination programs, needle exchange programs and safe injecting rooms). Tertiary prevention strategies provide treatment for problematic drug use (e.g. detoxification programs, pharmacological and psychological interventions).

13. Although the evidence on preventing drug related harm is increasing there remain significant gaps in the evidence base.^{8,16,17} Available evidence on causal pathways and effective interventions suggests that a **comprehensive systems approach* to prevention** of drug use and harm is required which acknowledges the range of interacting social influences on drug use and the many levels at which interventions may be delivered (e.g. social policy, schools, parents, peers, media, police).² A protection and risk reduction approach has been recommended which:

- integrates knowledge of developmental processes throughout the life-course with knowledge of broader social influences on behaviour and health outcomes;

* A systems approach to the prevention of illicit drugs acknowledges the dynamic complexity of interactions between structural, social and behavioural influences in determining illicit drug use. It allows the “mapping of systems, pathways and strategies that connect among and between risk factors, protective factors and drug use outcomes”.²

- emphasises the importance of reducing the known developmental risk factors that lead children and young people to become involved with risky drug use and harm while also enhancing protective factors;
 - acknowledges the importance of targeted early intervention strategies focused on strengthening protective factors for children and young people with a high number of developmental risk factors;
 - emphasises the use of brief interventions, treatment and harm reduction strategies to reduce drug-related harm for drug users who have a high number of risk factors, while also improving developmental opportunities for children; and
 - includes law enforcement as an essential element, not just for controlling the supply of drugs but also in influencing community values about drug use, diverting early offenders and acting to protect the community from crime and social disorder.²
14. In 2004 the Ministerial Council on Drug Strategy developed *The National Drug Strategy Australia's Integrated Framework 2004-2009* as a **national policy framework** to provide a coordinated, integrated approach to prevent and reduce the harms of drug use in the Australian community.¹⁸ The strategy, which builds upon the initiatives of a series of previous national illicit drug policies in place since 1985, is underpinned by the **principle of harm minimisation**.^{*} It is a comprehensive approach to the prevention and reduction of drug-related harm through a balance of demand reduction, supply reduction and harm reduction strategies. The eight priority areas for 2004-2009 are prevention; reduction of supply; reduction of drug use and related harms; improved access to quality treatment; development of the workforce, organisations and systems; strengthened partnerships; implementation of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2006*; and identification and response to emerging trends.¹⁸
15. The **Victorian Government's approach** is also based on the principle of harm minimisation. The Premier's Drug Prevention Council's approach to prevention involves a framework based on: addressing drug related issues at an individual, family, community and macro-environmental level; increasing the community's capacity to address drug related issues at a local level; and viewing the drug issue in a broad health context.¹⁹ The Council identified the following five strategic priorities: intelligence gathering to ensure that drug prevention directions and activities are evidence based; communication to promote community awareness about alcohol and drug related issues and how they are prevented; community based drug prevention initiatives addressing risk and protective factors; a major employment and mentoring program in collaboration with the business sector; and advocacy to provide leadership at a state and national level in relation to drug prevention policy, strategic directions and activities.
16. **Australian research** in the field of illicit drug use is modestly funded in comparison to international scales of investment. However, the number of publications by Australian researchers and their involvement in World Health Organisation committees on illicit drug epidemiology, treatment and policy is high. While there is a strong tradition of high quality epidemiological research on mortality and morbidity attributable to illicit drug use and on injecting drug use, there has been little research into the factors external to the individual which arise in the social or broader environment.

VicHealth principles

17. A comprehensive harm minimisation approach that reduces demand, controls supply and reduces harm from illicit drugs is supported.

* Harm minimisation strategies seek to minimise or limit the harms associated with drug use without necessarily seeking to eliminate use.²

18. An evidence-informed systems approach to reducing drug related harm is advocated.
19. In the absence of an optimal solution to the problems resulting from illicit drugs we need to support ongoing activities that identify and adopt solutions that create the least harm in the community, and in particular, those strategies that reduce the demand for drugs.
20. National and or state level policy frameworks provide an essential foundation for modifying or developing new strategies to minimise the adverse health, social and economic impacts of harmful illicit drug use.
21. HIV and other blood-borne infections (such as hepatitis C) are serious potential complications of injecting drug use for drug users and non-drug users alike. Policies for illicit drugs should take into account whether they will assist or hinder efforts to control the spread of these blood-borne infections.
22. There is a need for research studies that focus on social, cultural and economic determinants of drug use. Areas for further research include:
 - the influence of peers in the transition from drug use to abuse;
 - greater specificity of familial effects; protective factors;
 - ethnographic contexts of drug use;
 - the interaction of illicit drug use and child abuse;
 - the influence of the media, fashions and fads on recreational and dependent drug use;
 - impact of law enforcement on harms and the illicit drug market;
 - how to shape markets that produce the least adverse health effects; and
 - multidisciplinary studies on the variables – biological, contextual and social – associated with drug use.
23. Strong relationships between the State Government, the Australian Drug Foundation, Turning Point Alcohol and Drug Centre Inc, Centre for Harm Reduction at Macfarlane Burnet Centre, local governments, and other relevant health agencies, in the first instance will assist in extending and or enhancing partnerships with other sectors of government, community-based organisations and business groups.

VicHealth will undertake to

24. Continue to support the State Government's illicit drug strategy by participating in the Premier's Drug Prevention Council up to March 2006 and then review the role on the appointment of a new CEO.
25. Advocate for policies that will reduce economic and social inequality as this may reduce some of the risk factors associated with patterns of drug misuse and addiction.
26. Support innovative community-based trials that take into account the broader context of the needs and problems facing communities and or population sub-groups. This involves taking into account the levels of employment, health status (including mental health), homelessness, remoteness, recreation opportunities, cultural considerations, family support, community development and access to services (for example *ConnectUs* project, VicHealth Centre for Mental Health Promotion and Community Wellbeing).
27. Advocate for rigorous research and evaluation of implementation strategies to support evidence-informed policy making and assess the cost effectiveness of proven interventions.

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- ¹ Australian Institute of Health and Welfare. 2005. **2004 National Drug Strategy Household Survey: Detailed Findings**. AIHW cat no. PHE66. Canberra: AIHW (Drug Statistics Series No. 16). Accessed 11/7/2006 at: <http://www.aihw.gov.au/publications/index.cfm/title/10190>
- ² The National Drug Research Institute and the Centre for Adolescent Health. 2004. **The Prevention of Substance Use, Risk and Harm in Australia - a Review of the Evidence: Summary**. Canberra: Commonwealth of Australia. Accessed 11/7/2006 at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-mono_prevention-cnt.htm/\\$FILE/prevention_summary.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-mono_prevention-cnt.htm/$FILE/prevention_summary.pdf)
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- ⁴ Premier's Drug Prevention Council Victorian. 2005. **Youth Alcohol and Drugs Survey 2004. Illicit Drugs Findings**. Melbourne: Department of Human Services. Accessed 11/7/2006 at: <http://www.health.vic.gov.au/pdpc/reports.htm>
- ⁵ Jenkinson R and O'Keeffe B. 2006. **Victorian Drug Trends 2005: Findings from the Illicit Drug Reporting System (IDRS)**. NDARC Technical Report No. 256. Turning Point Alcohol and Drug Centre Inc. Accessed 11/7/2006 at: [http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/TR_32/\\$file/TR.256.pdf](http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/TR_32/$file/TR.256.pdf)
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- ⁷ Australian Drug Foundation. 2006. **Drugs and Their Effects: Different Types of Drug Use**. Drug Info Clearinghouse Webpage. Accessed 11/7/2006 at: http://www.druginfo.adf.org.au/article.asp?ContentID=about_drugs#why
- ⁸ The National Drug Research Institute and the Centre for Adolescent Health. 2004. **The Prevention of Substance Use, Risk and Harm in Australia - a Review of the Evidence: Monograph**. Canberra: Commonwealth of Australia. Accessed 11/7/2006 at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-mono_prevention-cnt.htm/\\$FILE/mono_prevention.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-mono_prevention-cnt.htm/$FILE/mono_prevention.pdf)
- ⁹ Public Health Group. 2005. **Victorian Burden of Disease Study. Mortality and Morbidity in 2001**. Melbourne: Department of Human Services. Accessed 11/7/2006 at: http://www.health.vic.gov.au/healthstatus/bodvic/bod_current.htm
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- ¹¹ Collins D and Lapsley H. 2002. **Counting the Cost: Estimates of the Social Costs of Drug Abuse in Australia in 1998-9**. Monograph Series No. 49. Canberra: AGPS. Accessed 11/7/2006 at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-mono.htm/\\$FILE/mono49.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-mono.htm/$FILE/mono49.pdf)
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¹⁹ Premier's Drug Prevention Council 2006 **About the Premier's Drug Prevention Council: Prevention Framework.** PDPC Webpage. Accessed 11/7/2006 at:
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