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Drug Policy and Results in Australia

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PREFACE

Only a decade ago, Australia had one of the biggest drug problems in the world. In 1998, 22% of the population took drugs at least once a year – a shockingly high figure, five times the global average. Today, ten years later, while drug use is still a problem in Australia, changes in policy have put the country on the right track. How has this happened, and what lessons can be learned by the rest of the world? Those questions are addressed in this report which reviews drug policy and results in Australia.

In 1998, United Nations Member States met in a Special Session of the General Assembly and agreed to take tougher action to reduce both the illicit supply of, and the demand for, drugs before 2008. Australia has taken that pledge seriously. In 1998 it introduced a “Tough on Drugs Strategy” that aims to reduce drug supply, trafficking, and demand as well as the harm caused by drugs. This Strategy seems to be working: drug use levels have dropped significantly. Indeed, the turn around has been dramatic. To improve global efforts to contain the threat posed by drugs, the United Nations Office on Drugs and Crime (UNODC) seeks to increase the body of knowledge available to policy makers. That includes collecting success stories. If Australia continues to build on its recent progress, it too could become a success story and provide inspiration and valuable lessons for other countries. This report, following a similar UNODC study of Sweden’s drug policy (2006), aims to contribute to a growing body of evidence that will help countries bring their drug problems under control.



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ABSTRACT

In response to increases in drug abuse in the 1990's Australia implemented a vigilant drug control strategy. As this report makes clear, drug control has long been a priority of recent Governments and effective changes in recent years were due to pro-active, empirically-based drug control strategy, and a well developed system of services at the state and local levels. This report analyses the developments and changes in Australia's drug policies over the last decades and their impact.

Australia implemented a rather repressive drug control policy from the beginning of the 20th century. This worked well until the 1970s. Australia shifted to harm-reduction approaches as of the mid 1980s, with a strong emphasis on prevention and treatment. This helped Australia to avoid a large-scale injecting drug use (IDU) related HIV/AIDS epidemic. In contrast to alcohol and tobacco where Australia achieved remarkable demand reduction through prevention activities, drug abuse continued rising and reached alarming levels by 1998.

In 1998 Australia introduced a *National Illicit Drugs Strategy "Tough on Drugs"* which strengthened the supply control aspects without weakening demand-side interventions or giving up harm-reduction approaches. In the case of heroin, the strategy focused clearly on a reduction of supply. There followed higher heroin prices, lower heroin purity and ultimately substantially lower levels of heroin consumption. Drug related deaths declined, as well as drug related crime. Use of other drugs also declined, both among the general population and among secondary school students- mainly due to improved prevention and treatment activities and more funds made available by the authorities to drug control in general.

The Australian National Council on Drugs (ANCD) incorporated many of the leading drug experts of the country and strengthened calls for higher budgets in the fight against the drug problem. Australia's drug policy has been based on a broad policy mix of supply reduction, demand reduction and harm minimisation policies. In addition, Australia has made commendable efforts at advancing the knowledge base for policy making. The country has consistently conducted in-depth research and evaluations of its various strategies and programmes – subsequently adjusting them according to efficacy. This concentration on empirically-based policy formulation continues to demonstrate positive results.

The drug policy was largely bi-partisan in nature as the States as well as the federal Government participated in its formulation and implementation (Until recently, the individual States were governed by different political parties than federal Australia). A new Australian Government, elected in late 2007, is yet to leave its mark on domestic drug strategies. It seems, however, likely to follow many aspects of the previously successful approaches – possibly further improving opportunities for treatment and harm reduction strategies for people with drug problems while keeping supply control efforts intact.

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INTRODUCTION

Similar to most other industrialized nations, Australia has been confronted with a strong increase in the use of illicit drugs since the late 1960s. Initial responses to the problem concentrated almost exclusively on law enforcement activities and did not prove particularly successful. Subsequent policies of harm reduction, pursued since the mid 1980s, were successful in preventing HIV/AIDS spreading among injecting drug users, but failed to limit the upward trend in drug abuse. By the end of the 1990s Australia had one of the highest levels of drug use worldwide.

The implementation in 1998, of the *National Illicit Drugs Strategy (1997)* - termed the “*Tough on Drugs*” strategy - saw the reversal of this trend. Though the basic elements of the previous policy had not changed and harm minimization remained the key concept, the policy strengthened other supply and demand reduction activities and increasingly built on research and evaluations to guide policy development. Parallel to the policy changes, the Australian Government established the Australian National Council on Drugs (ANCD), effectively raising the status of drug control on the overall policy agenda. The ANCD helped to coordinate the knowledge and work of the broad community of experts working in the various fields of drug control at the national and state levels. The *de-facto* prioritisation of drug control on the national health, welfare and security agendas also helped to substantially increase the overall drug budget for the implementation of the Government’s strategy (AUD\$1.3 billion over the 1998-2005 period). The total anti-narcotics budgets of the national and state governments was estimated at AUD\$3.2 billion in the fiscal year 2002/03. This was equivalent to 0.41% of GDP (up from some 0.1% of GDP a decade earlier), one of the highest such proportions among the industrialized countries, almost three times as much as the West European average and close to the ratios reported from the USA. Australia also experimented successfully with expanding police powers, establishing drug courts, and developing substance specific strategies.

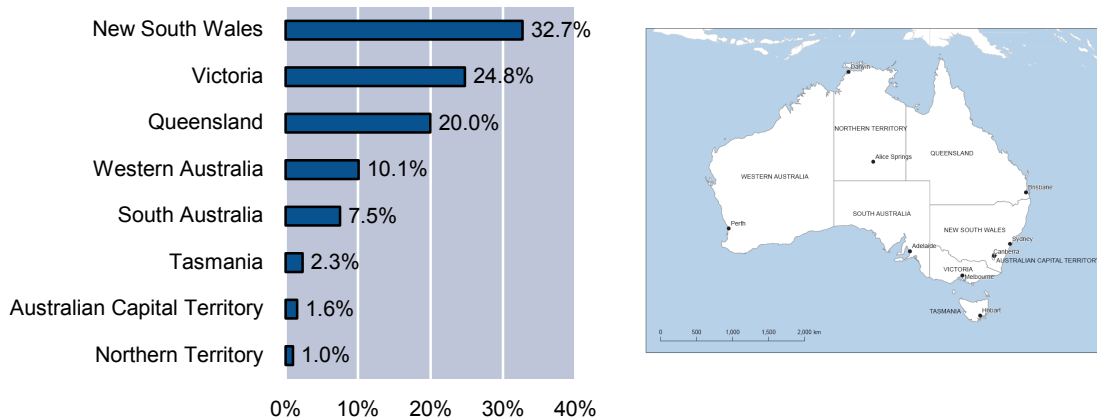
The country’s commitment to coordination and improving the knowledge base also seems to have contributed to the improvement in the overall supply and demand situation. This has occurred in an impressively short period of time. Between 1998 and 2007 overall illicit drug use declined close to 40%. Amphetamines use declined by 38%; cannabis use fell by close to 50%; and use of heroin dropped by an impressive 75%¹. Accompanying the dramatic decline in use, heroin overdoses fell by half and opiate related deaths declined by 61%. Greater coordination of policy and activities and methodical evaluation of ongoing practices led to improved treatment and prevention activities during this period, as did a targeted reduction of supply – engineered by the dismantling of some major heroin importing networks in close cooperation with South-East Asian countries and other international partners. All available data suggest that heroin use, as well as drug use in general, have remained at these lower levels to this day.

On 24 November 2007, Australian elected a new government at the federal level. Although the new Government is yet to spell out its own approach on drug policies, the pre-election platform commits the Government to curbing the supply of illegal drugs through effective law enforcement; tackling the underlying causes of both legal and illegal drug problems to reduce demand; implementing targeted public awareness campaigns to reduce demand; and increase the opportunities for treatment and harm reduction for people with drug problems.²

1. SOCIO-ECONOMIC CONDITIONS – VULNERABILITY TO DRUG CONSUMPTION

Australia, which in terms of square kilometres is the 6th largest country in the world is thinly populated at 2.7 persons per km². Australia's population (21.2 million in 2007) is clearly concentrated in the south-eastern parts of the country. Over 75% of the population lives in the states of New South Wales (1/3 of the total), Victoria (1/4) and Queensland (1/5). If South Australia is included, data show that 85% of the population live in south-eastern Australia.

Figure 1: Distribution of population of Australia – 21.2 million in 2007



Source: Australian Bureau of Statistics (ABS), *Australian Demographic Statistics*.

According to the United Nations Development Programme (UNDP) statistics, 88% of Australians live in urban areas (data refer to 2004), far more than the OECD average (75%) and far more than the global average (48%).³ This has had implications for the development of the country's drug problem. Such a large concentration of the population in urban areas makes communities increasingly vulnerable to drug use due to increased availability, better trafficking infrastructure (e.g. improved intra-regional roads and increased venues commonly associated with drug dealing such as clubs and raves), and differing social structures with less social cohesion and a greater tolerance towards individual differences.

Drug production within Australia is basically limited to cannabis and the amphetamine-type stimulants, notably methamphetamine and to a somewhat lesser extent, ecstasy both of which are also imported in large quantities. There is licit opium poppy cultivation, but controls are excellent and no reports of diversion have been received. Heroin and cocaine are smuggled into the country.

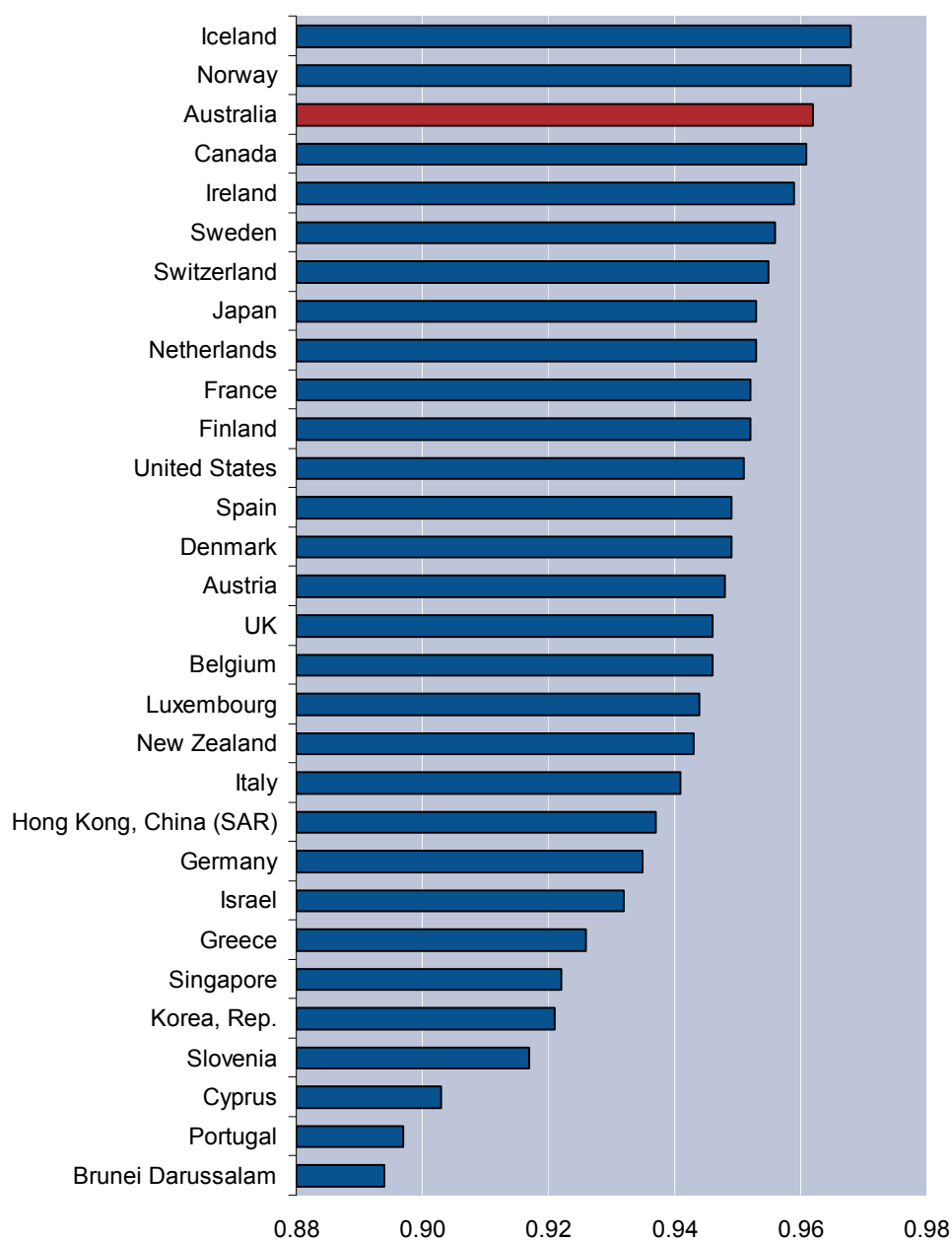
Australia is also a wealthy country. Its per capita GDP (US\$37,700 in 2006) was - according to World Bank data - more than 5 times the global average and the 15th highest worldwide, exceeding the GDP per capita of Japan, the European Monetary Union, and the average of the 'High-Income countries' (as defined by the World Bank) as well as the GDP per capita of neighbouring New Zealand (by more than 50%), Singapore (by 28%) and Hong Kong (by 36%).⁴ Australia is thus - beyond doubt - the richest country in the Asia/Pacific area. The downside of this is that such high income levels make Australia very attractive to drug traffickers. Drug prices are also high in Australia by international standards.

The UNDP ranked Australia in both 2006 and in 2007 third on its Human Development Index which is composed of various social, quality of life, and health indicators.¹ Australia was thus

¹ The Human Development Index, as developed by UNDP, consists of a life-expectancy index, which reflects the development of a country's health system, an education index (derived from adult literacy rate and the gross enrolment ratio) to measure knowledge in society and an index of 'GDP per capita based on purchasing power parities (PPP)' in order to measure the living standards. Results are based on data for the year 2006. (UNDP, *2007/08 Human Development Report*, New York, Nov. 2007.)

ranked ahead of countries such as Canada (4) Sweden (6), Switzerland (7), Japan (8), the USA (12), the UK (16) and neighbouring New Zealand (19).² This high ranking on this index is a relatively recent phenomenon. UNDP data show that Australia was still significantly behind countries such as the USA or Canada in 1975, and slightly below the levels reported from the UK or neighbouring New Zealand. However, Australia's score improved markedly in subsequent years and continued to improve over the 2000-2005 period.

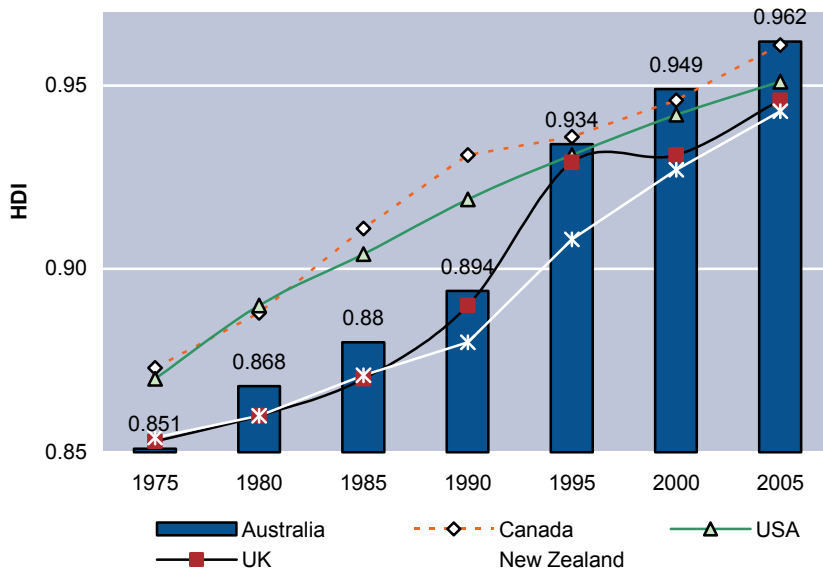
Figure 2: Human Development Index, 2007/08
(2007/08 Human Development Report, based on 2006 data)



Source: UNDP, 2007/2008 Human Development Report.

² Only Norway and Iceland were still ranked slightly higher than Australia. (UNDP, 2007/2008 Human Development Report, New York, Nov. 2007.)

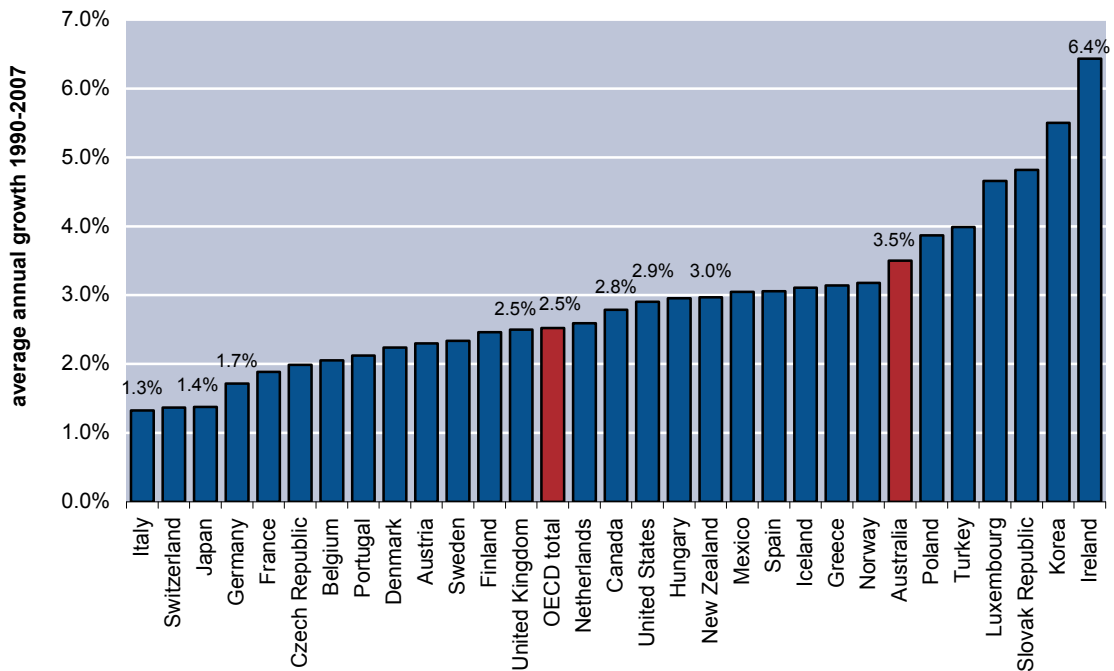
Figure 3: Trends in the Human Development Index for Australia and selected other countries, 1975-2005



Source: UNDP, 2007/2008 Human Development Report.

Among other things this has to do with the rapid expansion of the country’s economy over the last two decades (GDP growth: 3.5% p.a. between 1990 and 2007, about 40% more than the OECD average of 2.5%), and more than economic growth in New Zealand, the United States, Canada or the UK.

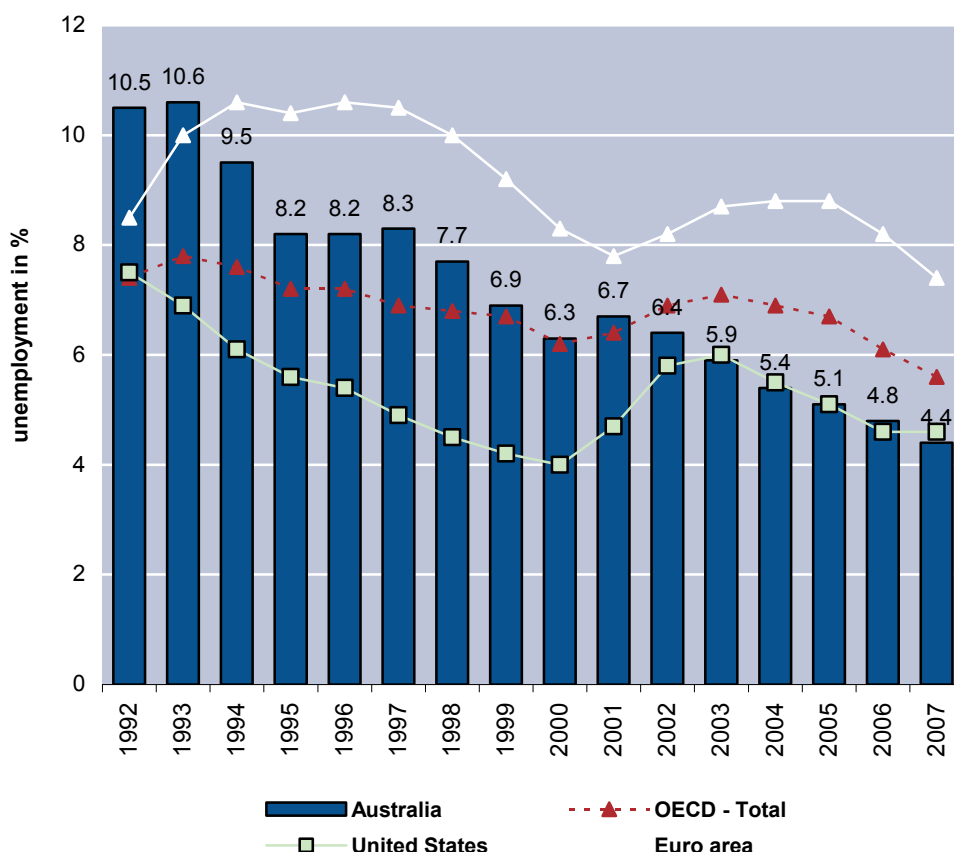
Figure 4: Average annual growth of GDP among OECD countries, 1990-2007



Source: OECD database.

According to OECD statistics, the rapid expansion has brought about a significant decline in unemployment, from 10.5% in 1992 to 4.4% in 2007. The decline in unemployment since the beginning of the 1990s was far stronger in Australia than in the USA, the euro-zone or the OECD average – and may well have played a role in reducing the country’s drug problem.

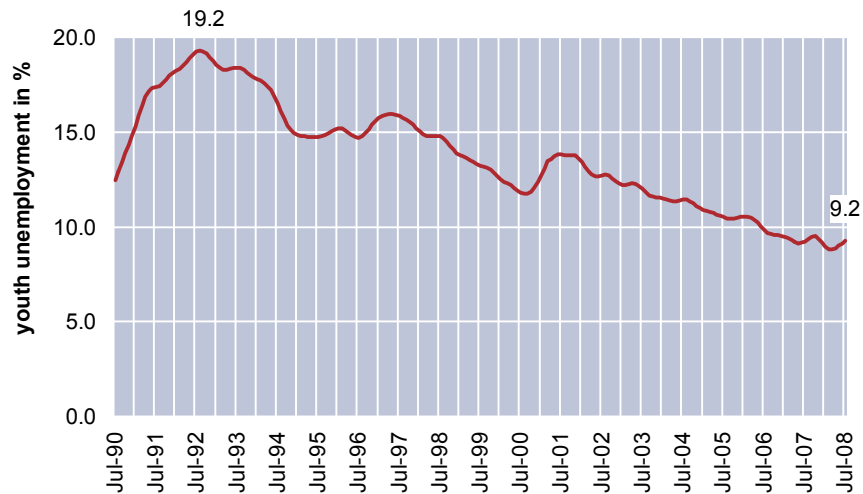
Figure 5: Trends in unemployment in Australia, the USA, the Euro-zone and the OECD average, 1992-2007



Source: OECD, Standardized Unemployment Rates, updated July 2008.

Youth unemployment, in particular, is significant in this respect. Unemployment affected 10.4% of the Australian labour force aged 15-24 in 2006 which was significantly lower than the OECD average (12.5%).³ Between July 1992 and July 2008 youth unemployment (persons aged 15-24) declined from 19.2% to 9.2%.

³ Youth unemployment in Australia was lower than in the USA (10.5%), Canada (11.6%) or the UK (13.9%) and significantly lower than Italy (21.6%) or France (23.9%).

Figure 6: Youth (age 15-24) unemployment in Australia, July 1990 to July 2008

Source: Australian Bureau of Statistics, 'Labour Force Status, Persons aged 15-24, Trend', August 2008

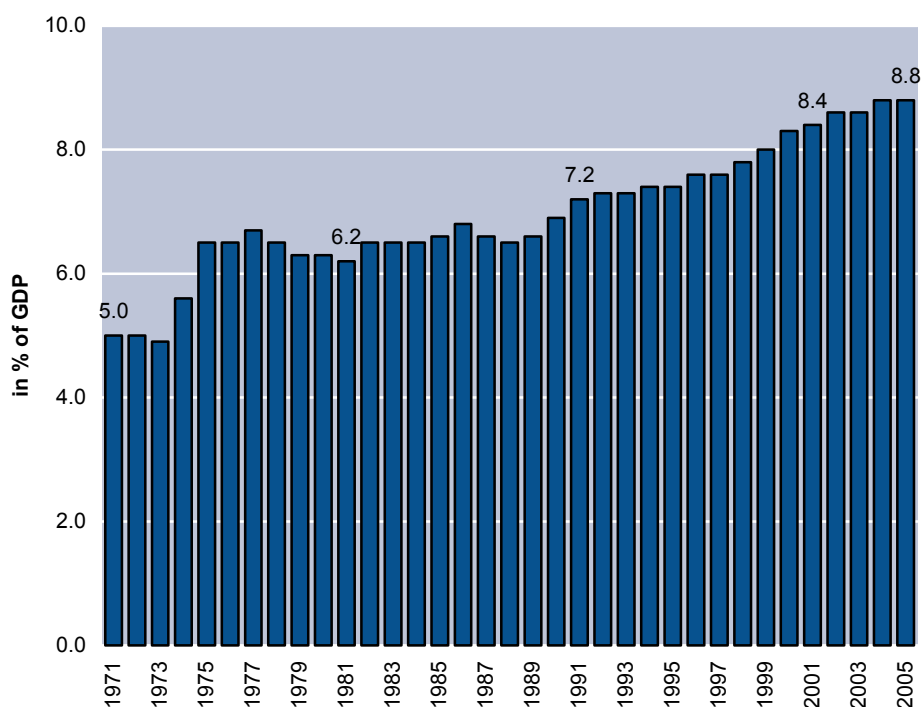
Australia has also achieved several notable prevention-based successes via its health care system. While the health care system itself is beyond the scope of this report, it will be shortly discussed as far as it is relevant for the topic of drug related treatment.

According to the latest UNDP data (referring to the year 2004) the Australian authorities spent an amount equivalent to 6.5% of GDP on providing health services, in addition to amounts equivalent to 3.1% of GDP spent by the private sector. Total health expenditure in Australia is thus equivalent to 9.6% of GDP which is not only clearly above the (unweighted) global average (6.2%) but also more than the (unweighted) OECD average (8.8%) and higher than the proportions reported from countries such as Sweden (9.1%), Denmark (8.6%), New Zealand (8.4%), the UK (8.1%) or Japan (7.8%) - though lower than for the USA (15.4%), Switzerland (11.5%), Germany (10.6%), France (10.5%) or Canada (9.8%).

Both public and private expenditure on health in Australia are clearly above the (unweighted) global average (3.6% and 2.5% of GDP, respectively) and slightly above the (unweighted) OECD average (6.3% and 2.5% of GDP, respectively). The share of the public sector in financing overall health expenditure (68% in Australia) is lower than among the European OECD countries (84% on average) but clearly higher than in the USA (45%). Australia's financing pattern of the health care system is, however, similar to the one observed for Canada (69%). In this context, it may be also interesting to note that Australia's drug policies are very similar to those pursued by Canada.

Total expenditure on health - expressed in purchasing power parity data- was US\$3,123 per person in Australia in 2004, the 10th highest expenditures worldwide and similar to those of France (US\$3,040). Australia's expenditures are higher than those reported from the UK (US\$2,560), Japan (US\$2,293), New Zealand (US\$2,081) or the OECD average (US\$2,590) but lower than those in Canada (US\$3,173), Switzerland (US\$4,011) or the USA (US\$6,096).⁵

Expenditure on health is not only high in Australia by international standards, it also increased substantially over the last few decades, showing that Australia invested heavily in the health sector. OECD data (based on a slightly different concept) show a steady rise of health-related expenditures over the last four decades, from amounts equivalent to 5% of GDP in 1971 to 8.8% of GDP in 2005.

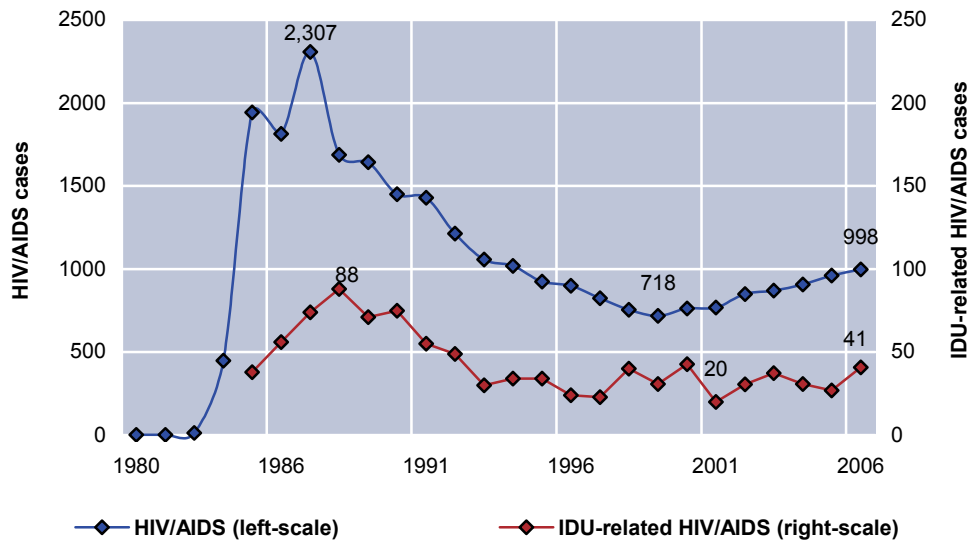
Figure 7: Expenditure on health in Australia, in % of GDP, 1971-2005

Source: OECD, OECD Health Data 2008.

Health services helped to increase life-expectancy from 72 years over the 1970-75 period to 81 years in 2005. Thus, life-expectancy in Australia exceeds the OECD average by 2 ½ years.⁶

Australia's comprehensive health system with its strong emphasis on prevention (primary, secondary and tertiary) also has had positive implications for limiting the spread of HIV/AIDS. Just 0.2% of the population age 15-49 is infected by HIV/AIDS (UNAIDS estimate for 2007). This is less than what is reported for most West and Central European countries (range: 0.1%-0.6%; average: 0.3%) or the USA (0.6%), and clearly less than the global average of 0.8%.⁷ The rate of newly diagnosed HIV/AIDS infections declined by 57% between the peak in 1987 and 2006. Over the 1988-2006 period the number of injecting drug use (IDU) related HIV/AIDS infections fell by 53%. IDU related HIV/AIDS infections accounted for 4.1% of all HIV/AIDS infections in 2006, down from 5.3% in 1988. Even though data also show that HIV in general and IDU related HIV infections have been showing an upwards in recent years, the decline over the last two decades remains, nonetheless impressive and a major achievement.

Figure 8: Newly diagnosed HIV/AIDS cases in Australia, 1980-2006

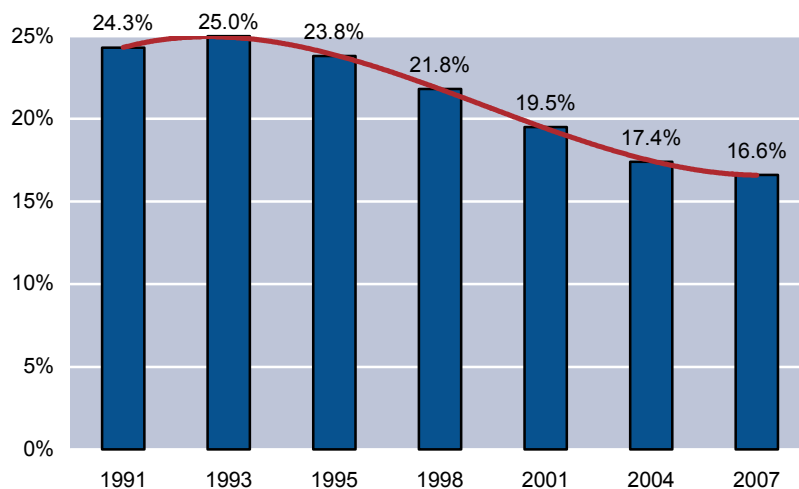


Source: National Centre in HIV Epidemiology and Clinical Research, Australian HIV Public Access Dataset (June 2007) and National Centre in HIV Epidemiology and Clinical Research, HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia, Annual Surveillance Report 2007.

Concerted public health campaigns were also successful in limiting and reducing smoking. Daily smoking of tobacco products declined from 25% of the population aged 14 years and over in 1993 to 16.6% in 2007⁸ i.e. an approximately 33% reduction. If long-term data for tobacco use among males are taken separately, the declines are even more impressive. Back in 1945, 72% of Australian males regularly smoked cigarettes⁹; by 1989 this rate declined to 30% and by 2007 the rate declined to 18%.

Australia has thus one of the lowest rates of tobacco use worldwide. According to data collected by UNDP, 19% of males and 16% of females regularly smoked in Australia in 2004 which is less than in neighbouring New Zealand (24% male / 22% female), less than in the USA (24% male / 19% female) and far less than in European countries (UK: 27% male / 25% female; Germany: 37% male / 28% female; Italy: 31% male / 17% female; or Netherlands: 36% male / 18% female).¹⁰

Figure 9: Daily smoking in Australia among the population age 14 and above, 1991-2007



Source: AIHW, 2007 National Drug Strategy Household Survey.

Reducing tobacco use among the general population as well as among youth also meant reducing the vulnerability of youth to experiment with illegal drugs. Thus, Australia's comprehensive health policy seems to have contributed to reducing the risk of drug consumption. The culture of prevention within the health care system and the use and practice of prevention campaigns have also supported and supplemented Australia's drug demand reduction activities.

2. DEVELOPMENT OF DRUG POLICY IN AUSTRALIA

2.1. Overview

The Crown Colonies which together covered the territory which today is the Commonwealth of Australia⁴, were faced with severe alcohol problems in the 17th, 18th and 19th century, prompting the authorities in the latter half of the 19th century to introduce legislation to reduce alcohol consumption. This proved to be successful. Alcohol consumption dropped significantly until the mid 1930s. It increased again after World War II but was again successfully reduced from the 1980s onwards - this time mainly due to information and awareness campaigns.

Australia was also among the first countries to ratify the first international drug conventions (starting with The Hague Convention of 1912 which was ratified in 1914) as well as the subsequent drug conventions of the League of Nations and, after World War II, the drug conventions of the United Nations. As a consequence it followed rather restrictive drug policies until the mid 1980s. The restrictive policies proved to be successful until the mid 1960s. However, as of the late 1960s drug consumption started to increase and continued rising over the next few decades, despite the increase in penalties throughout the 1970s. In the early 1980s, as HIV/AIDS began to affect Australian society (first amongst the gay and lesbian communities), government officials feared that it could also spread rapidly among injecting drug users. It was, in fact, the threat of an epidemic of HIV/AIDS spilling over from the intravenous drug user population to the general public, which was the impetus for 'harm minimisation' as a policy goal in Australia.¹¹ Thus drug policies were changed and harm reduction, an element of harm minimisation, became a determining characteristic of the Australian approach to the drug problem. While harm reduction approaches were successful in limiting the spread of HIV/AIDS, they failed, however, to limit the spread of drug abuse in the country.

In an attempt to re-equilibrate the policy mix, the Australian Government announced in late 1997 a *National Illicit Drugs Strategy "Tough on Drugs"*, which again gave a stronger focus to law enforcement and supply control without weakening demand reduction efforts. Harm reduction interventions were maintained. The research orientation of Australian drug policy was also maintained and strengthened. Ten years later, data suggest that this re-equilibration of the policy achieved some important successes. The subsequent chapters will provide more detail on the involvement of Australian substance abuse policy and its outcome.

⁴ Following sporadic visits by European explorers and merchants, starting in the 17th century, the eastern parts of Australia were claimed by the British authorities in 1770 and a systematic settlement by the British followed, including through penal transportations from 1778-1848. The first colony was New South Wales. As the population grew, five more colonies, eventually covering the whole of Australia, were established during the 19th century. In 1901 then six self-governing Crown Colonies joined to become a federation, known as the Commonwealth of Australia. (http://en.wikipedia.org/wiki/History_of_Australia)

OVERVIEW OF AUSTRALIAN DRUG POLICY AND RESULTS

1770-1880	High levels of alcohol abuse
1880-1930	Tightening of alcohol laws <ul style="list-style-type: none"> • Falling levels of alcohol use
1914-1985:	Restrictive drug policy; <ul style="list-style-type: none"> • Low levels of drug use from 1900 to the early 1960s • Rapidly rising drug use from the late 1960s to the mid 1980s • Increase in HIV/AIDS, including IDU related, in the early 1980s
1985-1998	Harm minimisation policies <ul style="list-style-type: none"> • Success in reducing HIV/AIDS infections • Rapidly rising levels of drug use until 1998
1998-2007	Tough on Drugs Strategy (1997/98). generous funding while maintaining harm-minimization approach <ul style="list-style-type: none"> • IDU related HIV/AIDS infections remained low • Significant decline in drug use

2.2. Development of Australia's legislation in response to substance abuse, starting in the colonial times

Australia's struggle with substance abuse at the national level can be traced all the way back to its early settlement. Since that time, and throughout the decades which followed, the country experienced extremely large amounts of alcohol consumption. In the early days of settlement alcohol fulfilled many functions. Both convicts and goalers lived in a harsh environment, far from home. Alcohol provided them entertainment and escape. As hard currency was scarce, rum even became an alternative form of payment in the country. The image of heavy-drinking Australians became part of the common lexicon and local identity and is referred to this day.

Statistics suggested that per capita consumption amounted to 13.1 litres of pure alcohol per year over the 1800-04 period.¹² Given the concentration of drinking among male Australians and the large number of children at the time (who mostly did not drink), the average alcohol consumption of male Australians was well above 20 litres of pure alcohol per man. Excessive and rapid drinking was encouraged by the practice of the 'shout' whereby each man in a group was expected to buy drinks for all. Male camaraderie under the influence of alcohol engendered violence, vandalism and general public disorder. Alcohol had devastating effects on the white (male) settlers, but even more so on the Aboriginal people.¹³

There was also concern about opium abuse, mainly linked to some pockets of Chinese population who had settled in the country. Against this background, most of the States and Territories introduced legislation to prohibit the smoking of opium, towards the end of the 1800s and early

1900s, in order to prevent the spread of opium smoking from the Chinese minority to the general population.¹⁴ Queensland prohibited the sale of smokeable opium to Aboriginal people under the *Sale and Use of Poisons Act 1891*. In 1895, South Australia prohibited all opium smoking. New South Wales, Queensland and Victoria followed suit. In general, these laws banned opium smoking and the sale, trafficking, manufacture and possession of opium suitable for smoking.¹⁵

Early regulation of other drugs occurred by way of poisons laws which imposed requirements on the sale and labelling of certain drugs – though their impact on availability was considered to have been rather limited.¹⁶ In fact, Australia was considered to have had one of the highest rate of consumption of ‘proprietary medicines’ per capita in the world in the 19th century. Such proprietary medicines contained, *inter alia*, substances such as arsenic (often linked to poisonings and homicides), opium, morphine and later also cocaine.⁵

There was also some medicinal use of cannabis in Australia in the 19th century. (Cannabis cigarettes were legally available in Australia into the beginning of the 20th century). But cannabis use did not play any significant role in Australia in the 19th century or the beginning of the 20th century.¹⁷

Towards the end of the 19th century, the temperance movement —like in several other Anglo-Saxon countries - became increasingly influential, which was also reflected in the legislation passed by the local authorities. Its main focus was, however, on alcohol. In the 1880s, for example, the Governments of New South Wales and Queensland banned the sale of alcohol on Sundays, and the minimum age at which alcohol could be bought was progressively raised in all Australian jurisdictions.

During and after World War I state Governments introduced ever more restrictive policies on alcohol. In addition the Great Depression reduced the level of income available for personal alcohol consumption. By 1932, average per person alcohol consumption in Australia fell to just 2.5 litres of pure alcohol.

This did not last, however. After World War II, when the economy began to expand, alcohol consumption levels rose again. However, at their peak of 9.3-9.8 litres per person (1973-83) consumption levels were still significantly lower than they had been during the colonial period.¹⁸ While women increasingly began to drink alcohol, the per capita consumption levels among men remained at less than half the level of the colonial period.

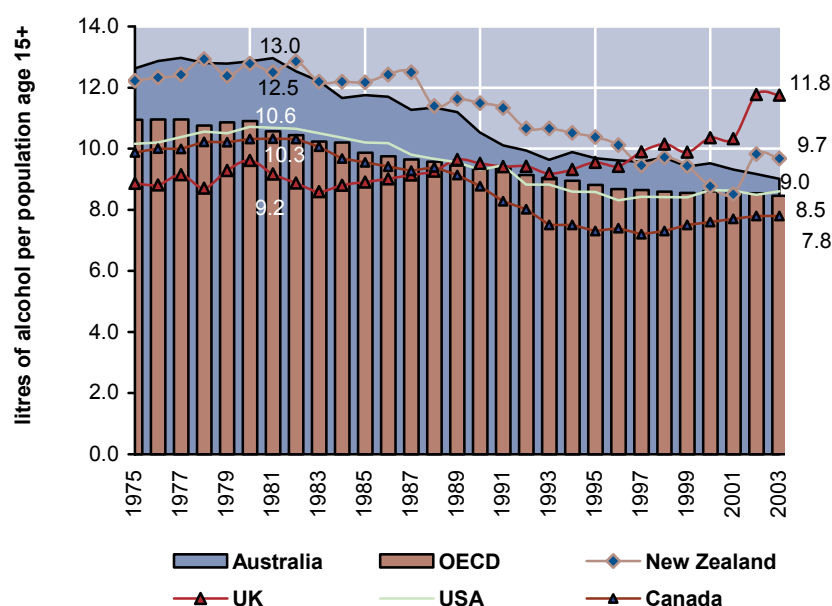
Over subsequent periods, alcohol consumption started falling again and by 2002 Australia's per capita alcohol consumption amounted to just 7.2 litres.¹⁹ Based on the World's Health Organisation database on alcohol, consumption declined in Australia among those age 15 and above from 13 litres of pure alcohol in 1981 to 9 litres in 2003. This is still above the OECD average (8.5 litres). However, the decline over the 1981-2003 period was stronger in Australia (-31%) than the OECD average (-20%). Australia ranked 36th in terms of per capita alcohol consumption in the world in 2003. In 1981, Australia had the 17th highest per capita consumption levels worldwide and in 1969, the 13th highest levels.

Alcohol consumption in Australia is still slightly higher than in North America, but 70% of all EU countries have now higher per capita consumption levels than Australia, including Ireland (13.7 litres) and the UK (11.8 litres). Australia used to have higher alcohol per capita consumption levels than the UK until 1997. While the UK's alcohol consumption increased, Australia's alcohol use continued declining. Australia's alcohol use levels are now also slightly lower than those of neighbouring New Zealand (9.7 litres).

⁵ In the early 20th century a Royal Commission was established by the Commonwealth Government to inquire into ‘Secret Drugs, Cures and Foods’. The Commission identified as ingredients used in common ‘proprietary medicines’ to include opium and morphine such as in Bonnington's Irish Moss; morphine in Cherry Pectoral, Kay's Essence of Linseed and Winslow's Soothing Syrup; and opium in Perry Davis' Painkiller, Atkinson's Royal Infant Preservative and Ayer's Sarsaparilla Mixture. The Royal Commission criticised the lack of controls on the composition and availability of proprietary medicines, advertising claims, the use of preparations containing cocaine and opiates to pacify infants and treat alcoholism, and their free availability to adolescents and adults alike. (See Jennifer Norberry, “Background Paper 12, 1996-97, Illicit Drugs, their Use and the Law in Australia, Parliament of Australia”, Parliamentary Library, May 1997.)

The Australian Government has recently announced a National Binge Drinking Strategy to reduce excessive alcohol consumption, particularly among young people aged under 18. The Strategy, which includes \$53 million worth of funding, will invest in community level initiatives to confront the culture of binge drinking, support innovative early intervention and diversion programs for young people and implement a national media campaign to confront young people with the costs and consequences of binge drinking.

Figure 10: Trends in consumption of pure alcohol per population age 15 and above in Australia, New Zealand, the USA, Canada and the OECD, 1975-2003



Source: World Health Organisation (WHO), Global Alcohol Database

2.3. Restrictive anti-drug policies in the 20th century - successful until the mid 1960s

With the Federation of the Australian colonies in 1901, the Commonwealth became empowered to deal with imports and exports of goods. In 1905 it banned the importation of opium suitable for smoking. In 1910, the Commonwealth made it an offence to be in possession of a prohibited import such as opium without reasonable excuse. The burden of proving 'reasonable' excuse was placed on the defendant.²⁰

Though the authorities in Australia had started with drug control efforts at the state level in the 19th century and at the federal level as of the beginning of the 20th century, it is largely recognized that the subsequent development of illicit drug laws and policies was strongly influenced by the emergence of the international drug conventions. (They continue to be important, with proposals for drug law reform being regularly assessed in terms of Australia's international treaty obligations).²¹

The Australian Government was among the first countries to ratify the *Hague Convention of 1912* (in 1914) and used it to extend import controls on a range of drugs, including opium, various other opiates, and cocaine. At the time of ratification, under Australia's federal structure, criminal law and the responsibility for enforcing the drug laws, was primarily the responsibility of State Governments. (This is still the case today). The Commonwealth *Customs Act of 1901* restricted direct legislative and enforcement responsibilities of the Commonwealth to controlling the entrance of illicit drugs into the country.²² However, the active participation of Australia in the international drug control system, through membership of various international bodies and adherence to international conventions and instruments, took place at the federal, or

Commonwealth, level. In this and other aspects Government policy at the federal level has played and continues to play a critical role in the development of the current framework of drug laws in Australia.

The Federal Government played, for instance, a key role in the gradual phasing out of heroin in medical use, in response to the international drug conventions. (Heroin had been used in Australia mainly in cough mixtures, for palliation in childbirth and in terminal cancer). In 1953, the Commonwealth Government introduced an absolute prohibition on the importation of heroin and urged the States to prohibit its manufacture, which they did.²³

In 1928 the *1925 Geneva Convention on Opium and Other Drugs* came into force. This was the first international convention to cover cannabis. The Commonwealth prohibited the importation of cannabis in 1926. The first penal controls on unauthorised cannabis use at the State level were introduced in Victoria with the *Poisons Act 1927*. Controls consisted of legislation penalizing the unauthorized use of Indian hemp and resin. Other States followed: South Australia in 1934, New South Wales in 1935, Queensland in 1937, Western Australia in 1950 and Tasmania in 1959.²⁴ Marijuana related penalties were based on legislation introduced in most of the States and Territories towards the end of the 1800s and early 1900s to prohibit the smoking of opium by Chinese people, and were rather severe. As a result, cannabis – today the most widely used drug – remained little used in Australia until the 1960s. Up until the late 1960s, the drug laws proved to be quite successful. Relatively few resources had to be devoted to policing the drug laws, due to little use of illicit drugs.²⁵

AUSTRALIA AND THE INTERNATIONAL DRUG CONVENTIONS

After World War II, Australia ratified all three UN drug conventions.

- The Single Convention on Narcotic Drugs (1953), ratified in 1967, as well as the Protocol amending the Single Convention on Narcotic Drugs (1972) (ratified in November 1972);
- The Convention on Psychotropic Substances (1971), ratified in May 1982; and
- the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988), ratified in November 1992.

The obligations in these treaties are carried out in three pieces of federal legislation:

- the *Narcotic Drugs Act 1967*;
- the *Psychotropic Substances Act 1976*; and
- the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act of 1990*.

At the State level, the main legislations are the following:²⁶

- New South Wales: *Drug Misuse and Trafficking Act, 1985*;
Drug Court Act 1998
- Victoria: *Drugs, Poisons and Controlled Substances Act 1981*
- Queensland: *Drug Misuse act 1986*;
Drug Rehabilitation (Court Diversion) Act 2000
- Western Australia: *Misuse of Drugs Act 1981*
- Tasmania: *Poisons Act 1971*
- Northern Territory: *Drugs of Dependence Act 1990*
- Australian Capital Territory: *Drugs of Dependence Act 1989*

Similar to what was happening in most other industrialised countries – also influenced by the ‘hippie’ culture - Australia experienced an upsurge in the use of illicit drugs as of the late 1960s²⁷, notably for marijuana and heroin. Moreover, the participation of Australia in the Vietnam war exposed young Australian soldiers to readily available cannabis and heroin. The Australian Drug Foundations established a clear link between the return of soldiers from Vietnam and the subsequent demand for opiate abuse related treatment facilities in Australia.²⁸ Even more important, many young US soldiers, who served in Vietnam, came for rest and recreation to Australia, bringing with them their newly acquired drug habits, thus prompting the creation of a cannabis and a heroin market on Australian soil, which eventually spilled over to the local population as well. Cannabis arrests in New South Wales (NSW) alone rose almost 1000 percent between 1966 and 1969. Drug use then extended from NSW into other Australian jurisdictions in the early 1970s at a time of social protest against the Vietnam War and rebellion against authority on university campuses across the country. Use of marijuana came to be closely associated, in the public mind, with the culture of protest and rejection of civil authority.²⁹ The increase in heroin dependence during the early 1970s also led to a marked increase in acquisitive crime in Australia.³⁰

Throughout the 1970s and early 1980s the government pursued a deterrent based drug control strategy. It was centred on providing a legal basis for a tough on drugs policy and on providing more resources to departments charged with law enforcement. Policies generally focussed on raising maximum penalties, creating additional offences, making offences easier to prove, and establishing new investigative bodies such as the National Crime Authority which significantly increased the powers and the technology available to law enforcement agencies to detect drug offences. Laws and offices were also established to provide for the confiscation of profits (civil asset forfeiture laws).³¹

The murder of a prominent anti-cannabis campaigner, Donald Mackay, in 1977 was pivotal in increasing the importance of drug control issues on the government agenda. This led to the establishment of the *Royal Commission of Inquiry into Drug Trafficking* in 1979 (the Woodward Commission) in New South Wales and, at the federal level, contributed to the decision to set up the *Australian Royal Commission of Inquiry into Drugs* (the Williams Inquiry) in 1979. The Woodward Commission, the Williams Inquiry and the Stewart Royal Commission of Inquiry into Drug Trafficking (1983) all facilitated “more and better law” and facilitated support for law enforcement, with supply reduction through law and legal enforcement being seen as the key policy elements in addressing the problem of illicit drug use.³²

Despite this unprecedented and concerted effort Australia’s drug problem did not abate. In fact, throughout this roughly twenty year period, it deteriorated. The advent of the HIV/AIDS epidemic in the early 1980’s and the increase in drug related crime throughout the two decades made this untenable from a public policy point of view.

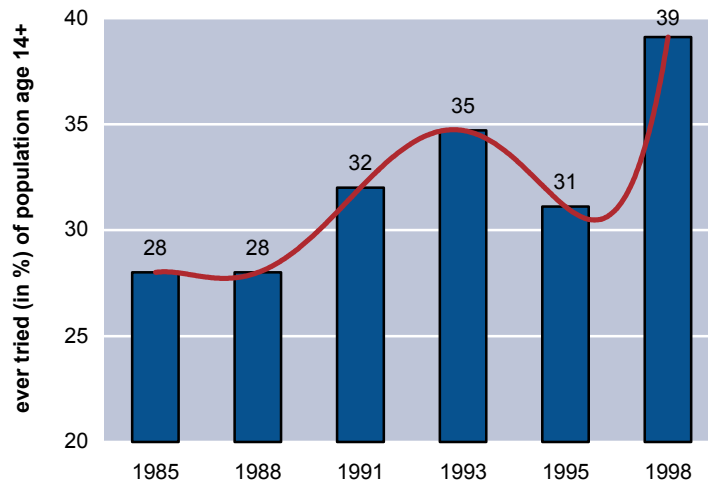
2.4. National Campaign Against Drug Abuse (NCADA) – implementation of harm reduction policies after 1985

By the mid-1980’s the country was to evaluate and re-direct its drug control policy to increase the emphasis placed on prevention and treatment. In many respects, the National Campaign Against Drug Abuse (NCADA), launched in 1985, codified the new policy orientation. The NCADA stressed that drug use should be treated primarily as a health issue. A core feature of the new approach was the perception that drug use was a complex phenomenon that will never be entirely eliminated. The excessively punitive approach was partially revised and supplemented with an increased focus on public health and harm reduction. The most tangible sign of the revision was that the political authority for drug policy was moved from the Federal Attorney General’s Department to the Federal Department of Health.

There are indications that the shift was misunderstood and/or - on purpose - misinterpreted to mean that the authorities had become defeatist and soft on drugs.³³ Drug use remained illegal -

though some criminal law penalties for the use of cannabis were transformed into administrative fines. Supply control was not abolished, but law enforcement was given a lower priority.³⁴ In fact, the burden of drug control was increasingly put on to the shoulders of prevention and treatment - however without sufficient financial resources for such a major undertaking. Drug abuse continued rising.

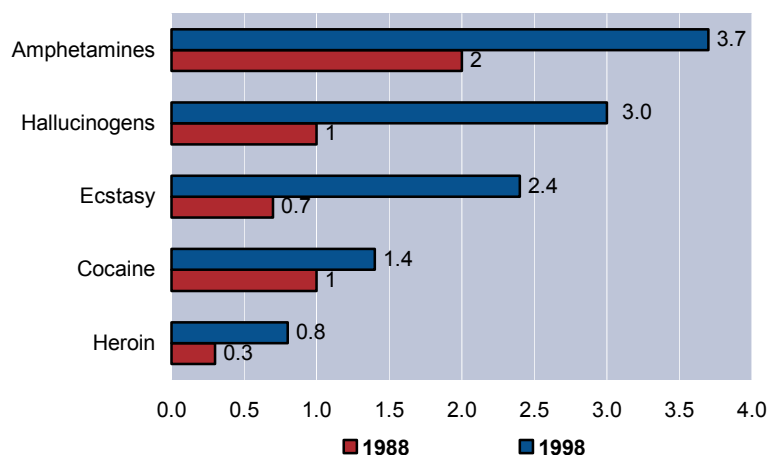
Figure 11: Proportion of population (age 14+) who ever tried cannabis, 1985-1998



Sources: NCADA National Household Surveys, 1985, 1988 and 1991 quoted in Department of Health, *Statistics on Drug Abuse in Australia 1992*, Canberra 1992 and Australian Institute of Health and Welfare (AIHW), *2004 National Drug Strategy Household Survey*, Canberra 2005.

The proportion of the population age 14 and above who ever tried cannabis rose from 28% in 1985 to 39% in 1998. In parallel, data show an increase in the annual prevalence of cannabis use from an already very high level of 12% of the population age 14 and above in 1988³⁵ to 17.9% in 1998 (questions on annual prevalence have been only asked in the survey since 1988).³⁶ Use of other drugs also increased. Annual prevalence of amphetamines use rose from 2% in 1988 to 3.7% a decade later; cocaine use increased from 1% to 1.4% and heroin use increased from 0.3% to 0.8%. Such prevalence data also suggested that drug use in Australia was higher than in most other countries.

Figure 12: Annual prevalence of illicit drug use, excluding cannabis, among the population age 14 and above, 1988-1998



Sources: Toni Makkai and Ian McAllister (National Drug Strategy) on behalf of Commonwealth Department of Health and Family Services, *Patterns of Drug Use in Australia, 1985-95*, Canberra 1998 and Australian Institute of Health and Welfare (AIHW), *2004 National Drug Strategy Household Survey*, Canberra 2005.

These increases may cast some doubts as to the effectiveness of the re-orientation of Australia's drug policy in the 1980s. The introduction of harm-reduction interventions, notably the Needle and Syringe Programs (NSPs), seem to have been effective insofar as they helped to decrease some of the associated health and social welfare costs related to drug abuse, notably with regard to HIV/AIDS. But drug use continued rising, affecting ever larger sections of Australia's society.

There were, however, a number of interesting innovations, which only much later would bear fruits. This concerned, in particular, efforts to improve coordination. This involved policy level partnership and coordination between the Commonwealth (or Federal Government), the States and the Territories, as well as between the health care and the law enforcement sectors. The latter also reflected the Government's new commitment to a comprehensive and integrated approach to drug control. Other hallmarks of the new approach reflected the development of a strategy that involved a coordinated approach for both licit and illicit drugs. A further element was increased attention to advocacy and awareness raising throughout the country through the provision and distribution of accurate information about the major licit and illicit drugs and their impact on health.

From a strategic point of view, the new policies adopted during this time focussed on the harm caused to society and the individual from the use and supply of dangerous drugs. Abstinence was still seen as an objective, but it was not any longer the exclusive goal of drug control. The rationale behind this was that in preventing harmful drug use and reducing the harmful effects of the supply and demand for illicit and licit drugs, Government policy could have a positive impact on the country's overall level of social and economic well being and health.

The policy of '*harm minimization*' also included supply reduction strategies, which differentiates the Australian approach from classical "*harm reduction*" strategies pursued in other countries which normally focus exclusively on demand reduction activities. In this sense, the country truly used its first major overhaul and consolidation to construct a new policy response which would address the problem with a unique mix of drug control interventions.

As this Report continues, it will be seen that the basic approach did not change much in subsequent periods, but became more refined - with the addition of a focus on evaluation and evidenced based policy formulation (which started a few years later) - as well as, starting from the late 1990s, more financial resources and the rediscovery of supply control as a key element in the overall harm-minimization mix in combination with a much clearer and unequivocal message that the Government would be again "Tough on Drugs".

The 1985 to 1993 period already set the stage for testing and evaluating the new policy. Consistent with this commitment to evidenced based policy development, the Ministerial Council on Drug Strategy (MCDS) commissioned two independent evaluations of the NCADA. The evaluations were designed to gauge the efficacy of the current activities with a view to designing and adjusting future programmes. The evaluations were concluded in 1988 and in 1992 respectively and formed the basis for the next period of the country's drug control experience..

2.5. National Drug Strategy (NDS), 1993-1997 – ongoing focus on harm reduction policies and greater balance of policies to minimize harm

The new *National Drug Strategy (NDS)* which was formulated and published in 1993 relied heavily on the recommendations from the two evaluations of the NCADA. Harm minimisation remained an overall goal of the policy with its main strategic goals being:

- minimize the level of illness, disease, injury and premature death associated with the use of alcohol, tobacco, pharmaceutical and illicit drugs;
- minimize the level and impact of criminal drug offences and other drug-related crime, violence and antisocial behaviour within the community;

- minimize the level of personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the inappropriate use of alcohol and other drugs; and
- prevent the spread of hepatitis, HIV/AIDS and other infectious diseases associated with the unsafe injection of illicit drugs.

The strategic plan identified six specific concepts which were to underpin the development and implementation of drug policy:

- harm minimization;
- social justice;
- maintenance of controls over the supply of drugs;
- an inter-sectoral approach;
- international cooperation; and
- evaluation.

What is interesting about both the overall policy is (i) the balanced way drug control is approached as a health, law enforcement and criminal justice problem, and (ii) the inclusion of evaluation as one of the six pillars of the policy.

Consistent with this commitment, the Australian Government evaluated the National Drug Strategy (1993-1997) in 1997. The evaluation report, entitled *The National Drug Strategy: Mapping the Future*, praised the National Drug Strategy (NDS) for this unique mix of approaches. Specifically the NDS was commended for:

- recognizing the complexity of drug issues and the need to provide front-line health professionals and others dealing with drug problems with a wide range of options based on the concept of harm minimization. These range from abstinence-oriented interventions to programs aimed at ameliorating the consequences of drug use among those who cannot be reasonably expected to stop using drugs at the present time;
- adopting a comprehensive approach to drugs which encompasses the misuse of licit as well as illicit drugs. Policies and programs to address the problems of illicit drugs, alcohol, tobacco and pharmaceuticals all fall under the aegis of the NDS;
- stressing the promotion of partnerships – between health, law enforcement, education, nongovernmental organizations, and private industry; and
- attempting to address drug issues in a balanced fashion. This refers to the appropriate balance of effort between the Commonwealth, States and Territories, a balance between supply and demand reduction strategies, and a balance between treatment, prevention, research and education.

Some adjustments were, nonetheless, recommended in the findings of the evaluation. These were contained in a seven point plan, which were largely implemented over the course of the following years:

1. strengthen National Drug Strategy partnerships and expand them to the local level. The cornerstone of the NDS was the promotion of a strong partnership between health and law enforcement. The NDS should expand the partnerships to nongovernmental organizations and extend the network of health, law enforcement and nongovernmental partnerships to the local level;
2. establish a dedicated National Drug Strategy unit with the capacity to assist the Ministerial Council for Drug Strategy (MCDS) and the National Drug Strategy Committee (NDSC) in providing leadership and an enhanced ability to properly manage the NDS;

3. train mainstream health, law enforcement and community officials to effectively minimize drug-related harm;
4. improve the cost effectiveness of treatment, prevention and research. A significant increase in the number of treatment and prevention programs subject to systematic outcome evaluation was recommended. High priority should continue to be given to research and prevention programs targeted at youth and other high-risk groups;
5. improve the ability to monitor the performance of the NDS and make new developments in prevention, treatment and research more readily available to health care practitioners, law enforcement officers and the public at large. To do this, the evaluators recommended that an Australian National Clearing House on Drugs be created. This body would create an inventory of drug programs and develop an electronic network of key resource centres for front-line professionals;
6. enhance the involvement and effectiveness of law enforcement in preventing drug-related harm. Police and courts should continue to give increasingly higher priority to the enforcement of trafficking offences versus possession offences;
7. redirect cost-shared funding used for ongoing services to the development and dissemination of new programming. There should be secure funding for ongoing specialized services required to deal with drug problems, such as residential and non-residential treatment. NDS funds are only a small part of the total amount of money spent by the Commonwealth and States and Territories for the prevention and/or treatment of drug abuse. They should not be used to fund ongoing services, but rather as a catalyst to develop more effective responses to drug problems in Australia.

Despite of the overall positive evaluation of the NDS for its innovative approach, no progress was made in reducing drug use levels in Australia. To the contrary, drug use continued growing, reaching dramatic levels by international standards by the late 1990s. Notably between 1995 and 1998 Australia experienced the largest increases in drug use ever seen in the country. Based on annual prevalence data collected in household surveys, illicit use of drugs rose by 29%. Dramatic increases were recorded for cannabis (37%), cocaine (40%) and amphetamines (76%). Heroin use doubled.³⁷ Opiate overdose deaths increased from just 6 in 1964 to 321 in 1990 and a staggering 1,116 in 1999.³⁸ As a consequence, Australia showed some of the highest drug use levels among all countries worldwide.³⁹

There was also a strong increase in hepatitis C. linked to injecting drug use – despite the existence of needle exchange programs. One study entitled "Hepatitis C transmission on the north coast of New South Wales (1997): explaining the unexplained" concluded that, "...*injecting drug use with the sharing of injection equipment accounted for transmission in 76% of all people with hepatitis C.*"⁴⁰ There were said to be 250,000 cases of hepatitis C in Australia with a new infection rate of 6,000 cases per annum. Hepatitis C patients also had a 2% chance of developing liver cancer and sufferers accounted for 25% of liver transplants.⁴¹

At the same time, drug related arrests and convictions fell, as did the proportion of the total prison population imprisoned for drug-related offences, reflecting the shift away from repressive drug policies. This proportion declined from 11% in 1995 to 9% in 1999.⁴² While some harm reduction goals had been achieved – notably with regard to HIV/AIDS - , the strong increases in drug related deaths throughout 1990s needed to be reversed and it was this that catapulted Australia into its next and current phase of drug control policy.

2.6. National Illicit Drugs Strategy “Tough on Drugs” (1997)’

In November 1997 the Australian Government launched the *National Illicit Drug Strategy “Tough on Drugs”*⁴³ seeking to reverse what it saw as an ever more serious public health and security problem.

The National Illicit Drugs Strategy “Tough on Drugs”

Supply reduction (*‘Stemming the Trade’*)

Objective: to make Australia a more difficult target for drug traffickers

Measure: extra-funding to increase the interception of drugs; extra-funds made available to:

- Increase the operational investigative staff at Australia’s Federal Police;
- Increase the capacity of the Customs Service’s cargo profiling system;
- Improve law enforcement agencies’ communication and IT capabilities;
- Identify trafficking patterns of heroin via the National Heroin Signature Programme and improve research into drug-crime links and increase funding for informant handling and witness protection;
- Enhance Australian Transaction Reports and Analysis Centre’s capacity to monitor suspicious financial transactions.

Demand and harm reduction (*‘Education, treatment and support’*)

- Prevention, focussing on young people, their parents, local communities, teachers and health professionals (*‘zero tolerance of drugs in schools’*);
- Dissemination of information to the general community, including parents, schools, universities, health professionals and health care facilities;
- Upgrading of existing community treatment services (cost-share funding arrangements);
- Establishment of new community treatment facilities;
- Diversion of drug users from prison to treatment programmes with a view to breaking the cycle of drug dependency and criminal behaviours.

Research

- Support new research and innovative harm minimisation measures; and
- Interdisciplinary research to achieve innovation in the prevention and treatment of illicit drug use with a stronger focus on abstinence-based treatment .

Under the title of ‘stemming the trade’, the strategy foresaw to make Australia a much more difficult target for drug traffickers and to provide more funds to border control and to the Australian Federal Police, in order to increase the number of investigative staff, increase the capacity of Australian Customs Service’s cargo profiling system, improve the communication and IT capabilities, fund a National Heroin Signature Programme to identify trafficking patterns, increase police funding for informant handling and witness protection and enhance the Australian Transaction Reports and Analysis Centre’s capacity to monitor suspicious financial transactions.

In parallel, the strategy foresaw measures to strengthen efforts to reduce the use of illicit drugs by focussing on school education and community information, focusing on young people, their parents, local communities, teacher and health professionals.

Another focus was on treatment, notably the establishment of new community treatment facilities as well as the upgrading of existing ones.

Despite the title “Tough on Drugs” the strategy also included proposals to enable the diversion of drug users from prison to treatment with a view to breaking the cycle of drug dependency and criminal behaviour. In addition, the strategy also singled out the importance of research, notably towards prevention and treatment of illicit drug use, with a stronger focus on abstinence-based treatment and eventual re-integration of users into the community.⁴⁴

The implementation of the new strategy began in 1998 and its fundamental principles continue. The *National Illicit Drugs Strategy “Tough on Drugs” (1997)* shifted the pendulum again in favour of stronger drug control measures – without reducing the level of demand and harm reduction. One immediate impact was a significant increase in drug seizures which helped to stabilize the market from the supply side. Having reduced the ‘supply push’ demand reduction policies had a higher chance to succeed. In the case of heroin, as will be discussed later, a supply shortage, resultant of law enforcement in 2000/2001, prompted heroin prices to rise and many heroin users left the market and underwent treatment. A “zero-tolerance” approach was introduced with regard to drug trafficking, notably with regard to drug trafficking near schools.⁴⁵

The strategy also foresaw to provide law enforcement agencies with the necessary powers to catch the organized crime syndicates running the drug trade. With the subsequently introduced *Measures to Combat Serious and Organised Crime Act 2001*, enforcement agencies were enabled - for the first time - to conduct strategic undercover operations to get hold of the leaders of the drug syndicates.⁴⁶

Under the *National Illicit Drugs Strategy “Tough on Drugs” (1997)* from 1998 to the present, the Australian (Federal) Government expended the largest budgetary outlay for drug control in history. In total, drug control expenditure has amounted to more than AUD\$1.4 billion.

The original strategy encompassed a range of supply reduction and demand reduction measures at a total cost of AUD\$516 million. Funding for the Strategy was split between demand-reduction strategies, implemented by the Department of Health and Aged Care, and the Department of Education, Training and Youth Affairs, with supply-reduction strategies, implemented by the Attorney-General’s Department, the Australian Federal Police and the Australian Customs Service.

A total of AUD\$213 million (41%) were allocated for a range of *supply reduction measures* to intercept more illicit drugs at borders and within Australia. Law enforcement efforts included funding for 10 new Federal Police anti-drug mobile strike teams to help dismantle drug syndicates within Australia as well as increased funding for the Australian Customs Service to enhance its capacity to intercept drug shipments.

1. The remaining AUD\$303 million (59%) were allocated for *demand reduction initiatives* covering five priority areas:
2. Treatment of users of illicit drugs, including identification of best practice;
3. Prevention of illicit drug use;
4. Training and skills development for front line workers who come into contact with drug users;

5. Monitoring and evaluation, including data collection;⁶ and
6. Research.

2.7. The National Drug Strategic Framework (1998/99 – 2002/03)

Almost in parallel with the implementation of the *National Illicit Drugs Strategy “Tough on Drugs”* (1997), the Australian Federal, State and Territory Governments drafted and adopted a *National Drug Strategic Framework* (1998/99 – 2002/03). The National Drug Strategic Framework basically maintained the policy principles of the previous phases of the National Drug Strategy (NDS) and adopted the recommendations of *Mapping the Future: An Evaluation of the National Drug Strategy 1993-97*. Its focus remained on harm minimization. It reflected the desire that a nationally coordinated and integrated approach was needed to reduce the harm arising from the use of licit and illicit drugs, including alcohol, tobacco and pharmaceutical drugs.

The NDS Framework continued seeking a balance between supply-reduction, demand-reduction and harm-reduction strategies, emphasizing 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 continued the emphasis on evidence-based practice. All supply-reduction, demand-reduction and harm-reduction strategies should reflect evidence-based practice, based on rigorous research and evaluation, including assessment of the cost-effectiveness of interventions. Best practice had to take into account the preferences of individual clients, their families and the wider community.

Strategies for tackling drug-related harm not only had to target the particular drug causing problems but had to be developed with regard to the broader context of the needs and the problems facing the affected community. Levels of employment, health (including mental health) status, homelessness, remoteness, recreation opportunities, cultural considerations, family support, community development, and access to services had to be taken into account.

Main objectives of the *National Drug Strategic Framework* were to:

- increase community understanding of drug-related harm;
- reduce the supply and use of illicit drugs in the community;
- prevent the uptake of harmful drug use;
- reduce the level of risk behaviour associated with drug use;
- reduce the risks to the community of criminal drug offences and other drug-related crime, violence and anti-social behaviour;
- 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;
- increase access to a greater range of high-quality prevention and treatment services; and
- promote evidence-based practice through research and professional education and training.

Emphasis was also placed on extending the partnership between health and law-enforcement agencies to take in a broader range of partners, as recommended in *Mapping the Future*. Thus the Intergovernmental Committee on Drugs, which consists of health and law-enforcement officers from each Australian jurisdiction, was expanded to include officers from the portfolios of Customs and education. The MCDS was also supported by the Australian National Council on Drugs, consisting of people with relevant expertise from the government, non-government and community-based sectors to provide policy advice. These bodies developed a series of National

⁶ Funding was provided to the Australian Institute of Criminology under the Australian Government’s National Illicit Drug Strategy to establish a research programme that would monitor illicit drug use amongst detainees. Quarterly collection began in January 1999 at East Perth (Western Australia) and Southport (Queensland), and June 1999 in Bankstown and Parramatta near Sydney (New South Wales). [Makkai 2000]

Drug Action Plans, specifying priorities for reducing the harm arising from the use of licit and illicit drugs, strategies for taking action on these priorities, and performance indicators.

In a further move to implement the harm minimization philosophy, the Commonwealth, State and Territory health and law enforcement ministers agreed in June 1999 on a national approach to the development of a *treatment instead of incarceration initiative* designed to divert illicit drug users from the criminal justice system into education and treatment. Diversion involves a graduated series of interventions appropriate to the seriousness of the offence and the circumstances of the offender. Diversion was not considered appropriate for trafficking offences. Drug-involved offenders can be cautioned on the streets and provided with treatment referral information if their offence is possession of a small quantity of drugs. They can be sent for assessment or directly to treatment rather than prison, as long as the offence is not serious and they do not pose a threat to society. Courts and correctional systems can also use commitment or referral to community-based treatment as an adjunct to probation or parole from prison. There is also treatment within correctional facilities and corrections-operated or funded therapeutic communities and halfway houses.

In order to support the *National Drug Strategic Framework*, the following structure⁴⁷ emerged:

- The *Ministerial Council on Drug Strategy (MCDS)* remained the peak policy and decision-making body in relation to licit and illicit drugs in Australia. The role of the MCDS is to bring together Commonwealth, State and Territory ministers responsible for health and law enforcement to collectively determine national policies and programs to reduce the harm caused by drugs. Under the framework, the MCDS functions as the peak policy and decision-making body in relation to licit and illicit drugs in Australia.
 - The *Intergovernmental Committee on Drugs (IGCD)* was created as the key executive body responsible for providing policy advice to the ministers on the full range of drug-related matters and is responsible for implementing national drug policies and programs, as directed by the MCDS. The IGCD supports the MCDS and is a Commonwealth-State-Territory Government forum consisting of senior officers representing health and law enforcement in each Australian jurisdiction.
 - The *Australian National Council on Drugs (ANCD)* was created and became responsible for ensuring that the expert voice of NGOs and others working in the drug field was reaching all levels of Government and could influence policy development. The ANCD has a broad representation from volunteer and community organisations, law enforcement, education, health and social welfare interests. It facilitates an enhanced partnership between Government and the non-government and community sectors in the development and implementation of policies and programs to redress drug-related harms.
 - Four *national expert advisory committees* responsible to the MCDS for the development of National Drug Action Plans under the NDSF, namely, *National Expert Advisory Committees on Tobacco, Alcohol, Illicit Drugs and School Drug Education*; the national expert advisory committees provide a range of advice to the MCDS and IGCD.
 - The *National Drug Strategy Reference Group for Aboriginal and Torres Strait Islander Peoples* responsible to the MCDS, recognizing that Indigenous peoples continue to suffer a greater burden of substance abuse than the rest of the population and that drug action plans and strategies in the past did not always relate well to the particular drug related issues affecting Aboriginal and Torres Strait Islander Peoples.
 - *Five committees and sub-committees* that provide advice to the IGCD and links with other national strategies, namely the (i) *National Drug Research Strategy Committee (NDRSC)*, (ii) *Monitoring and Evaluation Co-ordination Committee (MECC)*, (iii) *National Drug Strategy Local Government Sub-committee (NDSLGC)*, (iv) *Australian Pharmaceutical Advisory Council (APAC)* and (v)

the Sub-committee on the Intentional Misuse of Pharmaceutical Drugs and the Methadone and Other Treatment Subcommittee.

In May 2001, *the National Drug Strategy (NDS)* was evaluated by a team of experts, including Professor Eric Single (from Canada), who appeared before the Special Senate Committee on Drug Policy to present the outcome of this evaluation exercise. Prof. Single reiterated much of what his 1997 report *Mapping the Future* had already stated, pointing out the unique combination of features which have brought the Australian National Drug Strategy international attention and acclaim. It reported that:

- Based on the *concept of harm minimization*, the NDS recognized the complexity of drug issues and the need to provide front-line health professionals and others dealing with drug problems with a wide range of options. These options range from abstinence-oriented interventions to programmes aimed at ameliorating the consequences of drug use among those who cannot reasonably be expected to stop using drugs immediately.
- The goals, strategies, *guiding principles and performance indicators* for the NDS were established by a National Drug Strategy Committee. This committee consists of high-level civil servants from health and law enforcement ministries of each state and territory as well as their counterparts from the federal government. This shared decision-making has been seen as a strength of the NDS since it enhances government co-operation and ensures a high level of visibility for the drug strategy.
- Moreover, the Australian NDS adopted a *comprehensive approach* to drugs that encompasses the misuse of *licit* as well as *illicit* drugs. Australia's approach to drugs stresses the *promotion of partnerships* – between health, law enforcement, education, nongovernmental organizations, and private industry.
- The NDS also attempts to address drug issues in a *balanced* fashion. This means a balance is attempted in the effort made *by the federal Government, States and Territories*, a *balance between supply and demand reduction* strategies, and a balance between *treatment, prevention, research, and education*.
- A sound *research infrastructure* has been established by the creation of national research centres that are now among the world's leading institutions on alcohol and drug research.
- The Australian Government also followed up on a number of previous recommendations. For example, the NDS was renewed for five years, *funding was increased*, a specialized NDS unit was created within the Commonwealth Ministry of Health, and action plans were developed with regard to other recommendations.

In contrast to the National Campaign Against Drug Abuse (NCADA), adopted in 1985 and the first National Drug Strategy (NDS), adopted in 1993, the new NDS adopted in 1997/98, was in effect associated with a reduction in drug use as such, and did not only reduce some of the drug related side effects. In addition, increasing economic prosperity and falling unemployment were contributory factors to the decline in drug use. While many of the measures proposed and described in the *National Illicit Drugs Strategy "Tough on Drugs" (1997)* were not that different from those contained in the 1985 NCADA or the 1993 NDS, the sub-title "*Tough on Drug*" indicated, however, some major underlying changes in the attitude of the authorities. Harm minimization was not any longer associated with being lenient on drug use. It meant taking the drug problem seriously and addressing it on all fronts. Moreover, research results were increasingly used strategically to understand the problem and take appropriate counter-actions.

One of the additional elements for the success of Australia's drug policy seems to have been related to the creation of the *Australian National Council on Drugs (ANCD)* in 1998. The Council brought together expertise from various sectors of the community - from volunteer and community organisations, to law enforcement, health and social welfare - engaged in the struggle against drug use, and, in a consolidated way, advised the Australian Government and assisted it in the implementation of its drug policies. The resulting cooperation of experts from various fields was not only vital to guarantee the comprehensiveness of Australia's drug policy but proved to be a merit in itself, as it helped to reduce existing barriers between the different services. It also proved

to be important that the ANCD was not perceived as just another anonymous council, but that it had a leader who, based on strong moral convictions, filled the need for someone in the country to take on the role as Australia's drug czar.⁷ The ANCD thus also emerged as an important pressure group to increase the budgets available in the fight against drug abuse. Over the 1998-2005 period the Federal Australian Government provided in total more than AUD\$1.3 billion to the various initiatives which operated under the umbrella of the *National Illicit Drugs Strategy "Tough on Drugs" (1997)*. This was in contrast to previous periods when the implementation of Australia's drug policy suffered from a paucity of funds and a rather low national priority. New funds enabled improvements in supply reduction activities, in research, in treatment and in prevention.⁴⁸

Anti-narcotic budgets in Australia – 1987/88 to 2002/03

Like in many other countries, anti-narcotics expenditures are not regularly established in Australia. According to the 1989 Report of the Parliamentary Joint Committee on the National Crime Authority, *Drugs, Crime and Society*, supply reduction expenditures (drug related funds made available to Australian Federal Police, the National Crime Authority, Australian Customs Services, State Police, Prisons, Courts) amounted to AUD\$123 million in 1987/88⁴⁹, equivalent to just 0.04% of GDP.⁵⁰

This figure was subsequently challenged by some Australian researchers as too conservative. Robert E. Marks argued that the supply reduction costs actually amounted to more than twice as much: AUD\$320 million⁵¹ equivalent to 0.1% of GDP.

David J. Collins and Helen M. Lapsley arrived in their study on the social costs of drug abuse in Australia to the same levels. The total expenditure for law enforcement (supply control) amounted, according to their calculations, to AUD\$320 million (0.1% of GDP). The corresponding figures for 1992 were calculated to have amounted to AUD\$451 million. Expressed as a proportion of national income, law enforcement expenditure would have remained stable between 1988 and 1992 at 0.1% of GDP. Later estimates for the year 1996 put law enforcement expenditure between AUD\$300 and AUD\$400 million⁵², equivalent to 0.06% and 0.08% of GDP - which would be less than the Collins and Lapsley estimate for 1992.

Including public expenditure on substance abuse related prevention, treatment, research and some other cost items, Collins and Lapsley estimated such expenditure to have amounted to AUD\$941 million in 1988 (equivalent to 0.28% of GDP) and AUD\$1362 million in 1992 (equivalent to 0.32% of GDP).⁵³ It must be noted though that the authors included alcohol and tobacco in their calculations. Excluding expenditure on alcohol and tobacco, available data suggest that illicit drug related expenditures (law enforcement and health related costs) would have amounted to AUD\$342 million in 1988 and AUD\$484 million in 1992, equivalent to a rise from 0.10% of GDP in 1998 to 0.11% of GDP in 1992.

A renewed attempt to estimate total anti-narcotics related expenditures was undertaken by Timothy J. Moore in 2005, based on data for the fiscal year 2002-03. These calculations resulted in a total estimate of expenditure for fighting drugs and dealing with their consequences of AUD\$3.2 billion⁵⁴ equivalent to 0.41% of GDP. These data suggested that AUD\$2.4 billion, i.e. 76% of total expenditure or 0.3% of GDP, were related to supply control (law enforcement, interdiction and crime related), 21% was demand related (prevention, treatment, health related); others accounted for 3%. Strong efforts were made by the states, accounting for 83% of total anti-narcotics expenditures in 2002/03. Classifying expenditures in terms of 'proactive' and 'reactive', the study showed that 'reactive' expenditures (like in most other countries) account for the bulk of total expenditure.

⁷ A major impact for the success of the ANCD, and thus for the implementation of the drug policy in Australia was the nomination of Major Brian Watters as Chair of the Australian National Council on Drugs in 1998. Mr. Watters, a former Salvation Army Officer, had worked in the drug field for more than two decades and had managed various drug and alcohol treatment facilities. He fulfilled his post as chair of the ANCD from 1998 until his nomination as member of the International Narcotics Control Board in 2005.

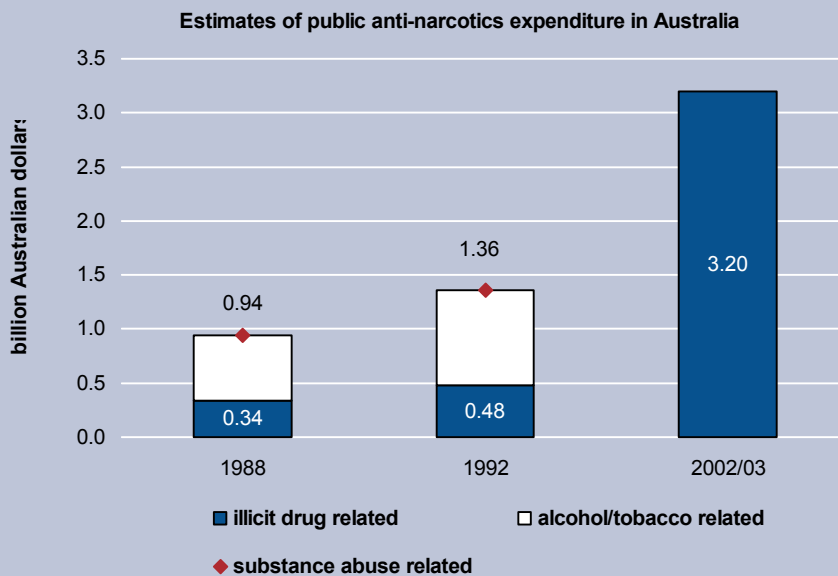
Breakdown of Australia’s anti-drug expenditure (in AUD\$), 2002/03

Proactive expenditure									
	Federal Government				State and territory governments				
	Expenditure (\$m)		Proportion (%)		Expenditure (\$m)		Proportion (%)		
	Main	Range	Main	Range	Main	Range	Main	Range	Main
Prevention	57.4	14.3 - 104.2	10.1%	3% - 17%	246.6	74.1 - 488.8	9.3%	3% - 17%	
Treatment	65.0	60.1 - 67.8	11.5%	11% - 12%	164.3	143.6 - 212.8	6.2%	5% - 8%	
Harm reduction	11.1	11.1 - 20.9	2%	2% - 4%	33.7	33.7 - 50.0	1.3%	1% - 2%	
Law enforcement	65.7	38.9 - 127.4	11.6%	7% - 20%	493.3	393.1 - 579.2	18.7%	15% - 21%	
Interdiction	181.5	149.2 - 351.8	32%	28% - 48%	0	0 - 0	0%	0% - 0%	
Other	9.9	6.3 - 11.8	1.7%	1% - 2%	8.5	5.3 - 20.8	0.3%	0% - 1%	
Reactive expenditure									
	Federal Government				State and territory governments				
	Expenditure (\$m)		Proportion (%)		Expenditure (\$m)		Proportion (%)		
	Main	Range	Main	Range	Main	Range	Main	Range	Main
Health-related	104.4	104.4 - 257.9	18.4%	18% - 36%	45.2	45.2 - 111.7	1.7%	1% - 4%	
Crime-related	21.8	5.5 - 21.8	3.8%	1% - 4%	1630.7	413.1 - 1652.5	61.7%	29% - 62%	
Other consequences	50.3	9.8 - 864.0	8.9%	2% - 63%	22.2	24.0 - 60.3	0.8%	1% - 2%	
TOTAL	551.9	399.6 - 1828	100%		2644.4	1132.1 - 3176.1	100%		

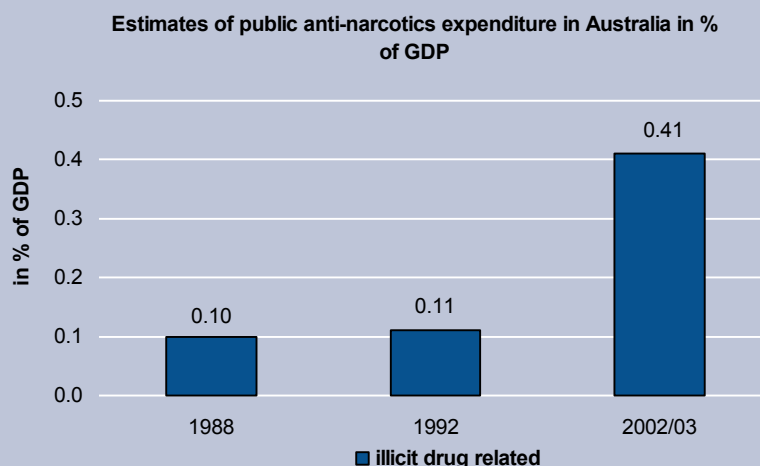
Note: The "low" percentage is calculated by dividing the low estimate for each category by that amount plus the sum of the main estimates for the other categories. The "high" estimate also uses the main estimates of the other categories in the percentage calculation.

Source: Timothy J. Moore, *What Is Australia’s “Drug Budget”? The Policy Mix Of Illicit Drug-Related Government Spending In Australia, Drug Policy Modelling Project Monograph 01, Turning Point Alcohol And Drug Centre, December 2005*

Though direct comparability – for methodological reasons – is limited, available data do suggest that anti-narcotics budgets rose significantly in the new millennium as compared to the late 1980s and early 1990s, reflecting, *inter alia*, The Australia Government’s *National Illicit Drugs Strategy “Tough on Drugs”* (1997). Expressed in nominal terms, the aggregate drug control budget has risen more than 6-fold over the last decade. Inflation adjusted, the increase would have been still 5-fold. Expressed as a percentage of GDP, the aggregate anti-narcotics budget seems to have risen 4-fold over the 1992 - 2002/03 period.

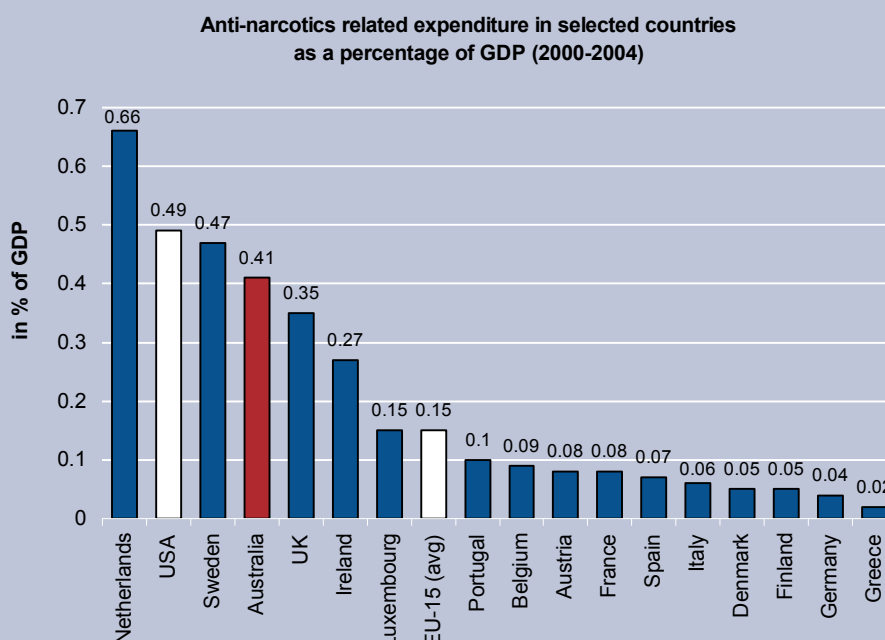


Sources: David J. Collins and Helen M. Lapsley, *The social costs of drug abuse in Australia in 1988 and 1992, Report prepared for the Commonwealth Department of Human Services and Health, Canberra 1996* and Timothy J. Moore, *What Is Australia’s “Drug Budget”? The Policy Mix Of Illicit Drug-Related Government Spending In Australia, Drug Policy Modelling Project Monograph 01, Turning Point Alcohol And Drug Centre, December 2005.*



Sources: UNODC calculations based on David J. Collins and Helen M. Lapsley, *The social costs of drug abuse in Australian 1988 and 1992, Report prepared for the Commonwealth Department of Human Services and Health, Canberra 1996* and Timothy J. Moore, *What Is Australia's "Drug Budget"? The Policy Mix Of Illicit Drug-Related Government Spending In Australia, Drug Policy Modelling Project Monograph 01, Turning Point Alcohol And Drug Centre, December 2005*, International Monetary Fund (IMF), *World Economic Outlook database for April 2007*.

Australia's anti-narcotics expenditures (0.41% of GDP in 2002/03) appear to be smaller – expressed as a percentage of GDP - than those reported from the USA (0.49% of GDP in 2002)⁵⁵ but seem to be higher than drug related expenditure in Western Europe (0.15% among the EU-15 countries over the 2000-04 period). Among the EU countries only the Netherlands and Sweden had – expressed as a percentage of GDP - higher anti-narcotics budgets. Anti-narcotics expenditure in the UK appears to have been slightly lower (0.35% of GDP).⁵⁶ Due to methodological differences in establishing the anti-drug budgets, comparisons must be treated, however, with caution.



Sources: Timothy J. Moore, *What Is Australia's "Drug Budget"? The Policy Mix Of Illicit Drug-Related Government Spending In Australia, Drug Policy Modelling Project Monograph 01, Turning Point Alcohol And Drug Centre, December 2005*, International Monetary Fund (IMF), *World Economic Outlook database for April 2007*, ONDCP, *The Economic Costs of Drug Abuse, 1992-2004, Dec. 2004* and EMCDDA, *Public expenditure on drugs in the European Union, 2000-2004, Lisbon 2004*.

2.8. The National Drug Strategy - Australia's Integrated Framework, 2004-2009

The *National Drug Strategy - Australia's Integrated Framework, 2004-2009* built closely on its predecessor, the *National Drug Strategic Framework 1998-99 - 2003-04*. Differences were mainly in presentation, not in content.

The mission of the New Drug Strategy was 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*”.⁵⁷ In the second paragraph it was made explicit that Australia's harm minimization approach - which continued to be the backbone of the Strategy - “*does not condone drug use*”.... “*It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches, including abstinence-oriented strategies.*”

At the time of publication, the new Australian Government was currently reviewing the National Drugs Strategy. It is likely that the main features of the Strategy will be retained.

Australia's harm-minimisation approach focuses on both licit and illicit drugs and includes preventing anticipated harm as well as reducing actual harm. Harm minimisation is consistent with a comprehensive approach to drug-related harm, involving a balance between demand reduction, supply reduction and harm reduction strategies. It encompasses:

- supply reduction strategies to disrupt the production and supply of illicit drugs, and the control and regulation of licit substances;
- demand reduction strategies to prevent the uptake of harmful drug use, including abstinence orientated strategies and treatment to reduce drug use; and
- harm reduction strategies to reduce drug-related harm to individuals and communities.

The main priority areas of the strategy 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.

For prevention, the link to research and evaluations is re-iterated and emphasized in order to identify effective prevention approaches, techniques and interventions.

For supply reduction interventions, it is emphasized that law enforcement activities also, (i) increase the likelihood of people seeking treatment, (ii) assist in prevention outcomes, (iii) reduce funds available for illicit drug purchases, and (iv) reinforce the message that illicit drug use is not condoned by the community. In addition to traditional supply reduction objectives, such as the dismantling of organized crime groups involved in drug trafficking and the disruption of local manufacture of illegal drugs a special emphasis is also placed on enhancing efforts to control the inappropriate supply and diversion of pharmaceuticals that can serve as precursors for synthetic drug production (such as ephedrine and pseudo-ephedrine containing substances used in the manufacture of methamphetamine).

In the area of harm reduction, the main emphasis is on public education campaigns to increase the understanding of drug related harm and to work with service providers to reduce drug use and drug related harm.

Improvements in the area of treatment are targeted towards, (i) reducing barriers to treatment, (ii) supporting new treatment options, (iii) building strong partnerships between treatment services and mental health services, and (iv) increasing the involvement of primary care such as general practitioners, in early intervention, relapse prevention and shared care.

It is also made clear in the Strategy that wherever possible, all supply-reduction, demand-reduction and harm-reduction strategies should reflect practices that are informed by evidence derived from rigorous research, critical evaluation, (including assessment of the cost effectiveness of interventions), practitioner expertise and the needs and preferences of the individual client or consumer.

The institutional support structure for the implementation of the strategy changed only marginally. The overall responsibility continues to be concentrated in the Ministerial Council on Drug Strategy (MCDS), though this is now made even more explicit. The institutional support structure for the implementation of the new strategy consists of:

- the *Ministerial Council on Drug Strategy (MCDS)*, a national ministerial-level forum responsible for developing policies and programs to reduce the harm caused by drugs to individuals, families and communities in Australia. The MCDS is the peak policy and decision making body on licit and illicit drugs in Australia. It brings together Australian Government, State and Territory ministers responsible for health and law enforcement, and the Australian Government Minister responsible for education. The MCDS is responsible for ensuring that Australia has a nationally coordinated and integrated approach to reducing the substantial harms associated with drug use. The MCDS is supported in its role by the following advisory structure:
 - the *Intergovernmental Committee on Drugs (IGCD)*, which provides policy advice to the MCDS on drug-related matters, and is responsible for implementing National Drug Strategy policies and programs, as directed by the MCDS. It also assists in facilitating specialist advice by way of a National Expert Advisory Panel (NEAP). Membership of NEAP consists of experts in a number of fields including local government, education, alcohol, illicit drugs, tobacco, Indigenous affairs, prevention and youth. The MCDS is supported by a Commonwealth/State/Territory Government forum—the Intergovernmental Committee on Drugs (IGCD). The IGCD consists of senior officers that represent health and law enforcement agencies in each Australian jurisdiction and in New Zealand, as well as representatives of the Australian Department of Education, Science and Training and the Ministerial Council on Aboriginal and Torres Strait Islander Affairs;
 - the *Australian National Council on Drugs (ANCD)* which provides ministers with independent, expert advice on matters connected with licit and illicit drugs. The ANCD reports annually to the Prime Minister and provides reports, on a regular basis, to the MCDS. It provides a non-government voice, to facilitate an enhanced partnership between the government and community sectors in the development and implementation of policies and programs to redress drug-related harms. Membership of the ANCD includes people with a wide range of experience and expertise on various aspects of drug policy, such as treatment, rehabilitation, education, family counselling, law enforcement, research and work in community organisations.
 - *National Drug Research Centres*, which regularly provide the MCDS with advice of research outcomes, contributes to informing the IGCD of emerging issues and trends. The National Drug Strategy also benefits from core research programs of the National Drug Research Centres.
 - *Annual Strategic Issues Workshop*, held in cooperation with the ANCD to enable the identification of emerging issues as well as appropriate approaches and policy responses. Relevant research is to guide the discussions at the workshop. This

approach is designed to ensure that via the ANCD the MCDS can fulfil its role of directing Australia's policy and program responses to drug issues.

2.9. Particularities of Australia's drug policy

While the *National Illicit Drugs Strategy "Tough on Drugs"* (1997) had a stronger supply reduction orientation, the subsequently passed *National Drug Strategic Framework (1998/99 – 2002/03)* and the *National Drug Strategy - Australia's Integrated Framework, 2004-2009* were not much distinguishable in orientation from the previous National Campaign Against Drug Abuse (1985) where the concepts of harm minimization and harm reduction were originally introduced. Yet, there are significant changes in the outcome. The 1985-1998 period was characterized by strong increases in drug use while the 1998-2006 period was characterized by major reductions.

Some elements that may explain the differences were already highlighted, such as the increase of drug control funds made available after 1998 or the re-equilibration of the country's drug policy resulting in a strengthening of supply reduction interventions after 1998 following a shift towards demand reduction and harm reduction after 1985. A few additional aspects will be discussed in the following sections. While some of these aspects are likely to have contributed to the fall in drug use, it is less clear for others.

2.9.1. Strengthened powers of the police

One aspect of Australian drug policy, which is not widely known outside the country, are the far reaching powers for the police to detect and investigate drug offences, which go further than in several other industrialized countries. While rising powers of the police must be always weighed against the consequences of reduced civil liberty for the individual, there can be no doubt that larger powers of law enforcement institutions facilitate the detection of criminal organisations, including drug trafficking syndicates, and Australia has clearly had major successes in this regard in recent years.

Under the Queensland *Drugs Misuse Act of 1986*, for instance, police has the power - in relation to any quantity of illegal drugs - (i) to stop, search, and seize motor vehicles, (ii) to detain and search persons or order internal body searches, and (iii) enter and search premises with or without a warrant. Linked to potential offences of drug trafficking, Queensland's police is also empowered to install listening devices on private premises and to use the results before court. For other states, telecommunications interception powers are available for the investigation of serious drug offences under the Commonwealth Telecommunication (Interception) Act of 1979.

In some Australian jurisdictions it is also possible for the police to obtain detailed information from electricity companies on the electricity consumption of their clients which can be used as an indication for the existence of hydroponic cultivation of cannabis or the existence of clandestine amphetamine-type stimulants laboratories.

In 2001, the Australian parliament passed *'The Measures to Combat Serious and Organised Crime Act'* which enables the Australian Federal Police to undertake strategic undercover operations related to a broad range of criminal activities in order to bring leaders of drug syndicates before the court even if it cannot be proven that they dealt in illicit drugs themselves. In the *National Crime Authority Legislation Amendment Act 2001*, the Australian parliament increased the powers of the National Crime Authority (NCA) in their hearings into organised criminal activity – most of which is linked to drug trafficking. It increased the penalties for noncompliance with NCA hearings from 6 months imprisonment and AUD\$1,000 fines to 5 years imprisonment and AUD\$20,000 fines.

Most jurisdictions have also passed confiscation of profits legislation which can be used to attack the assets of drug producers and drug traffickers. In most cases such action could only be undertaken after a person was convicted. In New South Wales a confiscation order can even be made before, as long as the Supreme Court is satisfied that 'is it more probable than not' that the person concerned is engaged in drug-related activities.⁵⁸ In 2001, the Federal Government also

introduced a *Proceeds of Crime Amendment Bill* which allows a Court to confiscate the assets of organised criminals.

2.9.2. Drug Courts

In the 1980s and the 1990s, the Australian criminal justice system responded to the illicit drug problem basically in two ways. The first was that a number of jurisdictions moved towards leniency in dealing with minor drug offences, aiming at relieving the courts from dealing with minor transgressions and as a way of minimising the harm associated with stigmatising users with prison records. Driven by a particular interpretation of “harm minimisation”, law enforcement agencies were encouraged to divert drug offenders to the health care system. The second response was to use more punitive measures to deter trafficking offenders. This involved governments passing ever tougher sentencing for drug trafficking and dealing (a process, which had started in the 1970s). By the mid 1990s, the median sentence for dealing and trafficking in drugs was already the third highest after homicide and robbery. Yet these mixed policy messages did not result in fewer individuals using illicit drugs, suggesting that neither leniency nor traditional incarceration methods actually deterred illicit drug use.⁵⁹

Against this background, the authorities looked for alternative options and investigated the possibilities for introducing the concept of drug courts in Australia, building on positive experiences made with this instrument in the USA. In fact, there are indications that drug courts played a positive role in the reduction of drug consumption in Australia (see below).

Drug courts combine criminal prohibitions with alternatives to imprisonment, as long as the offender shows his or her willingness to cooperate. The ultimate aim of drug courts is to divert drug dependent offenders from the criminal justice system into treatment. Their establishment represents a move towards a therapeutic model of offender management of shifting the focus from offenders and their actions to the problems and potential causes of their behaviour.⁶⁰ As imprisonment is constantly looming, the readiness of drug offenders to cooperate with the authorities, to undergo treatment and forego drug use in future is, general, rather high. Moreover, drug courts provide a necessary framework and structure to drug addicts and provide them with additional feelings of accomplishment, once they have mastered their lives.

Drug courts aim to help adult offenders, who have serious drug problems, break the cycle of drugs and crime by providing a supervised program of treatment and rehabilitation. Eligibility requirements and some other details of the operations of drug courts vary in each jurisdiction. In general, the defendant must plead guilty to his or her charges and satisfy the court that the drug dependency contributed to the commission of their offence(s). In New South Wales, for instance, entry is only possible for adult drug offenders who (i) participate in a detoxification process, (ii) have a potential for rehabilitation, and (iii) were not charged with violent or sexual offences, or with a wholly indictable drug offence. Once a drug court order has been made, participants follow a three-phase program over a 12-month period. During this time they will engage in a variety of drug rehabilitation and life skills programs aimed at reducing offending and drug use and preparing participants for community re-integration as non-drug using individuals.

Australian Drug Courts feature an integrated community-based treatment program, monitored through regular appearances before a judicial officer. The treatment program requires drug abstinence, verified through frequent, random drug testing. Participant accountability is increased through a series of sanctions and rewards. Unlike US drug courts, which generally target first-time offenders, the Australian programs primarily aim at offenders with a long history of property offending and are used as a final option before incarceration.⁶¹

Typically, the drug court team develops an individual program for each participant that lasts 12 months. This involves regular drug treatment and rehabilitation sessions, counselling sessions, education and job training, drug screening and reporting back to the Court. A case manager monitors each participant. The Judge and the drug court team monitor individual progress and may change or end the program if required. At the end of the program offenders receive a final

sentence from the drug court. This takes into account the offender's original sentence and their progress in the drug court program.⁶²

The concept, originally developed in the US, was successfully adjusted to make it work in the Australian context. Drug courts have been established in Queensland, New South Wales, South Australia and Victoria. In Victoria, drug courts were officially introduced with the *Drug Court Act of 1998*. The first drug court in New South Wales was opened in Parramatta (Sydney) in February 1999, and the authorities of New South Wales claim that this was actually the first fully operational drug court in Australia. In New South Wales, Victoria and Queensland Drug Courts have been established by legislation. In South Australia they operate on a less formalized basis.⁶³

Evaluations identified a number of positive outcomes from the Australian Drug Courts, including:⁶⁴

- reductions in drug use and criminal recidivism both during and after program completion;
- improvements in participant's health and well-being;
- monetary savings in prosecution, law enforcement, prison and court costs;
- social benefits such as the long-term reduction in drug use, increases in employment, education, and the reunification of families.

The evaluation of the drug court in South-East Queensland⁶⁵ was very much in line with these findings. It highlighted that:

- recidivism was significantly reduced for those who successfully completed the drug court program;
- few of the graduates re-offended once they complete the program and, where offending did occur, their average time to re-offending was longer than for the comparison groups;
- reductions in offending pre- and post-program were greater for drug court graduates than for the comparison groups.

2.9.3. Expiation Notice Schemes (CENs) and caution schemes for cannabis

One initially controversial policy element was the introduction of Cannabis *Expiation Notice Schemes (CEN)* and of cannabis caution schemes in several jurisdictions. While supporters highlighted – based on a harm minimization logic – that overall harm could be reduced, opponents feared that low or *de-facto* no criminal penalties would lead to higher cannabis use levels.

The National Drug Strategy provides a general framework for responses to drug problems. Drug offences and the penalties in Australia are, however, a matter of State and Territorial jurisdiction. There are, of course, limitations due to the international treaties which Australia ratified (*The Single Convention on Narcotic Drugs* (1961); the *Convention on Psychotropic Substances* (1971); and the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988). The key feature of these treaties is that signatories are obliged to establish control systems that limit the availability of controlled drugs, including cannabis, to scientific or medical use. There is, however, some degree of flexibility as to the extent drug use needs to be sanctioned. The implementation of non-incarcerative, non-criminal sanctions such as Australia's *expiation schemes* are, in general, not considered to be a violation of the country's international treaty obligations, even though administrative sanctions were not in the mind of the drafters of the international drug conventions. *Caution and warning systems* go even a step further and only threaten with sanctions if the offences are done again. The authorities highlight, however, that these changes made in the law do not constitute a decriminalization or legalization of cannabis use. Cannabis possession remains a criminal offence in all Australian jurisdictions. What has changed are the penalties for the possession of small amounts for personal use, which have been either reduced to administrative fines or are only threats in case of a repetition of the offence.

The impetus for marijuana law reform came out of the recommendations contained in the 1979 report of the South Australian Royal Commission into the non-medical use of drugs. The Commission recommended that minor marijuana consumption should not be treated as a criminal offence. The main arguments for an expiation system were the potential cost savings and the reduction of negative social impacts upon convicted minor marijuana offenders. These arguments were implicitly based on the belief that the potential harm from using marijuana were less than the harm arising from a criminal conviction. As a consequence, some Australian States and Territories changed their legislation and implemented administrative sanctions instead of criminal ones:

South Australia was the first jurisdiction to change legislation. Reform of the marijuana laws in South Australia came with the introduction of the *Controlled Substances Act Amendment Act*, 1986, which became operational in 1987. Under the *Cannabis Expiation Notice (CEN)* scheme adults coming to the attention of police for “simple marijuana offences” could be issued with an expiation notice. People were eligible for the CEN scheme for possession of up to 100 grams cannabis of herb, 20 grams of cannabis resin and cultivation of up to 10 plants of cannabis. Offenders were able to avoid prosecution by paying the specified fine within 60 days of the issue of the notice. The CEN fees ranged between AUD\$50 and AUD\$150 with an average value of issued CENs around AUD\$70.⁶⁶ Failure to pay the specified fees could lead to prosecution in court, with the possibility of a conviction. Underlying the CEN scheme is the rationale that a distinction should be made between private use of marijuana on the one side and producing and dealing in marijuana on the other. This distinction was emphasized at the introduction of the CEN scheme by the simultaneous introduction of more severe penalties for offences relating to the manufacture, production, sale or supply of all drugs, including offences relating to the sale of (larger) quantities of marijuana.

The Australian Capital Territory (in 1992) and the Northern Territory (in 1996) introduced similar expiation schemes. The current systems in place in these States are the *Simple Cannabis Offence Notices (SCONs)* in the Australian Capital Territory and the *Drug Infringement Notices (DINs)* in the Northern Territory.⁶⁷

Victoria implemented a system of *cautions* for minor marijuana offenders in 1998 and Western Australia has subsequently followed with a similar scheme. The Victoria Police *Cannabis Cautioning Program* involves police providing an official *police cautioning notice* for use or possession of cannabis. The person is then referred to a voluntary education program, operated by a community based drug treatment agency which is to assist participants to understand the effects of cannabis and to reduce its use. Participants can also be referred to further assessment and treatment services if appropriate.⁶⁸

New South Wales implemented a comprehensive *cautions* system in 2000, for both adults and youths.⁶⁹ An *Adult Cannabis Cautioning Scheme* was introduced by the NSW Government in April 2000. This gives police the discretion to caution rather than charge minor cannabis offenders. The authorities, however, underline that the scheme does not decriminalise or legalise cannabis. Using, possessing, cultivating, importing and selling cannabis remain illegal. Adults caught with a small amount of cannabis leaf (not more than 15 grams) and/or equipment for the administration of cannabis can be issued a *cautioning notice* by police. The notice provides health and legal information on cannabis use, and provides a contact phone number for the Alcohol and Drug Information Service (ADIS). ADIS, a 24 hour service, has been expanded to provide cautioned offenders with information about treatment, counselling and support services. The scheme means minor cannabis offenders avoid getting a criminal conviction. A person can, however, only receive two cautions. An offender who received a second caution will have to undertake a mandatory counselling and education session. If offenders continue to use cannabis and are caught by police, they will be charged and have to attend Court. People with a history of violent, sexual or drug offences are exempted from the caution system.⁷⁰

In addition, the *Young Offenders Act* was amended in New South Wales in April 2000 to include minor drug offences (i.e. those arrested for possession of small quantities of drugs, including cannabis). The change allows minor drug offenders to get help and aims to stop them offending again. Possession of drugs remains illegal, but the Young Offenders Act provides an alternative to a Court sentence. The police has, however, the discretion to charge the offender. (Young people

suspected of supply or drug trafficking are not dealt with under the Young Offenders Act; they are charged.) The Act applies to young people who are apprehended by police for a wide range of offences, including the possession of small quantities of illegal drugs or the possession of equipment for using drugs. A young offender can receive a *warning* or a *caution*, or, in more serious situations, can be referred to a *youth justice conference*.⁸ *Warnings* can be given by police for less serious non-violent offences. A warning is given on the street and the young person is not required to admit to the offence. The police records however the details of the young person and the offence. A *caution* is a more formal procedure where the young person is arrested and admits guilt. When cautioned, the young person is accompanied by a parent/guardian and possibly a drug and alcohol worker. The young person signs a *formal caution notice*. The young person is given information about the legal and health consequences of drug use and information about treatment and counselling services.⁷¹

As part of its new *Cannabis Control Act 2003*, Western Australia implemented a scheme of *Cannabis Infringement Notices Scheme* (CINs), starting in May 2004. The fines are AUD\$150 for 30 grams or less, or AUD\$100 for 15 grams of cannabis or less. Possession by an adult of a used smoking implement attracts a penalty of AUD\$100. Cultivation by an adult of not more than 2 non-hydroponic cannabis plants is eligible for an infringement notice with a penalty of AUD\$200. Adults in households where there are more than 2 plants are not eligible for an infringement notice. Persons cultivating cannabis hydroponically are not eligible for an infringement notice but are subject to criminal prosecution. Offenders are required to pay the penalty in full within 28 days or complete a specified cannabis education session. Those receiving more than two infringement notices across more than two separate days within a three-year period do not have the option of paying a fine. They must complete the education session or face a criminal charge. Juveniles are not eligible for an infringement notice under the CIN scheme but can be cautioned and directed to intervention programs. Police will lay criminal charges against persons who attempt to flout the intention of the scheme, for example by engaging in cannabis supply, even if they are only in possession of amounts otherwise eligible for an infringement notice. Where those otherwise eligible for an infringement notice face more serious charges for other concurrent offences police will issue criminal charges for the cannabis matters, rather than issue a CIN. Thresholds for dealing are 100 grams or 10 plants. Persons possessing hash, or hash oil are not eligible for an infringement notice. Implementation of the scheme has been accompanied by a public education campaign on the harms of cannabis and the laws that apply. 'Head shops' (cannabis paraphernalia retailers) and hydroponic equipment suppliers are subject to special regulation.⁷²

The impact of these changes in the legislation were first studied for South Australia which has been the subject of a number of evaluation studies. One study, based on National Drug Strategy Household Survey data, found that between 1985 and 1995 lifetime cannabis use, after controlling for age and gender, were in fact stronger in South Australia than the average in the other States and Territories. While there was a greater increase in lifetime cannabis use than in the rest of the country, similar increases also occurred in Tasmania and Victoria where there was no change in the legal status of cannabis use. Moreover, the change in the rate of weekly cannabis use in South Australia was not statistically significant.⁹ The study concluded that there was not sufficient evidence that the increase of cannabis use over the 1985-95 period in South Australia could be directly attributable to the introduction of the CEN scheme.⁷³

⁸ If the circumstances are more serious a youth justice conference may be held. Police and/or the Court can refer offenders to a youth justice conference. A conference is facilitated by a convenor, trained by the Department of Juvenile Justice. The young person is required to explain their actions and take responsibility for their offence. The young person and the victim, agree to a suitable outcome plan that the young person must complete. The plan is designed to address the drug and other problems that have contributed to their criminal behaviour. The plan may include treatment and counselling. Progress is monitored. If the plan is completed no further action is taken. Otherwise the case is returned to the police or Court.

⁹ This, however, is not very surprising as the sampling frame of the household survey was, primarily, geared towards getting reasonably accurate results for Australia as a whole and not for very detailed results in individual states. If this had been intended, the sampling size would have had to be significantly larger. For life-time prevalence, which has a high proportion, results may be still sufficiently robust; however, the same would not be true for weekly cannabis use.

A comparative study of minor marijuana offenders in South Australia and Western Australia concluded that the more punitive prohibition approach had little more deterrent effect upon marijuana users than the CEN scheme. The adverse social consequences of a marijuana conviction were, however, seen to outweigh those of receiving an expiation notice. In fact, a higher proportion of those apprehended for marijuana use in Western Australia reported problems with employment, further involvement with the criminal justice system as well as accommodation and relationship problems.⁷⁴

The CEN scheme also gained support by law enforcement. The scheme is seen to be relatively cost-effective and more cost-effective than the traditional approaches of prohibition.⁷⁵ One study came to the conclusion that all the costs related to issuing a CEN (including police time) amounted to AUD\$33 while the average value of an issued CEN was AUD\$70. Taking into account non-payments (and thus subsequent court cases), the revenue from the CEN fees was estimated to have amounted to AUD\$1.7 million while the total costs were AUD\$1.2 million in 1995/96 in South Australia. In case of a prohibition approach, the costs were calculated to amount to AUD\$2 million of which only half (1 million) would have been covered with revenues from fines and levies.⁷⁶

It has also been argued that the CEN scheme actually facilitated the work of enforcement agencies as they did not have any longer second thoughts in issuing cannabis expiation notices but simply implemented the law. The actual risks of a person to be detected, and being punished for cannabis possession or being confronted with its consequences, may thus have even increased. In fact, the number of detected and reported minor cannabis offences increased from around 6,500 in 1987/88 to 14,000 in 1991/92 and 17,425 offences in 1993/94 which was interpreted as a 'net-widening' phenomenon following the introduction of the CEN.⁷⁷ An alternative interpretation could have been that simply more people got involved in cannabis use and production. In any case, by 2005/06, the total number of issued CENs had fallen to 5,500 in South Australia, with a further 1,600 arrests of offenders who did not qualify for a CEN.⁷⁸

As of 2006, South Australia, the Australian Capital Territory, Northern Territory and Western Australia had civil penalty schemes or infringement notices. New South Wales, Queensland, Victoria and Tasmania, in contrast, had a cautioning and diversion to treatment system.⁷⁹

2.9.4. Establishment of a medically supervised injecting centre

One of the more controversial features of Australia's harm reduction approach has been the establishment of a medically supervised injecting centre (MSIC) in Kings Cross, Sydney (New South Wales) in 2001.

Medically Supervised Injecting Centres (MSICs) are legally sanctioned health and social welfare facilities that are intended to enable the hygienic injection of pre-obtained drugs under professional supervision. MSICs aim to reduce, (i) the mortality and morbidity associated with drug overdose; (ii) reduce the public nuisance associated with public drug use, intoxication and discarded injecting equipment; (iii) reduce blood borne virus risk behaviour and; (iv) should act as an access point to drug treatment and health care assistance.⁸⁰

Previous research had shown that there were around 74,000 injecting heroin users in Australia in 1997,⁸¹ of which about half (35,400) lived in New South Wales, far more than the share of New South Wales in Australia's total population (33%). The main problem area in New South Wales has been the Sydney agglomeration. Within the Sydney agglomeration, one of the main heroin markets is located in Kings Cross, which also had one of the largest cocaine markets of Australia. Kings Cross has had one of the largest illicit drug markets of New South Wales since the 1960s, in addition to being associated with prostitution and gambling.⁸² The area covered by Kings Cross accounts for less than 5% of the population of New South Wales, but had approximately 12% of all syringes distributed by the Needle and Syringe Program of New South Wales, accounted for 12% of all morphine-positive deaths (i.e. heroin-related deaths) of New South Wales between July 1996 and May 2001 as well as for some 20% of all drug overdose-related ambulance attendances in NSW.⁸³

In the mid 1990s, the NSW Royal Commission into the NSW Police Service already exposed the operation of clandestine 'shooting galleries' in the Kings Cross area and recommended the establishment of licensed supervised injecting rooms instead. An unsanctioned supervised injecting

centre (the Tolerance Room) operated briefly in May 1999, run by health and welfare workers, the clergy and parents of living and deceased drug users. But, this was closed down later in the month by the police.

Following a drug summit, hosted by the New South Wales Government in late May 1999, which discussed options for reducing the impact of drugs on society and users, a decision was made by the NSW Government to establish a medically supervised injecting centre in Kings Cross. The centre was eventually opened - against heavy opposition from the Federal Government - on a trial basis for a two year period in May 2001. Following an overall positive evaluation, the NSW Government decided to prolong its operations to 2007 and in June 2007 it took the decision to prolong it for another four years. The State Government claimed that the centre prevented some 2000 drug users from dying from a drug overdose since the centre was established six years earlier.⁸⁴

The evaluation report,⁸⁵ covering the first 18 months of the trial period, was published in 2003. Though overall in favour, the report provided, nonetheless, a rather mixed picture, showing that in many instances the 'heroin shortage', resultant of law enforcement, had a stronger impact on the improvement of the situation in Kings Cross than the operations of the centre.

The number of opiate related overdose ambulance attendances, for instance, decreased in the Kings Cross area subsequent to the opening of the centre. The evaluation report acknowledged, however, that these reduction were primarily associated with the fall in heroin availability at the time. It concluded that there were no detectable changes in heroin overdoses at the community level linked to the operations of the centre.

The rate of overdose among clients of the centre was 7.2 per 1000 visits, mostly related to heroin (80%). Over the 18 months test period 409 drug overdoses were registered in the centre, of which 329 were heroin related. Some of these overdoses could have been fatal if medical staff of the centre had not intervened. At least four heroin related deaths per year were prevented (out of 3810 individuals registered with the centre over the 18 months trial period). Kings Cross had in 2001 a total of 11 heroin related deaths, down from 35 cases in 2000. However, most of this decline, as mentioned before, was likely due to lower heroin availability.

Theft and robbery incidents declined in the area following the establishment of the center. But the same also happened in other parts of New South Wales, and the authors attributed this again to other factors, mostly linked to the heroin shortage.

However, the centre appears to have had a positive impact in preventing the spread of blood borne viral infections. Prevalence of HIV infections among injecting drug users was low during the study period. No new cases among females were identified and the new HIV cases among males were mainly linked to non-protected homosexual activities, but not a single case was linked to drug injecting. Notifications of hepatitis B and hepatitis C infections remained stable in the Kings Cross while they increased in the rest of Sydney.

The evaluation also found some indications that the very poor health status of clients showed signs of moderate improvement. There was also a small decrease in the frequency of injecting-related problems among the clients. In one out of every four visits, clients asked and received health care services. The centre provided referrals to treatment for drug dependence for 11% of the clients.

The frequency of public injection among clients decreased. This was confirmed in community surveys. Thus, residents and business respondents supported the centre, while remaining opposed to drug consumption in general.

The set-up costs for the centre amounted to AUD\$1.3 million and the initial operating costs to AUD\$2 million. The costs per client visit were AUD\$63 in the initial year, though they were projected to fall to AUD\$37 per visit in the subsequent year. Based on some economic methods to calculate the value of averted deaths (potentially lost income) and the value of prevented ambulance attendances and some other items, the evaluation report arrived at a benefit/cost ratio of between 0.7 and 2 in the initial phase and an expected ratio of between 1.2 and 2 in future periods, suggesting that the potential rate of return from the centre was comparable to other public health measures.⁸⁶

The evaluation convinced the State Government of New South Wales to continue running the centre. But it did not convince the Federal Government and no further Medically Supervised

Injecting Centres were opened in Australia. Only the Australian Capital Territory has so far passed a similar legislation as New South Wales. But so far, it has not opened a Medically Supervised Injecting Centre.⁸⁷

After having considered the 18 month evaluation of the Medically Supervised Injecting Centre (MSIC) in Sydney, the *Australian National Council on Drugs* (ANCD), made the following observations⁸⁸:

- Kings Cross presents a unique set of community circumstances and the particular MSIC model used may be inappropriate for other locations;
- whilst the evaluation itself is a careful analysis of the work and outcomes of the MSIC, it is recognised that the estimates of lives saved and reduction of harms from the MSIC evaluation are difficult to quantify, and that there are many issues involving the work and outcomes of MSIC that warrant further investigation; and
- initiatives that save lives, reduce the risk of HIV, other blood borne infections and diseases, and lead to improvements in community safety and well being, are deserving of support;
- Given the limitations and difficulties in interpreting the MSIC evaluation results, and noting the decision of the NSW Government to continue to operate the MSIC as a trial, the ANCD will be referring the MSIC report to a specialist committee for further review;
- It is hoped that further evaluation will focus on the current MSIC model's capacity and appropriateness to engage with and potentially refer clients to other health and welfare services, including drug treatment agencies;
- The ANCD also acknowledged that some members do not support injecting centres because of a number of significant concerns, including a view that such centres give a perception to the community that drug use is condoned or accepted, and that there are cheaper and more effective ways to engage those clients targeted by the MSIC;
- Finally, the ANCD acknowledged the independent nature of the evaluation and commended both the evaluation team and the staff of the MSIC for their work in this difficult area.

The centre has been opposed by the *International Narcotics Control Board* for violating the international treaty obligations.¹⁰ The INCB reiterated its criticism in its annual report for the year 2006.¹¹

¹⁰ Para 159: "The Board regrets that local authorities in the Australian state of New South Wales have permitted the establishment of a drug injection room, setting aside the concerns expressed by the Board⁶⁹ that the operation of such facilities, where addicts inject themselves with illicit substances, condones illicit drug use and drug trafficking and runs counter to the provisions of the international drug control treaties. The Board notes that the national policy in Australia does not support the establishment of drug injection rooms. The Board urges the Government to ensure that all of its states comply fully with the provisions of the international drug control treaties, to which Australia is party. (INCB, Report of the International Narcotics, Control Board for 2001, New York 2002).

¹¹ Para "175. The Board notes with concern that, despite its ongoing dialogue with the Governments concerned, drug injection rooms, where drug abusers can abuse with impunity drugs acquired on the illicit market, remain in operation in a number of countries, including Australia, Canada, Germany, Luxembourg, the Netherlands, Norway, Spain and Switzerland. The Board regrets that no measures have been taken to terminate the operation of such facilities in the countries concerned...

176. The Board wishes to reiterate that the provision of rooms for the abuse of drugs, regardless of whether they are under the direct or indirect supervision of the Government, are contrary to the international drug control treaties, particularly article 4 of the 1961 Convention, which obligates State parties to ensure that the production, manufacture, import, export, distribution of, trade in, use and possession of drugs are limited exclusively to medical and scientific purposes.

177. The Board believes that any national, state or local authority that permits the establishment and operation of rooms or any outlet to facilitate the abuse of drugs, by injection or any other route of administration, also provides an opportunity for illicit drug distribution. The Board would like to emphasize that Governments have an obligation to combat illicit drug trafficking in all its forms and that parties to the 1988 Convention are required, subject to their constitutional principles and the basic concepts of their legal systems, to establish as a criminal offence the possession and purchase of drugs for personal non-medical use.

178. In some jurisdictions, local authorities have encouraged or promoted the establishment of rooms for the abuse of drugs. The Board would stress that it is the Government that is responsible for ensuring compliance with the country's obligations under the international drug control treaties."(INCB, Report of the International Narcotics, Control Board for 2006, New York 2007).

3. SUBSTANCE SPECIFIC STRATEGIES AND LEGISLATION WITH REGARD TO CANNABIS AND ATS

Another special feature of Australian drug policy has been the development of substance specific strategies.

In November 2004, the Ministerial Council on Drug Strategy (MCDS) agreed to the development – in line with National Drug Strategy 2004-2009 - of a *National Cannabis Strategy* to consider the health, psychological, legal and public health issues associated with cannabis use. The Cannabis Strategy was officially endorsed by the MCDS in May 2006. It encompasses supply reduction strategies to disrupt the production and supply of illicit drugs and to control and regulate licit substances; demand reduction strategies to prevent the uptake of harmful drug use, including abstinence-oriented strategies and treatment to reduce drug use; and harm reduction strategies to reduce drug-related harm to individuals and communities. The strategy contains detailed recommendations for action on more than 30 pages. On the demand side, the strategy promotes, inter alia, the development and implementation of ongoing social marketing campaigns, similar to the *Quit* tobacco campaigns, to inform the public of the harms associated with cannabis use (mental health problems, dependence, etc.) and urges the expansion of early intervention programs. One of the proposed actions to reduce availability of cannabis is, for instance, “to encourage ... electricity...providers, as a part of a police intelligence process, to provide information regarding suspected cannabis...”. Emphasis is also placed on the link between cannabis production and organized crime and on regulating the sale of hydroponic equipment.⁸⁹

In response to the new Strategy, and against the background of a strong rise in hydroponic cultivation of cannabis in recent years and the increasing involvement of organized crime groups in these activities, New South Wales amended in 2006 its *Drug Misuse and Trafficking Act 1985* and introduced special provisions concerning the *commercial cultivation of prohibited plants by enhanced indoor means*. Enhanced indoor cultivation is defined in Section 3 of the Act. It includes nurturing the plant in nutrient enriched water as opposed to soil (hydroponics), suspending the plants roots and spraying them with a nutrient-rich solution (aeroponics) and/or the use of an artificial source of light or heat. The legislation also introduces new offences of cultivating prohibited plants by enhanced indoor means in the presence of children. Effective from 14 July 2006, these amendments were introduced as a result of New South Wales authorities identifying an increase in the involvement of highly organised crime groups, including former Yugoslavian criminal groups, in the indoor cultivation of cannabis in domestic premises. The new provisions set commercial and large commercial quantities at five times lower than outdoor cannabis to reflect the higher yields produced by hydroponic methods (NSW Legislative Council, 2006). The new provisions also amend the *Law Enforcement (Powers and Responsibilities) Act 2002, (NSW)* to enable police to respond effectively to clandestine and organised activity, and the *Electricity Supply Act 1995 (NSW)*, to increase maximum penalties associated with the stealing of electricity to support hydroponic systems.⁹⁰

In May 2006, the Ministerial Council on Drug Strategy (MCDS) endorsed the development of a *National Amphetamine-Type Stimulants (ATS) Strategy*,⁹¹ based again on a comprehensive consultation process. Emphasis was again on preventing ATS use, reducing ATS related problems, strengthening frontline services, improving ATS specific treatment, strengthening law enforcement, notably with regard to precursor shipments from China and other Asian countries as well as the diversion of pharmaceutical preparation for the clandestine manufacture of ATS within Australia.⁹²

A number of legislative measures have already been taken – prior to the finalization of the ATS Strategy. There has been, for instance, a concerted effort against domestic production and clandestine laboratories recently through the establishment of a range of national working groups and initiatives. This included the *National Working Group on the Prevention of the Diversion of Precursor Chemicals into Illicit Drug Manufacture*, a chemical industry *Code of Practice for Supply Diversion into Illicit Drug Manufacture* and a proposal for the development of a *National Clandestine Laboratory Database* to be hosted by the ACC. In addition, pseudoephedrine-based medications were rescheduled to category S3 in January 2006 to restrict availability to ‘pseudo

runners' posing as genuine customers at pharmacies and obtaining the products over-the-counter. One particular initiative, *Project Stop*, was implemented in Queensland and involved the development of a centralised pharmacy database to enable real-time reporting of pseudoephedrine sales.⁹³

In 2002, a five-year National Strategy to Prevent the Diversion of Precursor Chemicals into Illicit Drug Manufacture (the National Precursor Strategy) was developed to contribute to the supply reduction aspect of the National Illicit Drug Strategy by preventing legitimately available chemicals being used to make illicit synthetic drugs in illegal clandestine drug laboratories. Implementation of the Strategy is informed and supported by the National Working Group on the Prevention of the Diversion of Precursor Chemicals into Illicit Drug Manufacture (the Precursor Working Group), which brings together 45 members from Commonwealth, State and Territory law enforcement agencies, forensic and health services, and non-government members including the pharmaceutical and chemicals industries. Projects under the National Precursor Strategy are delivered against four broad outcomes: enhanced intelligence and information sharing capacity, enhanced law enforcement, forensic and judicial responses through training, national consistency in precursor controls and awareness-raising on precursor diversion for key stakeholders.

Earlier, the Ministerial Council on Drug Strategy had developed a *Psychostimulants National Action Plan, 1995-1997*,⁹⁴ which was endorsed by the MCDS in June 1995. This had followed a *National Action Plan on Problems Associated with Amphetamine Use* (March 1991).

The Psychostimulants National Action Plan foresaw:

- *A review of the current strategy* (reviewing existing initiatives and relevant evaluation data related to the implementation of the 1991 *National Action Plan on Problems Associated with Amphetamine Use* in the areas of research, treatment, education and supply control);
- *Monitoring of health and law enforcement issues* (reviewing and updating available health and law enforcement data on psychostimulants in Australia; the impact of the precursor legislation; developing a model system for using forensic information to monitor and review trends in the illicit manufacture and supply of psychostimulants in Australia; developing a clearing house function for information relating to psychostimulants);
- *Best practice models of intervention and care* (specialist treatments in the areas of behavioural therapy; pharmacotherapy for the management of acute episodes and maintenance pharmacotherapy as well as clinical guidelines to support interventions by primary health carers);
- *Recommendation of research priorities* (development of national priorities for research into psychostimulants);
- *Improvement of competencies and skills of professional staff* (reviewing existing initiatives in education and training of law enforcement; specialist drug treatment; primary health care and other relevant personnel, to identify needs and gaps in education and training);
- *Development of effective models for communication and intervention* (reviewing current communication strategies and campaigns, such as the 'Speed Catches Up With You' campaign; examining existing research to identify current needs and undertake further research in order to develop effective models for communication and intervention with identified priority group, notably recreational users of psychostimulants; regular heavy users; Aboriginals and Torres Strait Islanders; transport industry workers; and non-users in the school population).

3.1. Regional and International Illicit Drug Initiatives

Directly linked to Australia's domestic supply reduction strategies have been its international illicit drugs initiatives, but particularly those focused on the Asia Pacific region.

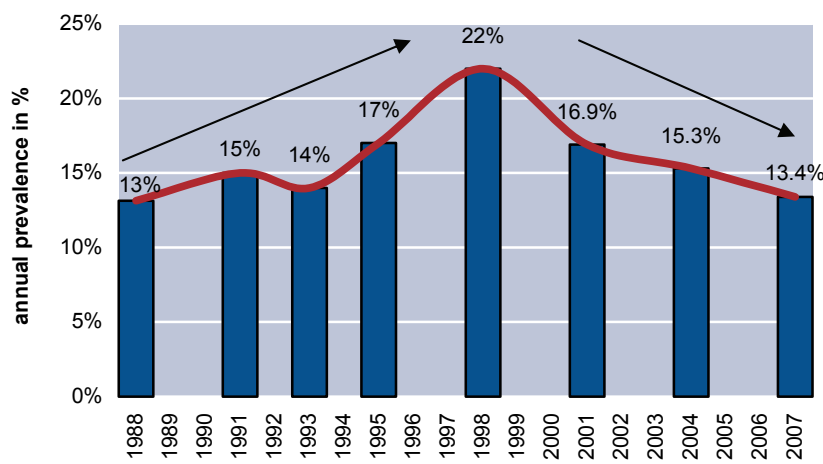
- The Australian Federal Police (AFP) International Network has 87 liaison officers posted in 28 countries, mostly in the Asia Pacific. The officers are involved in brokering cooperation and joint investigations overseas law enforcement agencies. New positions in Laos and China were developed specifically to address ATS and precursor issues.
- The AFP's Law Enforcement Cooperation Program (LECP) facilitates capacity building in the Asia Pacific region through the provision of training, personnel and equipment to key countries. These programs assist in the promotion of joint investigations into major narcotics syndicates operating across multiple jurisdictions.
- The Australian Customs Service works with regional countries to build law enforcement capacity and strengthen border protection measures throughout the Asia Pacific region. Specific Customs initiatives to build capacity in the region include the Customs Asia Pacific Detector Dog Program, the Customs Asia Pacific Enforcement Reporting System and International Precursor Awareness Training. Customs also plays a lead role as the Oceania focal point for Project PRISM, an international project which focuses on preventing the diversion of precursors into illicit drug manufacture.
- The Asian Collaborative Group on Local Precursor Control (ACoG) was established by the Australian Government in 2006 to prevent the diversion of precursors for Amphetamine-Type Stimulants (ATS) manufacture in the Asian region by promoting the adoption of best practice national regulatory, administrative and legislative policies and practices. Participants include representatives from 16 regional countries and the United Nations Office on Drugs and Crime.
- Also in 2006, the South Pacific Precursor Control Forum (SPPCF) was established as a mechanism for building the capacity of Pacific regional countries to address issues associated with precursor diversion and clandestine illicit drug manufacture. The aim of the SPPCF is to prevent precursor diversion by promoting information sharing, forensic capacity, technical assistance, public awareness and education of key stakeholders around issues of ATS manufacture in the Pacific region.

4. IMPACT ON DRUG CONSUMPTION

4.1. Overview of drug use

Overall drug use increased 69% over the 1988-1998 period, notably between 1995 and 1998. This upward trend was reversed once the Australian Government started implementing its *National Illicit Drugs Strategy "Tough on Drugs" (1997)* in 1998. Between 1998 and 2007, annual prevalence of drug use – as reflected in household survey results (among the population age 14 and above) - declined by almost 40%. Use of amphetamines fell by 38%, cannabis by 49% and heroin use even fell by 75%. Only ecstasy use continued showing an upward trend, from an annual prevalence rate of 2.4% in 1998 to 3.4% in 2004 and 3.5% in 2007. Cocaine use increased slightly, from 1.4% in 1998 to 1.6% in 2007.

Figure 13: Annual prevalence of illicit drug use in Australia among the population age 14 and above, 1988-2007



*

* Figure for 1988 extrapolated from cannabis prevalence data

Sources: AIHW, 2007 National Drug Strategy Household Survey, Canberra 2008 and previous years.

Changes in drug use in Australia, 1998 – 2007

- all drugs: - 39% (from 22.0% to 13.4%)
- including:
- cannabis : - 49% (from 17.9% to 9.1%)
- amphetamines: - 38% (from 3.7% to 2.3%)
- heroin: - 75% (from 0.8% to 0.2%)
- hallucinogens: - 80% (from 3.0% to 0.6%)
- inhalants: - 56% (from 0.9% to 0.4%)
- cocaine: +14% (from 1.4% to 1.6%)
- ecstasy: +46% (from 2.4% to 3.5%)

Source: AIHW, 2007 National Drug Strategy Household Survey

4.2. Cannabis

Overall illicit drug use levels reflect mainly changes in the use of cannabis. Cannabis use increased by 49% between 1988 and 1998 but fell again by 49% between 1998 and 2007 (annual prevalence).

What could have prompted such changes – massive increases over the 1988-1998 period and strong declines between 1998 and 2007? No definite answers exist. Drug use and changes in drug use are, in general, multidimensional phenomena, depending on a large set of factors. A detailed discussion of all potential factors would certainly go far beyond what could be tackled in this report. Nonetheless, a few policy relevant factors, that could have played a role, will be discussed here.

The increases in cannabis use over the 1988-1998 period are most probably linked to changing perceptions of the risks of cannabis use⁹⁵ and its rising availability.⁹⁶ There should not be too much disagreement with this statement.

One key question is whether the drug policy had an impact on these attitudes and/or the availability of cannabis. So, one hypothesis could be that the introduction of the *Cannabis Expiation Notice (CEN) Scheme* in South Australia in 1987, followed by similar schemes a few years later in the other States, may have been misinterpreted by potential users to signal a *de-facto* decriminalization of cannabis, affecting their risk attitudes as well as the overall availability of cannabis (as small scale cannabis production was then covered by these schemes, leading to less risk and thus a shift in the aggregate supply curve).

The evaluation study on the impact of the Cannabis Expiation Notice (CEN) scheme on prevalence rates in South Australia⁹⁷ found, in fact, that the life-time prevalence in South Australia rose between 1985 and 1995 – based on unadjusted raw data – by 27% (from 27.8% to 35.2%), i.e. far more than in the rest of Australia (+4%; from 30.7% to 32%).¹²

The study refrained, however, from linking the introduction of the CEN system with the increase of cannabis use in South Australia. It argued that there were significant increases in some other states as well. Data presented in the study showed an increase in Victoria of 21% (from 26.4% to 32%¹³), in New South Wales of 29% (from 25.6% to 33%) and in Tasmania of 56% (from 21.1% to 32.9%). The Northern Territory (+18%; from 44.1% to 52.1%), Western Australia (+16%; from 31.9 to 37%), the Australian Capital Territory (+12%; from 35.0% to 39.1%) and Queensland (+11%; from 26.6% to 29.5%) showed clearly lower growth rates. Though cannabis use increased across Australia, in fact, only one State, Tasmania, had a stronger growth rate of cannabis life-time prevalence than South Australia. In other words, these empirical data would lend support to the view that the *de-facto* decriminalization of cannabis use may have contributed to higher levels of cannabis consumption.

However, higher growth rates in South Australia – as compared to the rest of the country – were not found for ‘weekly’ cannabis use. The authors admitted that this was probably due to the small sample sizes available to undertake such an analysis.⁹⁸ Though the authors of this (and previous) evaluations did not find sufficient evidence to link the CEN system to rising levels of cannabis use, they also did not provide convincing evidence that such a link did not exist.

The CEN system implemented in South Australia may have had an indirect impact on other jurisdictions, sending a message across the country that cannabis consumption cannot be such a health risk if its use was *de-facto* decriminalized and remaining penalties were significantly lowered.

In fact, an analysis of the consequences of partial decriminalisation of cannabis in the USA in the 1970s found – like the authors of the Australian studies - no direct link between states that

¹² For Australia as a whole, the increase in life-time prevalence of cannabis use was around 10% (from 28% to 31%) over the same period. Adjusted for age and gender, the increase in South Australia was even stronger (+41%, from 25.7% to 36.3%).

¹³ All subsequent data in this paragraph are based on ‘adjusted values’, i.e. re-adjusted for age and gender in the respective state, based on Australian Bureau of Statistics population estimates.

partially decriminalized cannabis and those who maintained a prohibitionist regime.⁹⁹ Yet, overall cannabis use increased strongly in the USA in the 1970s. After these policies had been reversed across the USA in the 1980s, cannabis use declined. These - partly contradictory - results suggest that a policy of partial decriminalization does not necessarily have its main and only impact on the constituency where it is being implemented, but it may also have an impact for the country as a whole, mainly by the message it sends to potential users.

One problem with such an explanation for the Australian example is that most of the increases of cannabis use apparently took place between 1995 and 1998, i.e. more than 8 years after the introduction of the CEN scheme in South Australia. How could the lowering of penalties in one State have had an impact on other States so many years later? One possible explanation could be that an intensive public discussion of whether or not to follow the South Australian example only started in several Australian States after 1995, leading to the introduction of a CEN type system in the Northern Territory in 1996 and of a caution system in Victoria in 1998, followed by a caution system in New South Wales. All of this could indicate that the introduction of the CEN system in South Australia in 1985 may have still played a role for the strong increases of cannabis use over the 1995-98 period.

At the same time, the CEN scheme as well as the other expiation and caution systems had a number of advantages. This made them attractive, including for the police. (See chapter on ‘Expiation Notice Schemes (CENs) and caution schemes for cannabis‘ in this report).

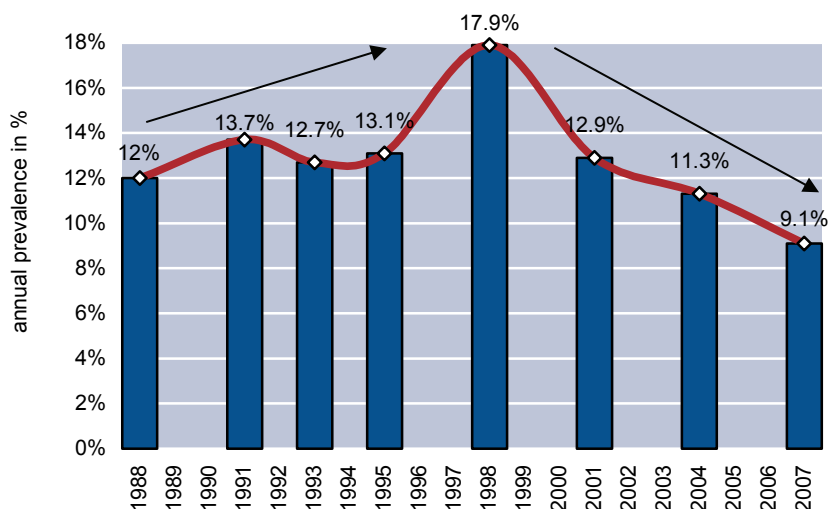
The use of other drugs also increased over the 1988-1998, and notably over the 1995-1998 period. How could a reduction in cannabis penalties go hand in hand with an increase in the use of other drugs? It would be probably too simple to link this directly to the potential role of cannabis as a ‘gateway drug’. But, it could be linked to a general perception at the time that drug use – in all its forms - was becoming socially acceptable and tolerated by society, including by the authorities.

It goes without saying that a number of alternative explanation attempts for the increase are also possible and legitimate (changes in youth culture, music and fashion, influences from the media, influences from abroad, changes in the socio-economic conditions, religion etc.) and may have a stronger explanatory power than attempts to link the changes exclusively to drug policy.

A more interesting question is why cannabis use declined again after 1998. In fact – in contrast to the USA - there are no indications that cannabis related legislation became any stricter in Australia. On the contrary, the CEN and the caution schemes became even more widespread across the country. This clearly indicates that the lower penalties *per se* are not a problem. If there is a problem it is linked to the message and socio-political context in which such measures are “taken on board” and interpreted by the general public.

The attitude towards drugs, including cannabis, changed following the implementation of the *National Illicit Drugs Strategy “Tough on Drugs” (1997) Strategy*. Growing availability of hydroponically grown cannabis, and the higher risks associated with such cannabis, may have also played a role in this regard. Experiences with such new grades of cannabis, containing high levels of THC, had an impact on changing the image of cannabis among ever larger sections of society. The media also played a role in this respect, discussing more in-depth the potential dangers of cannabis consumption, thus supporting the Government efforts. Research, partly funded through the *National Drug Strategic Framework*, also highlighted the potential risks in an objective way. These research findings made it into the popular press. The very benign image of cannabis thus started to change.

Figure 14: Annual prevalence of cannabis use in Australia among the population, age 14 and above, 1988-2007



Sources: AIHW, 2007 National Drug Strategy Household Survey and previous years.

This was reflected in the 2001 national household survey.¹⁰⁰ It showed, for instance, the number of people finding regular drug use to be acceptable declined from 25.5% in 1998 to 23.8% in 2001 for cannabis (as well as for other drugs).

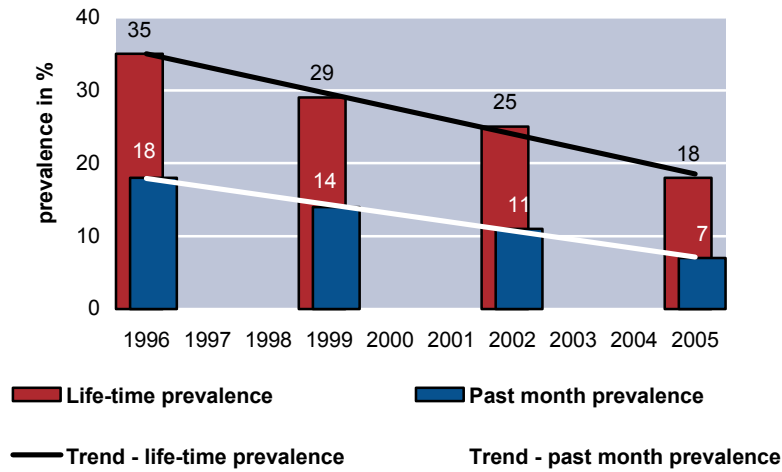
There was also a small decline in the number of people who wished to see cannabis legalized (from 29.4% to 29.1%). In parallel, the proportion of people in favour of stricter penalties for the sale or supply of cannabis (and other drugs) increased (from 59.4% to 61.1%).

Asked to allocate \$100 across education, treatment and law enforcement, funds dedicated to law enforcement would have increased (from 29.3% in 1988 to 33% in 2001 for cannabis) while funds for demand reduction would have declined. Still, Australians would have given the main focus to prevention related expenditure (41.8% of all expenditure in the case of cannabis).

The downward trend in cannabis use observed over the 1998-2001 period continued over the 2001-2004 period as well as over the 2004-2007 period. Between 1998 and 2007, annual prevalence of cannabis use fell by 49%, from a prevalence rate of 17.9% of the population age 14 and above in 1998 to 9.1% in 2007. The proportion of people who found it acceptable to regularly use cannabis declined, from 25.6% in 1998 to 6.6% in 2007 – a major change in attitudes. Availability of cannabis also declined. While 24.2% of the population had been offered cannabis in 2001, this proportion fell to 20.6% in 2004 and to 17.1% in 2007.

Finally, large scale prevention campaigns in schools apparently started to bear fruit. Life-time prevalence of cannabis use among 12-17 year old students was almost halved between 1996 and 2005, from 35% to 18%. Monthly prevalence of cannabis among 12-17 year old secondary school students declined from 18 percent in 1996 to 7 percent in 2005, equivalent to a decline of more than 60% over a decade.

Figure 15: Cannabis use among secondary school students (age 12-17) in Australia, 1996-2005



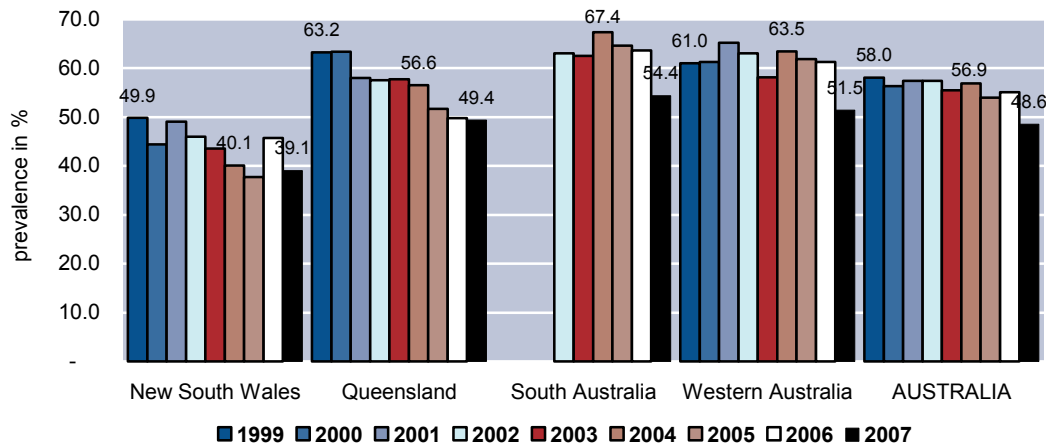
Source: The Cancer Council of Victoria, Australian secondary school students' use of over-the-counter and illicit substances in 2005, June 2006

Lower use of cannabis also went hand in hand with lower use of other drugs among students, as will be shown later. The falling trend of cannabis use among Australia's youth also continued in subsequent years. The household survey data show a decline in the annual prevalence rate for cannabis use among 14-19 years old males from 18.4% in 2004 to 13.1% in 2007 (-29%) and from 17.4% to 12.7% (-27%) among females.

Nonetheless, cannabis remains the most widely consumed drug in Australia (annual prevalence: 9.3% or 1.6 million persons; life-time prevalence: 5.8 million persons or 33.5% of the population age 14 and above).

The proportion is even higher among special groups of society. Thus, on average, around 49% of people detained at a police station/watchhouse in selected sites across Australia, who provided urine samples, tested positive to cannabis in 2007. But, this was down from 58% in 1999, suggesting that cannabis use is also declining among high-risk groups. A decline was reported across all States, both over the 1999-2004 period and - even more pronounced - over the 2004-2007 period. Nonetheless, close to 70% of all drug related arrests are still cannabis related.

Figure 16: Testing of arrestees for cannabis use in Australia*, 1999-2007

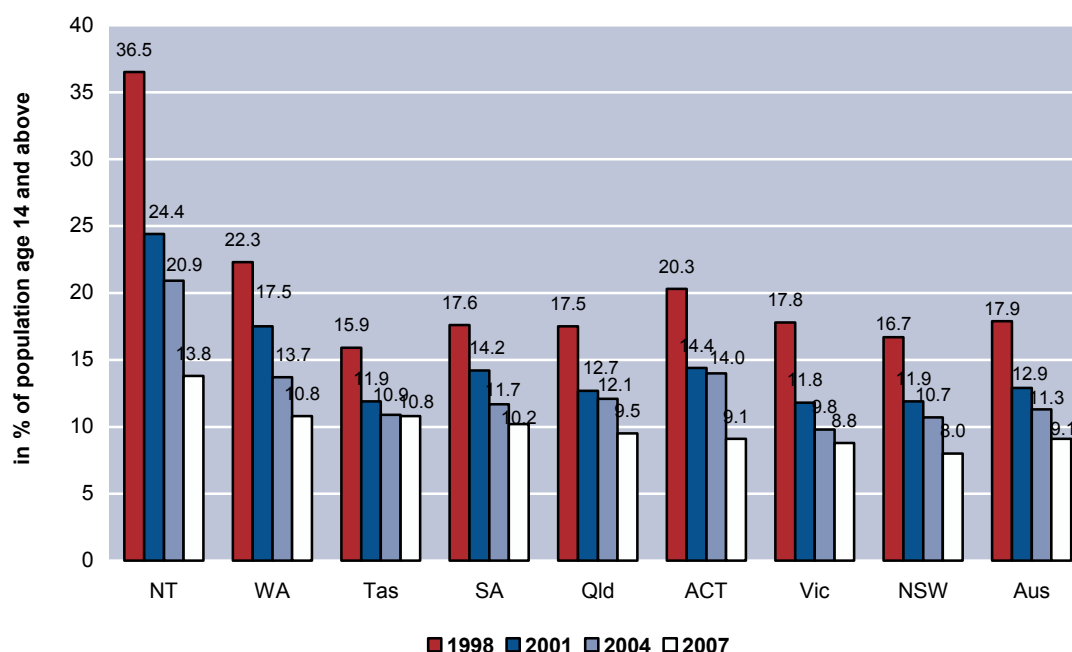


* unweighted average of results from Western Australia (East Perth), South Australia (Adelaide and Elisabeth), New South Wales (Parramatta and Bankstown (Sydney)) and Queensland (Brisbane and Southport).
Source: Australia Institute of Criminology, Drug Use Monitoring in Australia (DUMA).

In terms of regional distribution, the highest prevalence rates of cannabis use are reported - according to the 2007 household survey data - from Northern Australia (13.8% of those age 14 and above), followed by Western Australia (10.8%) and Tasmania (10.8%). South Australia and Queensland and are still above the national average. Cannabis prevalence rates in New South Wales and Victoria are slightly below the national average.

Comparisons of the 2007 household survey results with those of previous surveys show declines across all jurisdictions. If the 1998-2007 period is considered, the strongest declines were found in the Northern Territory (-62%), in the Australian Capital Territory (-55%), in Western Australia (-52%), in New South Wales (-52%) and in Victoria (-51%).¹⁰¹

Figure 17: Annual prevalence of cannabis use among the population age 14 and above, 1998- 2007



Sources: AIHW, 2007 National Drug Strategy Household Survey - State and territory supplement, Canberra 2008, AIHW, 2004 National Drug Strategy Household Survey - State and territory supplement, Canberra 2005, AIHW, 2001 National Drug Strategy Household Survey - State and territory supplement, Canberra 2002, AIHW, 1998 National Drug Strategy Household Survey - State and territory supplement, Canberra 2000.

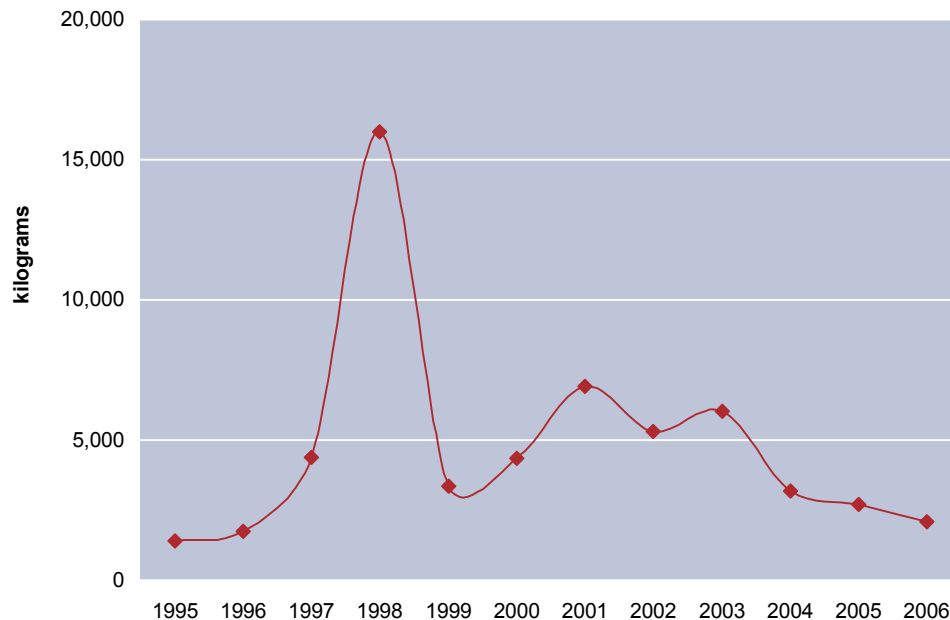
Cannabis consumption in Australia remains, however, high among its indigenous communities.¹⁰² A study, conducted in 2002, found an annual prevalence rate of cannabis use of 19% among the indigenous population age 15 and above,¹⁰³ far higher than the national average (12.9% in 2001). The 2004-05 National Aboriginal and Torres Strait Islander Health Survey revealed that almost 22.6% of Australia’s indigenous population consumed cannabis¹⁰⁴ in the twelve months prior to the survey which is twice as high as the national average (11.3%) in 2004.¹⁰⁵ A number of initiatives have already been taken to address this specific problem.¹⁰⁶

One interesting question is whether the overall decline in cannabis use after 1998 was prompted primarily by a reduction of supply or whether it was due to a genuine shift in the demand curve. Two indirect indicators are available which can shed some light on this question: seizures and prices.

Cannabis herb seizures, as reported in reply to UNODC’s Annual Reports Questionnaire (ARQ), show indeed a similar pattern as prevalence data. Following a strong increase of marijuana seizures over the 1995-1998 period, cannabis herb seizures declined in subsequent years (with most of the decline reported in 1999). *Prima facie*, this could be taken as an indication that

declines in supply after 1998 led to declines in trafficking, thus to less seizures, and ultimately to less consumption.

Figure 18: Australian cannabis herb seizures (in kg), 1995-2006

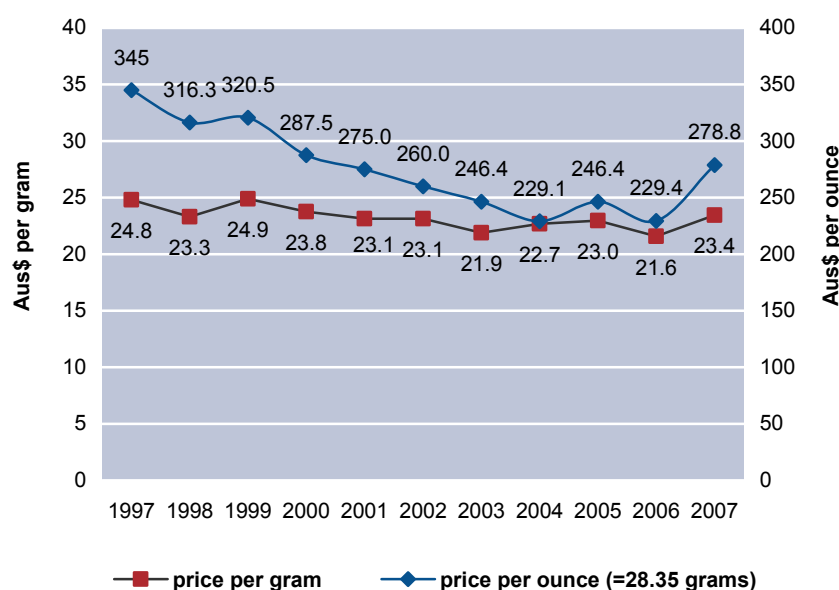


Source: UNODC, Annual Reports Questionnaire Data.

Available price data (calculated on the basis of unweighted averages of price data reported from the various states and territories), however, fail to show any shortage on Australia's cannabis markets which could have been expected from any supply driven reduction. To the contrary, cannabis herb prices, reported in ounces, showed a gradual decline from the late 1990s to 2004 followed by a period of stabilization until 2006. There was also some decline in prices reported per gram. However, this decline (-13% over the 1997-2006 period) was less pronounced than the decline in 'ounce' prices (falling by about a third), possibly reflecting an increasing 'professionalisation' of the cannabis business in Australia in recent years.

In any case, price data do not provide any evidence that the decline of cannabis consumption in Australia was supply driven (as this would have resulted in rising cannabis prices). Prices only started rising in 2007. The decline in cannabis use, however, was a gradual phenomenon, starting much earlier. Even though supply may have – by now – also declined (as evidenced by questions on cannabis availability in the household surveys), the overall decline of cannabis use was primarily a success of demand reduction policies (preventions activities) and a number of other factors, discussed earlier in this chapter (changing health perceptions, rising potency, role of the media etc.).

Figure 19: Trends in cannabis prices (unweighted average) in Australia, 1997-2006



* Data between 1999 and 2000 are not completely comparable due to shift in data source.

Sources: UNODC calculations based on NDARC, *Australian Drug Trends 2007 – Findings from the Illicit Drug Reporting System (IDRS)*, *Australian Drug Trends Series No. 1*, NDARC, *Australian Drug Trends 2006 – Findings from the Illicit Drug Reporting System (IDRS)*, *Monograph No. 60, Sydney 2007* and *Australian Crime Commission, Australian Illicit Drug Reports, 1997-2001*.

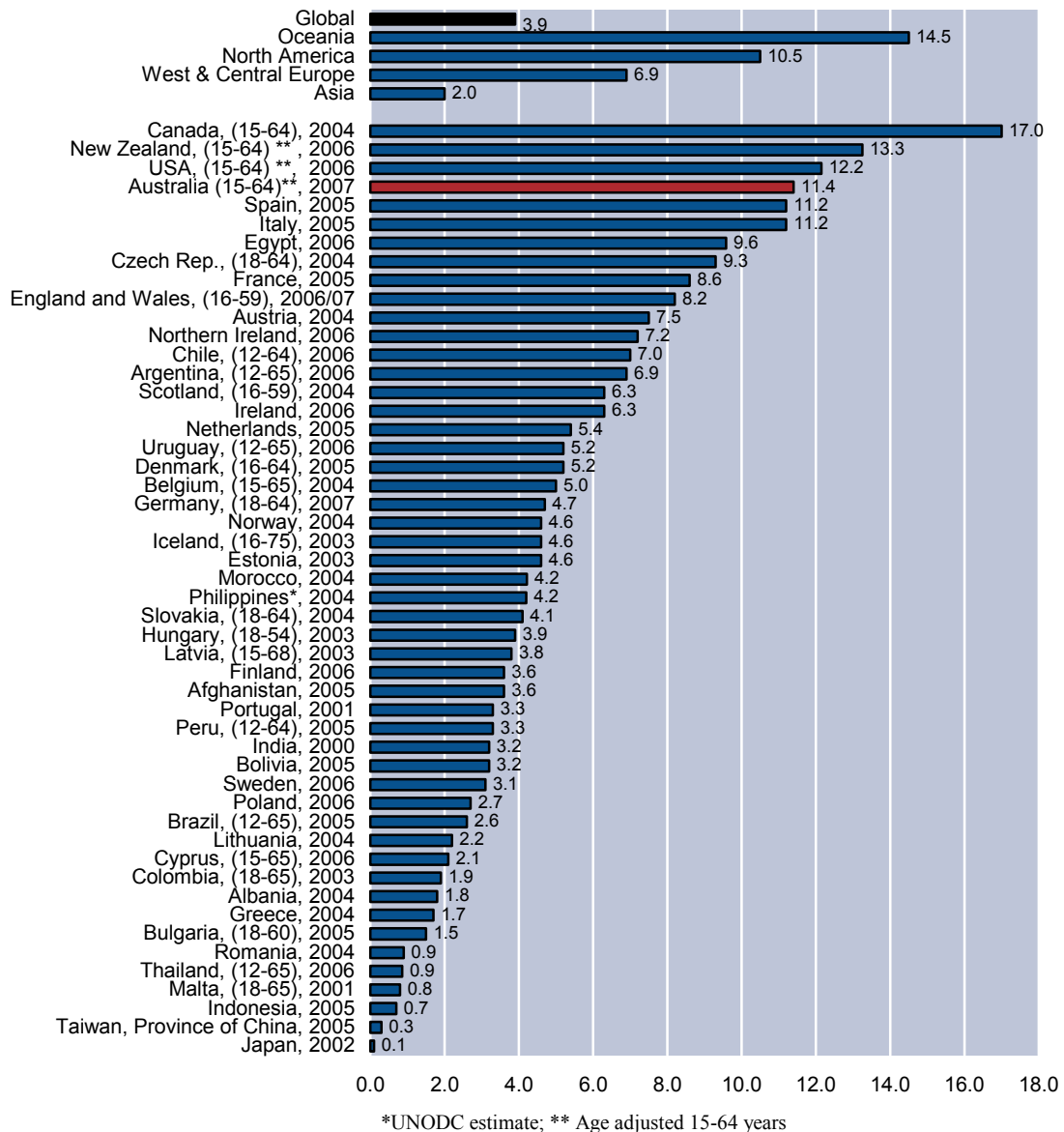
Despite of the successes in reducing cannabis use in Australia after 1998, its use is, however, still high by international standards.¹⁴ In the age group 15-64, the annual prevalence of cannabis use was 11.4% in 2007. This is nearly 3 times the global average (3.9%), and higher than the averages in North America (10.5%), West and Central Europe (6.9%) or Asia (2.0%). However, cannabis use in Australia seems to be now below average in the Oceania region (14.5%).¹⁵

Among the countries with reliable monitoring systems, Canada, New Zealand and the USA show higher levels of cannabis use. However, Canada which pursues similar drug policies as Australia shows notably higher prevalence of annual use (17%). Levels in New Zealand (13.3%) and the USA (12.2%) are similar to those reported from Australia, as are levels from Spain and Italy, both at 11.2%. Cannabis use in Australia is still more than 3½ times higher than in Sweden (which has followed a very restrictive drug policy since the early 1970s).

¹⁴ The statement “high by international standards” needs to be qualified. Australia is known to have high rates of survey compliance and, generally, a population which is familiar and comfortable with participating in surveys. It is thus likely that surveys are responded to relatively more comprehensively and carefully in Australia than in other countries, which could create some bias.

¹⁵ But, this has to be treated with caution as it is mainly due to a high estimate provided by the authorities of Papua New Guinea back in 1996 (which could not be verified).

Figure 20: Annual prevalence of cannabis use in selected countries, standardized for ages 15-64 in 2006/07 or latest year available



Source: UNODC, 2008 World Drug Report.

The bulk of the cannabis consumed in Australia continues to be of domestic origin. Cannabis imports into Australia are limited to small amounts of cannabis resin, cannabis oil, or high quality cannabis. In 2006/07, the bulk of total imported cannabis seized by customs (45.6 kg) embarked by weight from Canada, the USA, and the UK. The majority of cannabis detections at Australian borders continue to be for personal use, either found on air passengers or in the post.¹⁰⁷ Exports from Australia are not reported.

Cannabis produced in Australia ranges from outdoor bush plots either with a few or tens of thousands of plants, to the more commonly detected hydroponic indoor cultivation within residential premises, which are lower in size but are yielding far higher amounts per square meter. Like in many other industrialized countries, hydroponic cultivation increased in recent years. The most frequently detected method of cultivating cannabis in Australia is already related to hydroponics (or other enhanced indoor cultivation techniques). Such cultivation depends on the availability of seeds for high THC content strains of the plant. The seeds are primarily smuggled in from the Netherlands. They are typically sold online and delivered by post. Over half of all cannabis product detections in the financial year 2006/07 involved such seeds.¹⁰⁸

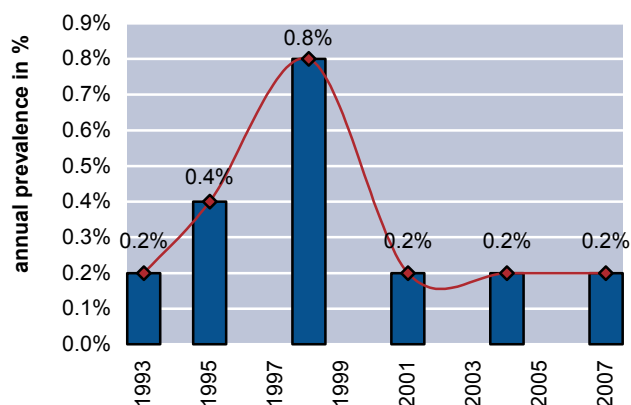
Most cannabis production is for personal use and/or for close friends and acquaintances (which may well be an outcome of the CEN-type systems). However, organized crime groups (e.g. outlaw motorcycle gangs) have also started to enter this line of business. There are even indications that Vietnamese-Australians have entered into contact with criminal Vietnamese groups from Canada to improve their cultivation knowledge and skills.¹⁰⁹ These Asian groups in Canada have significantly enhanced the indoor cultivation methods in recent years to yield ever larger quantities of high potency cannabis, used to supply the local Canadian market as well as the lucrative market of the United States.¹¹⁰

In order to give a new impetus to the fight against the spread of cannabis, the authorities drafted the country's first *National Cannabis Strategy* in 2006 – in line with National Drug Strategy. It aims to provide a comprehensive and balanced approach to supply reduction, demand reduction and harm reduction strategies. (See chapter on 'Substance specific strategies and legislation with regard to cannabis and ATS').

4.3. Heroin

The strongest decline in the use of any drug was reported for heroin: -75% between 1998 and 2007, based on household survey data. This followed strong increases in the 1990s which, at least partly, were a consequence of ever larger shipments of heroin from the Golden Triangle into Australia as supply for the USA market shifted from South-East Asian to Latin American (Colombia/Mexico) heroin. However, in 2001 the Australia authorities succeeded, mainly due to supply reduction interventions, in reducing the prevalence rates. All available indicators suggest that the rates remained at the lower levels in subsequent years as well.¹¹¹ This was a unique success of the Australian Government's *National Illicit Drugs Strategy "Tough on Drugs" (1997)*. The decline in heroin use – shown below – has been reflected in basically all available indicators.

Figure 21: Annual prevalence of heroin use in Australia, among the population, age 14 and above, 1993-2007

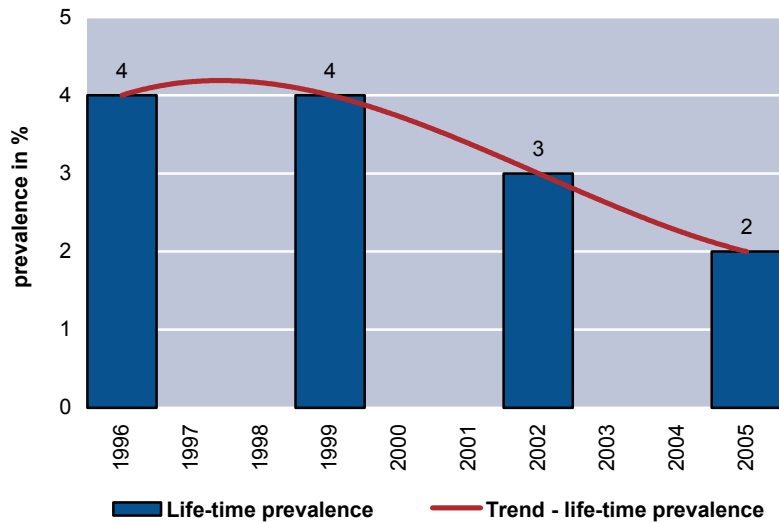


Sources: AIHW, 2007 National Drug Strategy Household Survey and previous years

This decline had also a positive impact on injecting drug use. This fell from 0.8% in 1998 to 0.6% in 2001 and 0.4% of the population age 14 and above in 2004.¹¹² At the same time, data from the National Centre in HIV Epidemiology and Clinical Research suggest that among remaining injecting drug users participating in needle and syringe exchange programs, the importance of heroin declined as well. In 2000, 59% of the clients reported that heroin (alone or in combination with cocaine) was their last drug injected, this proportion fell to 31% in 2007.¹¹³

Significant declines in heroin use were also reported among Australia's youth. Life-time prevalence of opiate use among Australian students, age 12-17, fell by 50% between 1999 and 2005. The decline was even more pronounced among those aged 16-17 (-60%).

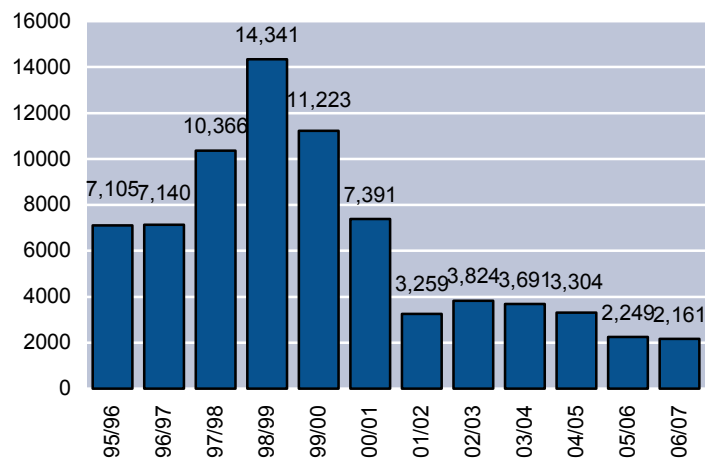
Figure 22: Opiate use among secondary school students (age 12-17) in Australia, 1996-2005



Source: The Cancer Council of Victoria, Australian secondary school students' use of over-the-counter and illicit substances in 2005, June 2006

Though most of the decline in heroin consumption – at the national level – took place in 2001, there are no indications of any re-establishment of the heroin market at previous levels in recent years. Opiate related arrests fell by 81% between 1998/99 and 2006/07. The number of seizure cases in 2006/07 (N =1,471) as reported by the police, had declined substantially since their peak in 1998/99 and have remained essentially unchanged since 2001/02. The highest numbers were reported from New South Wales (56%) followed by Queensland (15%) and Victoria and Western Australia both with 13%.¹⁴ The highest numbers of heroin related arrests in 2006/07 (N=2,161) were seen in Victoria (49% of the total), followed by New South Wales (26%).¹⁶

Figure 23: Number of heroin and other opiates related arrests, 1995/96 to 2006/07



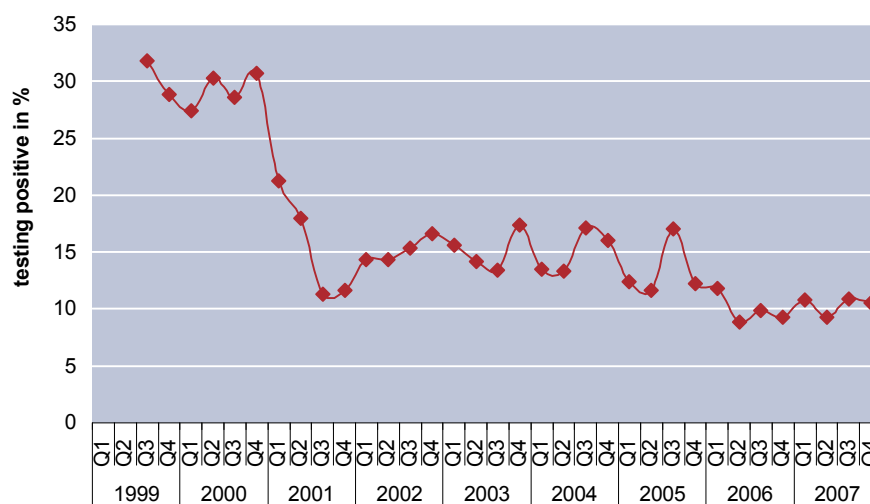
Source: O'Brien et al. (2007) Australian Drug Trends 2005: Findings from the Illicit Drug Reporting System, Sydney 2006 and Australian Crime Commission, Illicit Drug Data Report 2006-07, June 2008 and previous years.

¹⁶ The discrepancy in the proportions of heroin seizures and heroin arrests for New South Wales could be a consequence of the Medically Supervised Injecting Center at Kings Cross, Sydney.

Some of the most interesting data collected systematically in Australia are derived from the *Drug Use Monitoring in Australia (DUMA)* project which tests detainees for drug use by means of urine tests in selected sites¹⁷ across the country. These tests take place within 48 hours after arrest at a police station and show whether or not a person tested positive for drugs. This project, modelled upon the now defunct USA ADAM project, is run by the Australian Institute of Criminology (AIC). The main advantage is that, the project does not have to rely on the truthfulness of the persons interviewed which is typically the case for traditional surveys based on self-reports. As the persons arrested often form part of the group of heavy drug users, the DUMA data tend to provide a good insight into the market segment of heavy drug users who account for the bulk of overall drug consumption.

Between the end of 2000 and the first quarter of 2001, the DUMA project showed a massive decline in the proportion of detainees testing positive for heroin, notably at the Parramata police station, which is part of the Sydney¹⁸ agglomeration. The proportion of male detainees in Parramata testing positive for heroin fell from 47% in the fourth quarter of 2000 to just 5% by the first quarter of 2002.¹¹⁵ A number of subsequent studies confirmed the emergence of an acute heroin shortage, starting around Christmas 2000 which lasted for at least two quarters.

Figure 24: Detainees testing positive to heroin in Australia*, 1999-2007



* unweighted average of results from Western Australia (East Perth), South Australia (Adelaide and Elizabeth), New South Wales (Parramatta and Bankstown (Sydney)) and Queensland (Brisbane and Southport).

Source: Australia Institute of Criminology, *Drug Use Monitoring in Australia (DUMA)*.

The unweighted average of all the sites investigated across Australia showed a decline from 30% of detainees testing positive for heroin abuse in the fourth quarter of 2000 to 10% in the third quarter of 2002 and a gradual recovery to around 15% in 2005. However, it fell again to about 10% during 2007.

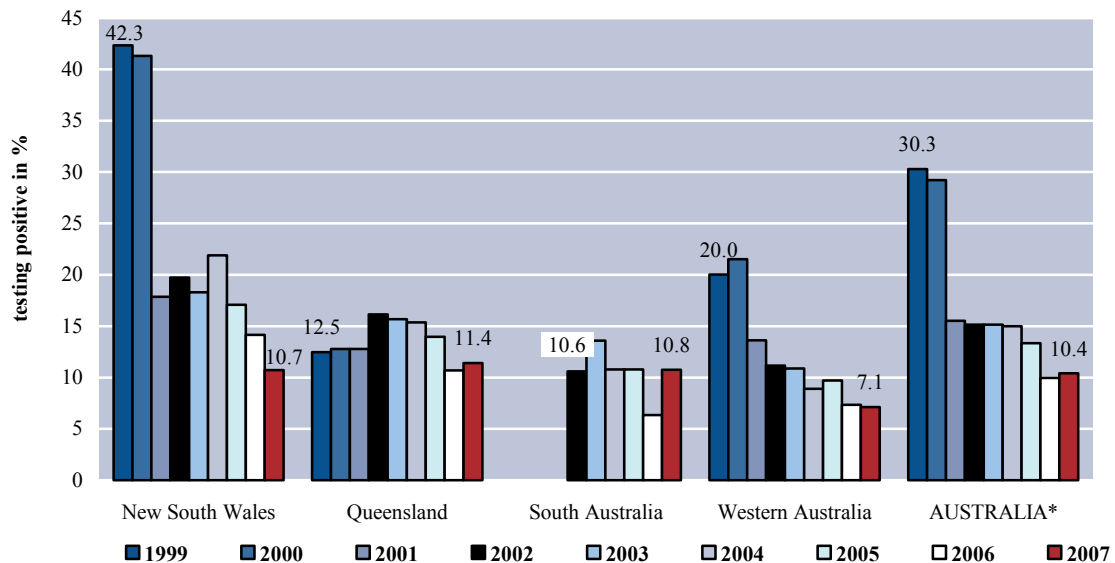
The decline in 2001 was most pronounced in New South Wales, Australia’s largest heroin market. New South Wales reported strong increases in heroin prices, dramatic decreases in purity at the street level, as well as reductions in the ease with which injecting drug users reported being able to

¹⁷ The sites are in New South Wales: Parramatta and Bankstown, both in the Sydney agglomeration, in Queensland: Brisbane and Southport; in South Australia: Adelaide and Elizabeth; in Western Australia: East Perth. The programme is currently being expanded to cover additional sites in Victoria (Footscray) and in the Northern Territory (Darwin).

¹⁸ Traditionally, Sydney has had Australia’s largest heroin market and has been the main re-distribution centre for heroin entering Australia from abroad.

obtain heroin.¹¹⁶ The strong declines of heroin availability in New South Wales in 2001 were also reflected in the DUMA data.

Figure 25: Detainees testing positive to heroin in Australia*, 1999-2007



* unweighted average of results from Western Australia (East Perth), South Australia (Adelaide and Elizabeth), New South Wales (Parramatta and Bankstown (Sydney)) and Queensland (Brisbane and Southport).

Source: Australia Institute of Criminology, *Drug Use Monitoring in Australia (DUMA)*.

One key question, which created a major debate in Australia and outside the country, was why heroin abuse declined so suddenly in Australia. The answer seems to be quite clear by now. In addition to a number of factors on the demand side discussed earlier (i.e. improved treatment facilities, drug courts, prevention activities etc.) a massive reduction in supply played a key role. In fact, most analyses came to the conclusion that the sharp decline in heroin use was primarily due to reduced supply.¹¹⁷

In 2000, Australia, in cooperation with the USA and a number of South-East Asian countries, dismantled several key trafficking networks that had supplied the Australian market with heroin from South-East Asia.¹¹⁸ Increased funding, better internal cooperation between the Australian Federal Police (AFP) and the Australian Customs Service (ACS) as well as a stronger international orientation of Australia's federal drug law enforcement have contributed to this success. This enabled AFP and ACS to interdict large shipments of heroin, dismantle several criminal networks and disrupt the activities of others involved in high-level heroin importation. Cooperation between governments and law enforcement agencies improved across the countries of the Asia/Pacific region as of the late 1990s. There were thus a number of large seizures in 2000 as well as arrests of key facilitators who shipped heroin from South-East Asia to Australia. This meant that a number of trafficking networks operating for years were effectively disrupted or dismantled.

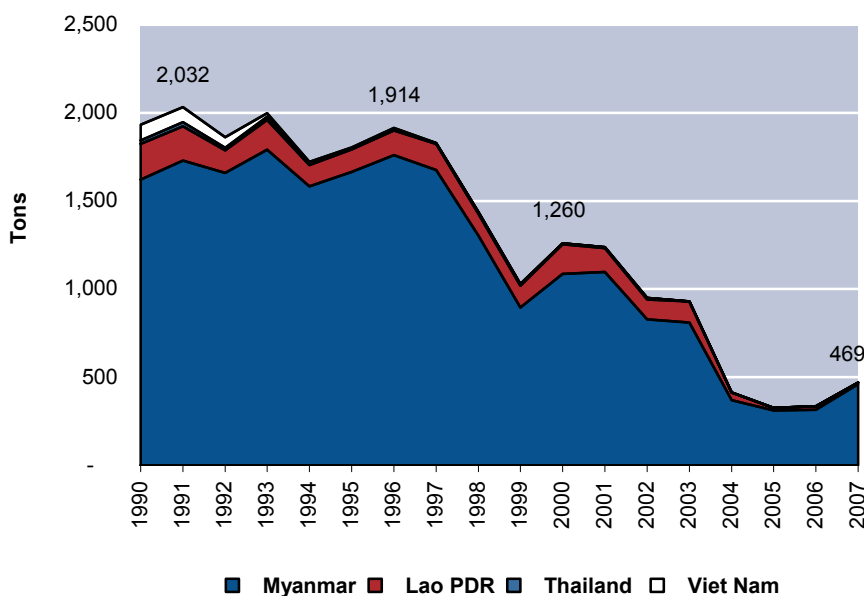
The following factors played a key role: (i) the development of a capacity by Australian law enforcement to work offshore with other law enforcement agencies (after 1998); (ii) the identification of many of the importation methods used by Asian heroin syndicates (intelligence information suggested that a large proportion of the heroin imports into Australia relied on a centralized network based around a small number of key wholesale suppliers relying on sea cargo shipments); (iii) rising volume of heroin seizures (thus reducing profitability) and; (iv) the disruption of major heroin trafficking syndicates in mid 2000 by an Australian-led international task force.

All of this also prompted those responsible for financing heroin imports to withdraw. In parallel, local-level law enforcement interventions showed some success in disrupting the heroin markets in Sydney (notably Cabramatta), Australia’s key re-distribution centre.¹¹⁹

As a result of all of this, the supply of heroin to Australia was substantially reduced in 2001. Indicators for heroin availability (prices, purity, key informants interviews) showed a pronounced reduction of heroin availability, notably over the January to April 2001 period. As of 2002, trafficking resumed and supply to Australia grew again. However, heroin trafficking is now more decentralised with smaller volumes frequently imported via parcel post and air streams. Thus heroin availability did not return to its pre-December 2000 levels.

The ongoing decline of opium production in the Golden Triangle, the key source for the opiates found in Australia, also played a key role. Though opium production in South-East Asia had already declined by 34% between 1996 and 2000, more heroin was shipped during this period to Australia as heroin supply for the USA shifted from South-East Asia to Latin America in these years. The reduction in opium supply from South-East Asia became, however, more pronounced in subsequent years. Between 2000 and 2007, opium production in South-East Asia declined by 63%.¹²⁰ With the Chinese market continuing growing, there was not much left for shipments to Australia. As a consequence of the continued supply squeeze, the street-level purity of heroin stayed low and abuse levels remained low in Australia.¹²¹

Figure 26: Opium production in South-East Asia – main source for opiates in Australia



Source: UNODC, 2008 World Drug Report.

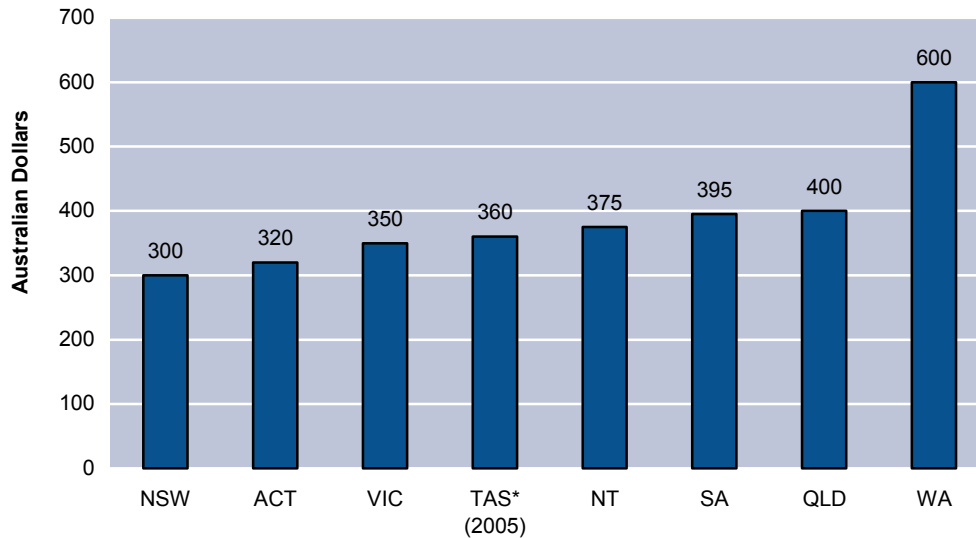
Availability of sufficient treatment facilities also proved to be a key pre-requisite for the success of the supply induced reduction in heroin demand. One study showed that there was a strong increase in admissions to methadone treatment programs in Cabramatta (then considered to have been the largest heroin market of Sydney) over the December 2000 to February 2001 period, followed by a decline in subsequent months.¹²²

The market situation is also well reflected in the development of heroin prices. As part of the *Illicit Drug Reporting System (IDRS)*, run by the National Drug and Alcohol Research Centre (NDARC), heroin prices are regularly collected from injecting drug users (N = 909 in 2007; at least 80 per jurisdiction) and the median prices per jurisdiction have been calculated.

The lowest prices of heroin in Australia were reported - according to the *Illicit Drug Reporting System* - for 2006, like in previous years, from New South Wales. This reflects the fact that this state continues being used by drug traffickers as the main entry point for heroin deliveries into

Australia. The highest levels were reported from the Northern Territory and from Western Australia, the two states which are furthest away from New South Wales.¹²³ (Data provided through the IDRS fall well within the price ranges reported by the Australian Police).¹²⁴

Figure 27: Average heroin prices per gram (at street purity) in Australia, by region, 2006/07



Source: National Drug and Alcohol Research Centre (NDARC), *Australian Drug Trends 2007, Findings from the Illicit Drug Reporting System (IDRS)*, Sydney 2008.

For the purposes of this study, the various prices from the individual jurisdictions were aggregated and a national average price trend was calculated - once as an unweighted average of the prices reported from the various jurisdictions and once as an average price weighted by the number of arrests and heroin seizure cases reported in the various jurisdictions over the 2005/06 and 2006/07 periods¹⁹.

Calculating the average of the heroin related arrest distribution and the heroin seizure distribution for 2005-07 shows similar levels for New South Wales (38.6% of total) and for Victoria (35.9% of total), followed by Queensland (13.1%), Western Australia (8.0%) Southern Australia (2.6%) and the Australian Capital Territory (1.4%). The lowest levels are reported from the Northern Territory (0.1%) and from Tasmania (0.5%). Given Australia's population distribution²⁰ data suggest that per capita consumption of heroin is rather high in Victoria and slightly above average in New South Wales while it seems to be below average in the other states.

¹⁹ The latter approach is based on the understanding that for the calculation of a national average more significant weights should be used for prices reported from larger markets and vice versa. In other words, prices reported from New South Wales and Victoria, known to be a large heroin markets, should be given a larger weight than prices found in Tasmania where the heroin market is known to be still limited. An additional assumption here is that the effectiveness of law enforcement is largely comparable across the various jurisdictions of the country. Larger numbers of heroin related arrests and seizures in a state should therefore be - primarily - a reflection of a larger market. In order to avoid distortions from unusually high seizures or arrests made in a particular year, the averages for the fiscal years 2005-06 (July 2005 to June 2006) and 2006-07 (July 2006 to June 2007) were calculated, for both heroin related arrests and seizures. Analyzing the distributions of these variables across jurisdictions, one finds, however, some significant discrepancies: heroin seizures are primarily reported from New South Wales (56.8% of total over the 2005-07 period), reflecting the ongoing role of New South Wales (notably Sydney) as Australia's main entry point for heroin into the country, while heroin arrests are primarily reported from the neighbouring state of Victoria (50.5% of total over 2005-07 period), notably in and around Melbourne. This has been the case now for several years.

²⁰ Population distribution: NSW 33%; Victoria 25%, Qld 20%; WA 10%; SA 7.5%; Tas 2.3%, ACT 1.6% and NT 1%, as of December 2007.

Breakdown of Australian heroin market by jurisdictions, 2005-2007

	Heroin related arrests						Number of heroin seizure cases						Overall average 2005-07
	July 2005– June 2006		July 2006– June 2007		Avg. 2005-07		2005–06		2006–07		Avg. 2005-07		
NSW	633	28.1%	565	26.1%	599	27.2%	745	57.4%	828	56.3%	786.5	56.8%	38.6%
Vic	1159	51.5%	1068	49.4%	1113.5	50.5%	159	12.2%	188	12.8%	173.5	12.5%	35.9%
Qld	255	11.3%	290	13.4%	272.5	12.4%	174	13.4%	220	15.0%	197	14.2%	13.1%
WA	108	4.8%	149	6.9%	128.5	5.8%	128	9.9%	186	12.6%	157	11.3%	8.0%
SA	50	2.2%	50	2.3%	50	2.3%	62	4.8%	26	1.8%	44	3.2%	2.6%
ACT	28	1.2%	22	1.0%	25	1.1%	28	2.2%	21	1.4%	24.5	1.8%	1.4%
Tas	16	0.7%	16	0.7%	16	0.7%	1	0.1%	0	0.0%	0.5	0.0%	0.5%
NT	0	0.0%	1	0.0%	0.5	0.0%	1	0.1%	2	0.1%	1.5	0.1%	0.1%
Total	2249	100%	2161	100%	2205	100%	1298	100%	1471	100%	1384.5	100%	100%

Source: Australian Crime Commission, Illicit Drug Data Report 2006-2007, Canberra 2008.

A breakdown of the results of the 2007 household survey on drug abuse seems to confirm some, though not all of these findings. According to these data, the highest heroin use levels in 2007 were in Victoria, Tasmania, and the Northern Territories (0.3% of the population age 14 and above), above the levels in New South Wales (0.2%) while the lowest levels (0.1%) were found in Southern Australia.¹²⁵

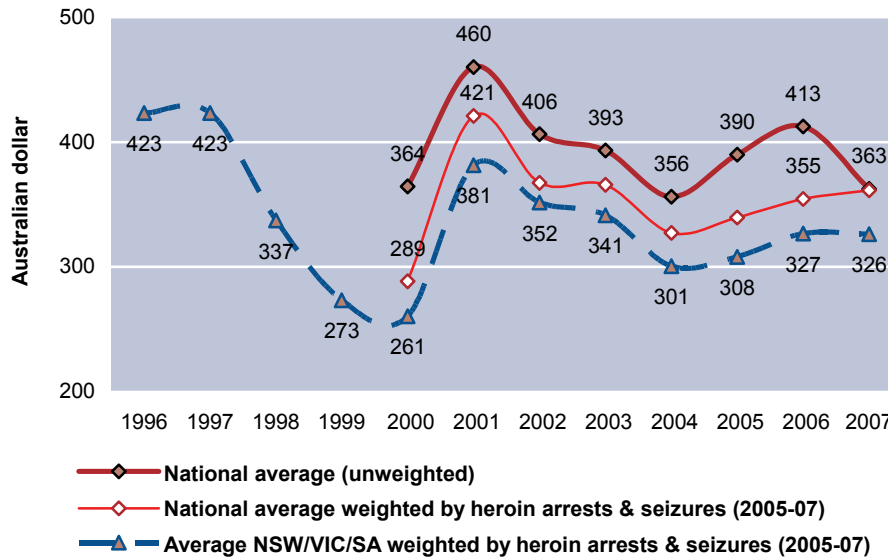
However, household survey data are generally not considered to be very reliable when it comes to drugs such as heroin as many heroin addicts no longer live in households. Moreover, the sample size for the individual states are probably too small to accurately measure the extent of heroin abuse. Against this background, the weights used for aggregating the price data from the individual states were based on the average of the heroin arrest and seizure data.

Prior to 2000, price data from the IDRS were only available for New South Wales, Victoria and South Australia. Using the weighted average (by heroin seizures) for these three jurisdictions and comparing this with the results for all eight jurisdictions, does not show much of a difference for the 2000-07 period. This suggests that the price trends found in the three jurisdictions – New South Wales, Victoria and South Australia – are a reasonable proxy for national heroin price trends.

Heroin price trends at the national level (based on unweighted and weighted data) suggest that there was:

- (i) a considerable decline of heroin prices in Australia in the late 1990s, in line with reports of rising levels of supply from South-East Asia which fuelled domestic consumption; followed by;
- (ii) a sharp increase in 2001, reflecting a heroin shortage on the Australian market (prompted by law enforcement activities);
- (iii) a gradual decline of prices until 2004 as trafficking recovered and demand remained weak;
- (iv) an ongoing increase in prices in 2005 and 2006 as supply weakened again, reflecting ongoing declines of opium production in South-East Asia in combination with ongoing strict controls in Australia.

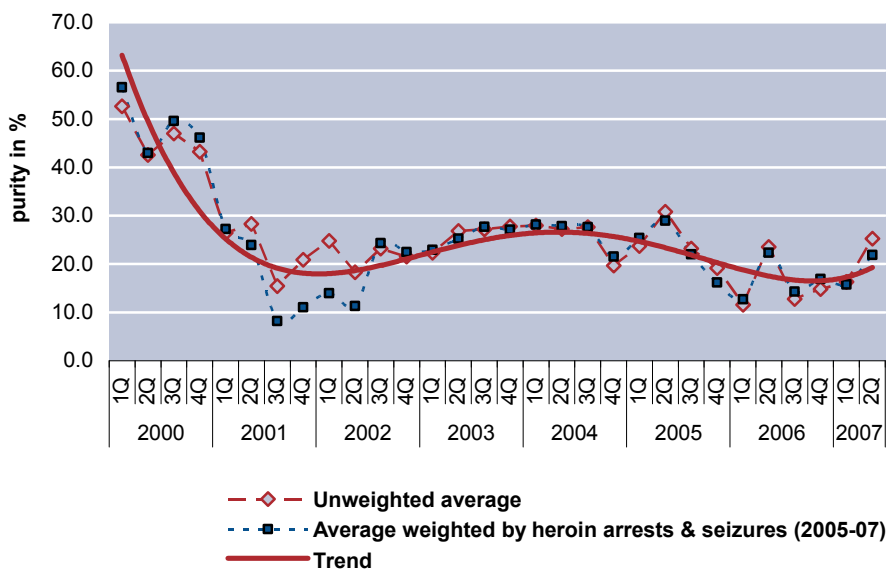
Figure 28: Heroin prices per gram (at street purity) in Australia, 1996-2007



Sources: UNODC calculations based on National Drug and Alcohol Research Centre (NDARC), Australian Drug Trends 2007 (and previous years), Findings from the Illicit Drug Reporting System (IDRS) and Australian Crime Commission, Illicit Drug Data Report 2006-2007, Canberra 2008.

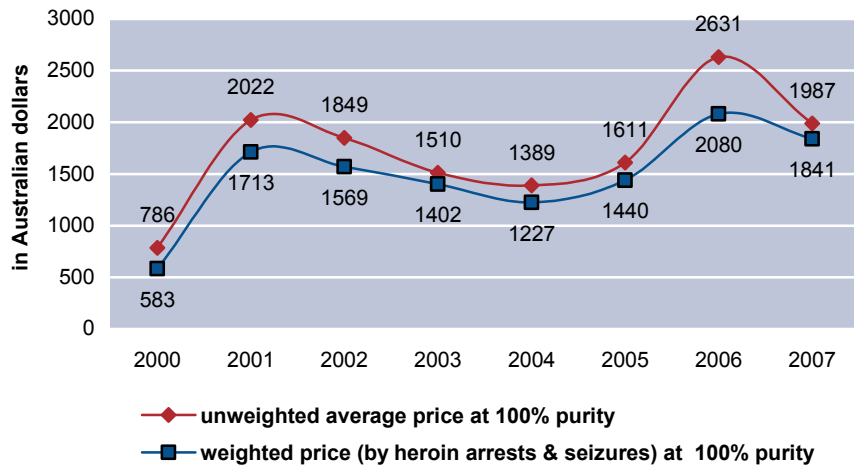
The purity-adjusted price increases in 2001 were far more significant than the increases of heroin prices at street purity. This was due to a strong fall of heroin purity levels in 2001. Purity levels as reported by the State police forces (derived from seizures made) fell from, on average, 40%-60% in 2000 to levels around 10%-20% in 2001 and basically remained within a 20%-30% range over the next four years before declining to less than 20% in 2006. If the national heroin prices are adjusted for heroin at 100% purity, prices almost tripled in 2001 as a result of the heroin drought. Though gradually declining in subsequent years until 2004 as trafficking started to resume, prices remained twice as high as in 2000. Between 2004 and 2006 prices increased by more than 60%, reflecting production declines in South-East Asia in combination with ongoing efforts to fight heroin smuggling to Australia.

Figure 29: Heroin purity as reported by the state police forces across Australia



Source: UNODC calculations based on Australian Crime Commission, Illicit Drug Data Report 2006-07 (and previous years).

Figure 30: Calculated heroin prices per gram at 100% purity in Australia, 2000-2006*

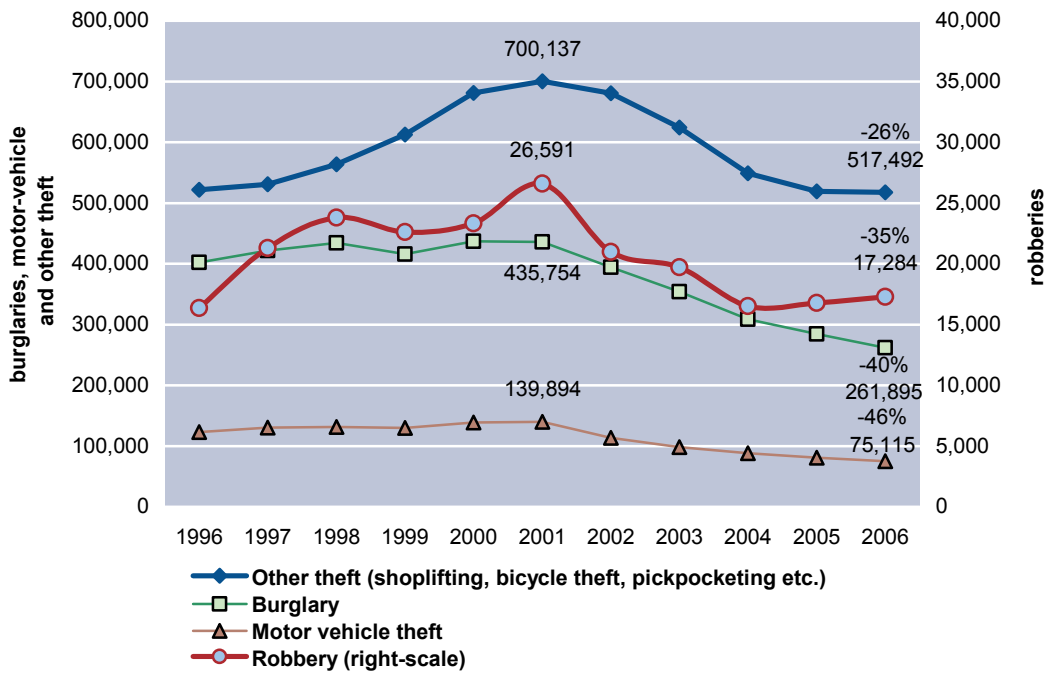


Calculation for 2007 based on purities reported over first two quarters of 2007.

Sources: UNODC calculations based on Australian Crime Commission, *Illicit Drug Data Report 2006-07* (and previous years) and National Drug and Alcohol Research Centre (NDARC), *Australian Drug Trends 2007* (and previous years), *Findings from the Illicit Drug Reporting System (IDRS), Sydney 2008*.

Initial fears that rapidly rising heroin prices in 2001 would result in an increase in crime levels did not materialize.¹²⁶ There was still some increase in crime in 2001, notably for robberies (showing a spike in the first quarter which disappeared again until June), but higher heroin prices prompted heroin users to switch to other drugs or leave the market. As a consequence of the latter, overall crime rates declined. Typical acquisitive crimes related to the financing of a drug habit declined substantially. Between 2001 and 2006 burglaries declined by 40%, robberies by 35%, motor-vehicle thefts by 46% and other thefts (shoplifting, pick-pocketing, bicycle theft etc.) fell by 26%.

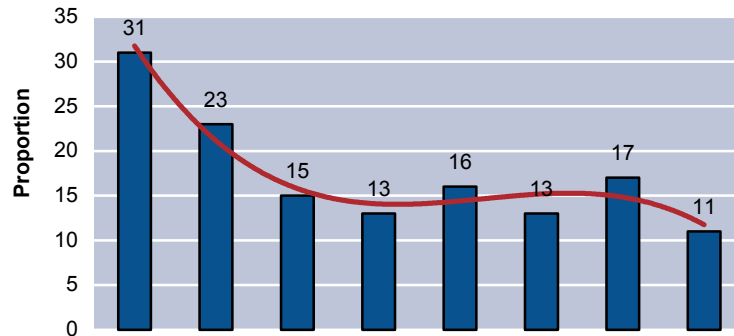
Figure 31: Areas of crime frequently linked to the financing of a drug habit, 1996-2006



Source: Australian Institute of Criminology, *Australian Crime Facts & Figures 2006*, and previous years

Lower supply of heroin also had a positive impact on heroin overdoses. Their number declined by two-thirds between 2000 and 2007, with the biggest decline occurring in 2002 and are currently at the lowest level of the new millennium.

Figure 32: Proportion of recent heroin users in Australia reporting a non-fatal heroin overdose over the 12 months preceding the interview, 2000-07

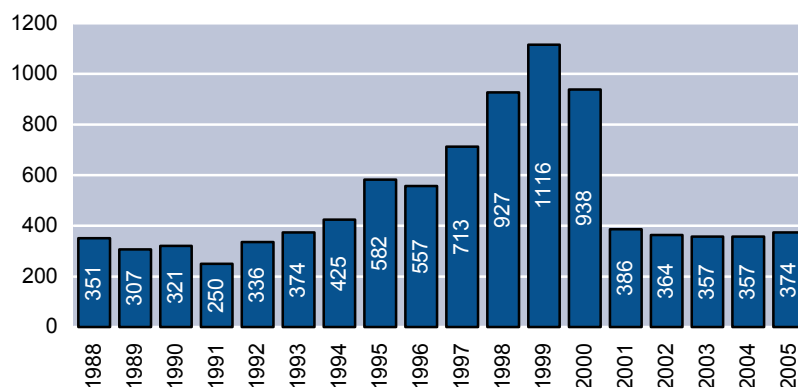


Source: Australian Drug Trends 2007: Findings from the Illicit Drug Reporting System, Sydney 2008

Lower supply also had a positive impact on the number of opiate related deaths, which declined between 1999 and 2001 by 65% and remained at the lower levels in subsequent years. In 2005, opiates related deaths were 66% lower than at the peak in 1999. It must be mentioned, however, that the documented benefits from reduced heroin supply occurred in a setting in which treatment and harm reduction measures were well integrated into the country’s overall drug policy. Thus, treatment places, including places for substitution treatment, were available for opioid dependence and were increased which reduced the severity of some of the potentially negative consequences of rapidly reduced heroin supply.¹²⁷

The Australian Needle and Syringe Program Survey found a low level of HIV among Syringe Program clients which fluctuated between 2% in 1995 to 1.4% in 1999 and 0.9% in 2005 to 1.5% in 2006, Injecting drug use accounted for just 8% of all new HIV diagnoses in Australia in 2005. The development of hepatitis C infections among injecting drug users has fluctuated, falling from 1995/96 (63% among clients) to 1998/99 (49%) but increasing in proportional terms again in subsequent years (61% among clients by 2005/06).¹²⁸ Nonetheless, given the strong decline in the total number of injecting drug users (some 50% between 1998 and 2004), the total number of new hepatitis C infections (of which the majority occurs among injecting drug users) fell in Australia by more than a quarter (from more than 14,000 cases in 1999/2000 to less than 10,000 cases in 2005).¹²⁹

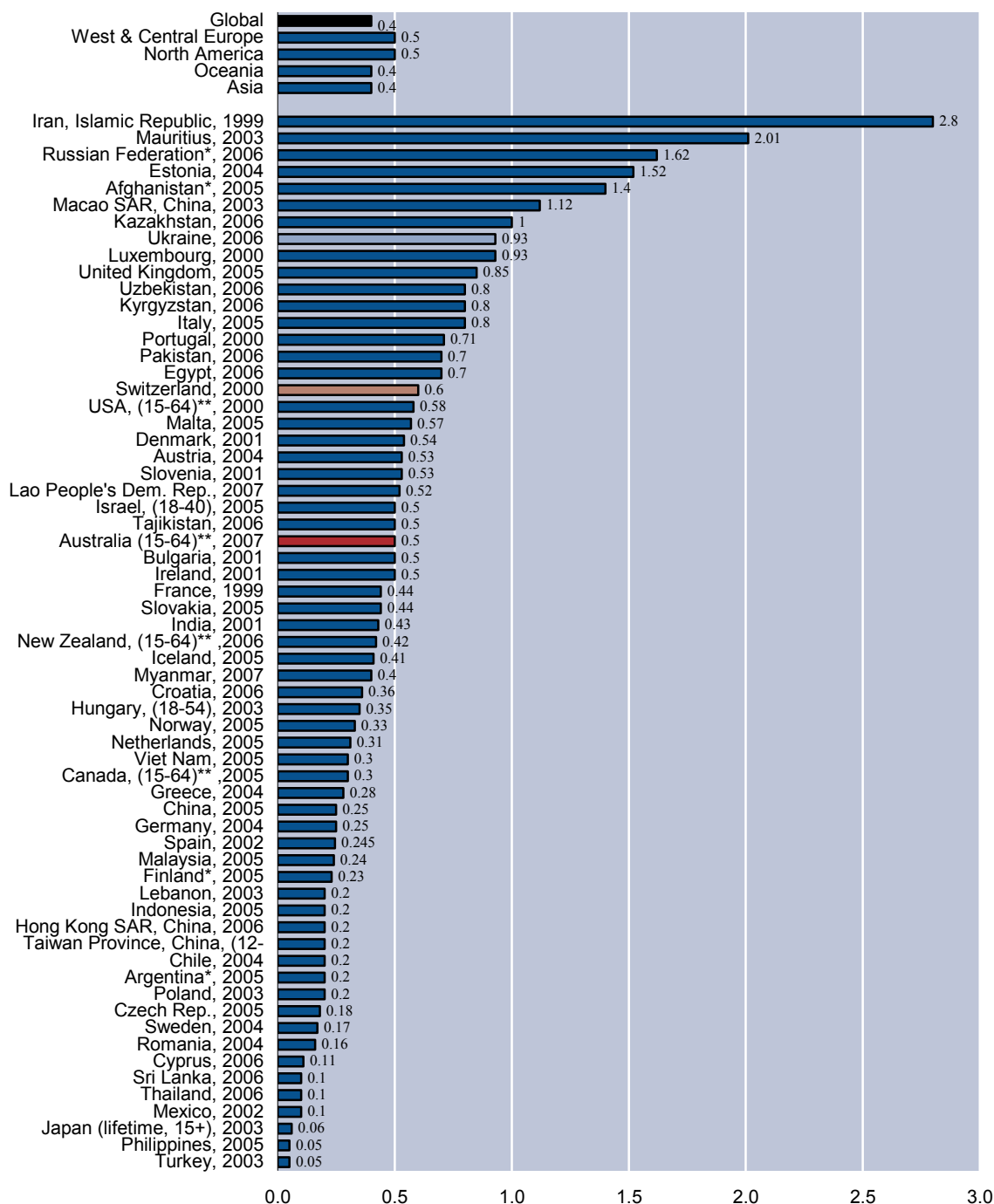
Figure 33: Number of heroin and other opiate related deaths among those aged 15-54, 1988-2005



Source: Source: O'Brien et al. (2007) Australian Drug Trends 2005: Findings from the Illicit Drug Reporting System, Sydney 2006 and L. Degenhardt and A. Roxburgh, 'Accidental drug induced deaths due to opioids in Australia, 2005, Sydney 2007.

Including synthetic opiates, Australia’s overall proportion of opiates use affects 0.5% of the population age 15-54. While Australia used to rank among the highest opiate abusing countries in 1998, its levels are now close to the global average (0.4%) and similar to those of West and Central Europe and North America. The UK (0.9%), for instance, is faced with a more serious heroin problem and levels in the USA are slightly higher (0.6%). Opiate abuse in Japan, Finland and Sweden, in contrast, is, still significantly lower.

Figure 34: Annual prevalence of opiate use in selected countries, standardized for ages 15-64 in 2006/07 or latest year available



*UNODC estimate; ** Age adjusted 15-64 years

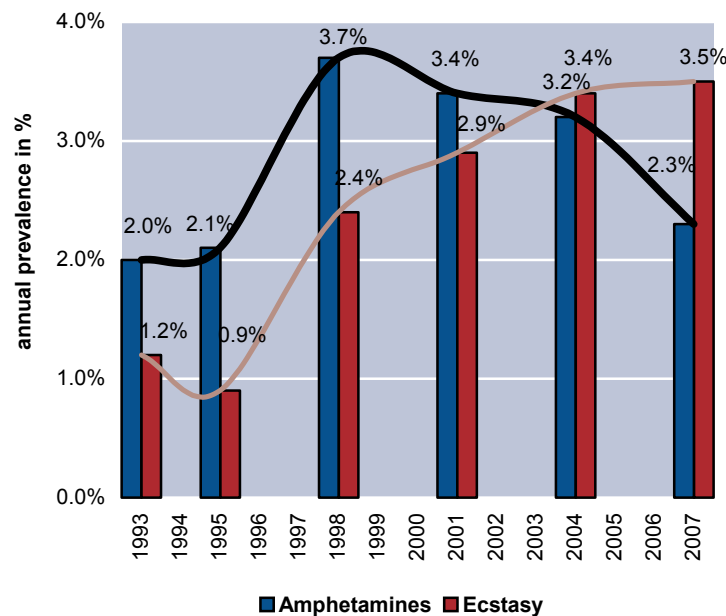
Source: UNODC, 2008 World Drug Report.

Heroin found on the Australian market traditionally originated in South-East Asia and this was also the case during the financial year 2006-07. Embarkation points for South-East Asian heroin have been Viet Nam, Thailand, Malaysia, Cambodia, Hong Kong, Indonesia, Singapore and Macau. Given the reduction of opium production in Myanmar, significant border detections in 2006-07 period also included heroin smuggling from India (facilitated by the emergence of West African criminal networks in that country) with increasing attempts to import Afghan heroin into Australia. Such heroin was shipped to Australia via India, Nigeria, Turkey, Pakistan, Kyrgyzstan and the United Arab Emirates.¹³⁰

4.4. Amphetamine-type stimulants

Australia's second most important group of drugs – in terms of prevalence of use – are the amphetamine-type stimulants, mainly methamphetamine and ecstasy. In terms of treatment demand, ATS are the third most important group of substances after cannabis and heroin.¹³¹ Both methamphetamine and ecstasy use showed – according to the national household surveys - strong increases in the 1990s. While data suggest that amphetamines use has declined notably among the general population (aged 14 years or above) over the 1998-2007 period (-38%), ecstasy use continued showing an upward trend (+46%). If considered together, ATS use since 1998 showed, however, a slight decline.

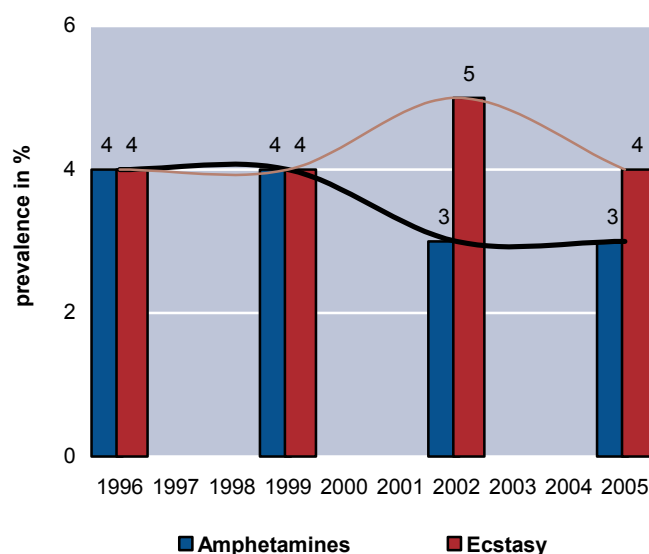
Figure 35: Annual prevalence of amphetamines (methamphetamine and amphetamine) and ecstasy use in Australia, among the population, age 14 and above, 1993-2007



Sources: AIHW, 2007 National Drug Strategy Household Survey

The decline of amphetamines use among the general population is also reflected in results from student surveys. Use of amphetamines among the student population (age 12 to 17) declined from a life-time prevalence of 4% in 1999 to 3% in 2005. Past month prevalence declined from 3% to 2% over the same period. A decline was noticed among both male and female students.

In contrast to the increase of ecstasy use among the general population until 2004 school surveys only show an increase until 2002. This was followed by a decline (from a life-time prevalence of 5% in 2002 to 4% in 2005), mainly reflecting a reduction of ecstasy use among female students. Ecstasy use remained stable among male students. Past month prevalence of ecstasy use among all students (male and female) remained unchanged at 2% over the 1999-2005 period.

Figure 36: ATS use among secondary school students (age 12-17) in Australia, 1996-2005

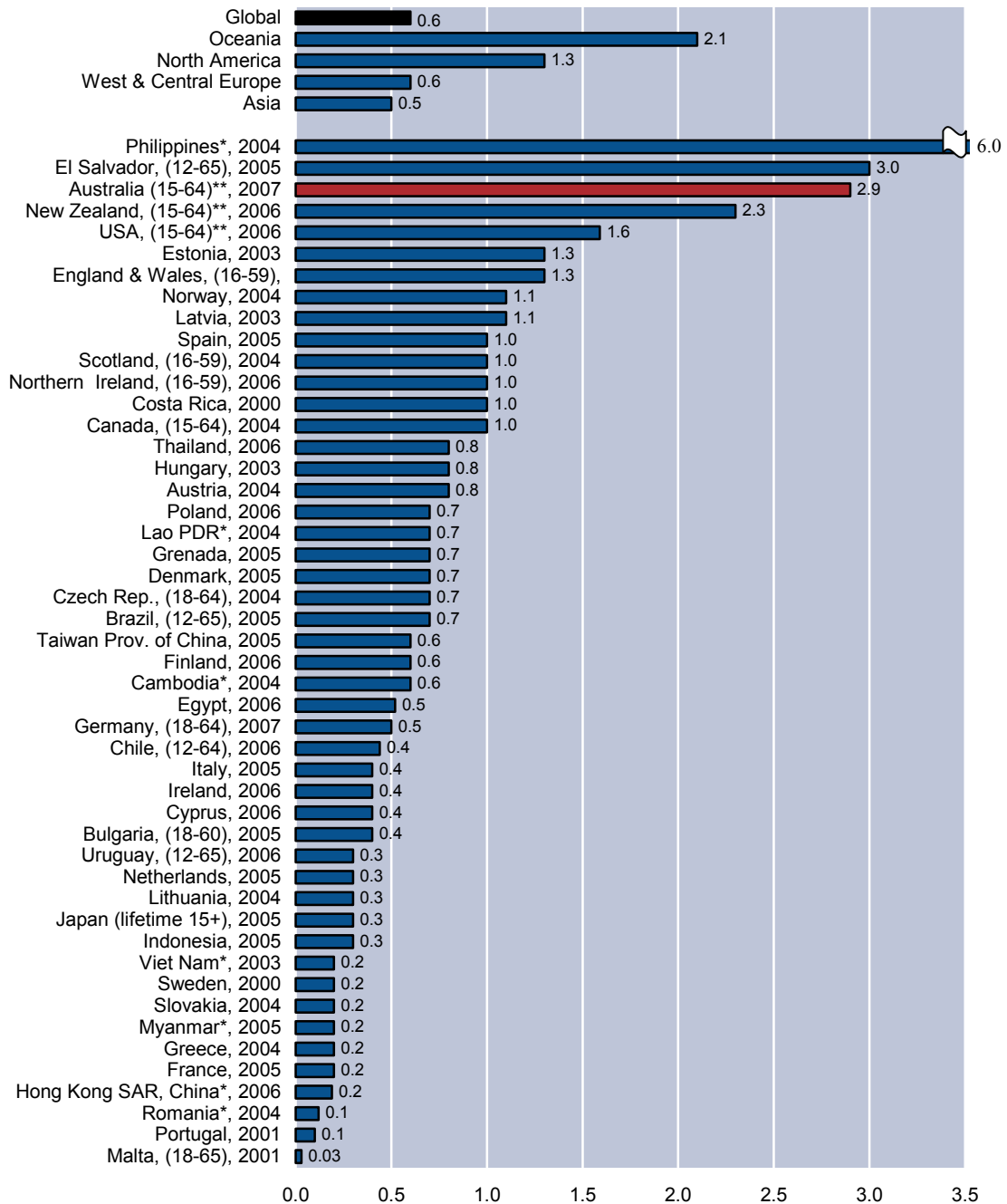
Source: The Cancer Council of Victoria, *Australian secondary school students' use of over-the-counter and illicit substances in 2005, June 2006*

Use levels of amphetamine-type stimulants are, however, high by international standards.²¹ In particular, the extent of methamphetamine use is high in Australia which prompted the authorities, *inter alia*, to hold a national forum to address the methamphetamine problem in the country in December 2006. Significant government funding has since been dedicated to developing ATS prevention packages, treatment programs and improvements of ATS monitoring trends.¹³²

Australia's annual prevalence of the use of amphetamines for the population age 15-64 is equivalent to 2.9%. This is the third highest rate worldwide after the Philippines (6%), ahead of New Zealand (2.3%) and the USA (1.6%). Australia's prevalence rate is nearly 5 times the global average (0.6%) and far higher than the average in North America (1.3%) or in West and Central Europe (0.6%). Australia's amphetamines use levels are almost three times the current levels reported from England and Wales (1.3%).¹³³

²¹ The statement "high by international standards" needs to be taken in its proper context. Australia is known to have high rates of survey compliance in general and, generally, a population which is familiar and comfortable with participating in surveys. It is likely that, overall, in an international context, surveys are responded to relatively more comprehensively and carefully.

Figure 37: Annual prevalence of amphetamines use in selected countries, standardized for ages 15-64 in 2006/07 or latest year available



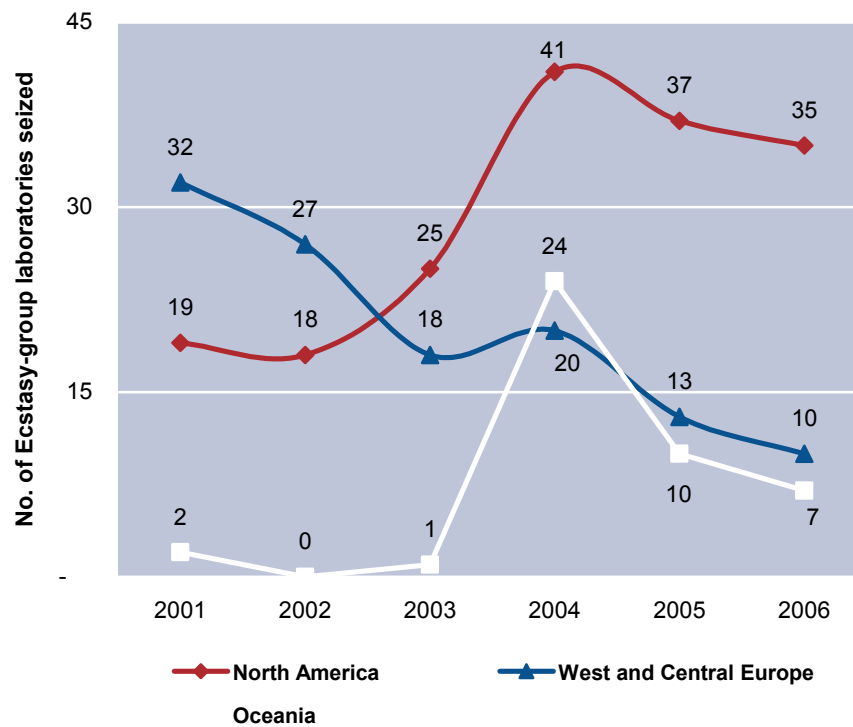
*UNODC estimate; ** Age adjusted 15-64 years

Source: UNODC, 2008 World Drug Report.

Regarding ecstasy use, Australia’s prevalence rate of 4.4% among the population aged 15-64 is the highest worldwide, ahead of the Czech Republic (3.5%) and New Zealand (2.6%), more than twice as high as in England and Wales (1.8%), and four times the level found in the USA (1%) or in West and Central Europe (0.8%).

The increase in ecstasy use may be related to increases noted in domestic manufacture of ecstasy. Beginning around 2003-2004, notable increases were seen in the number of domestic clandestine laboratories, as manufacture in Western Europe (notable the Netherlands and Belgium) declined while concurrently locating closer to consumer markets in Canada and the USA, and Australia.

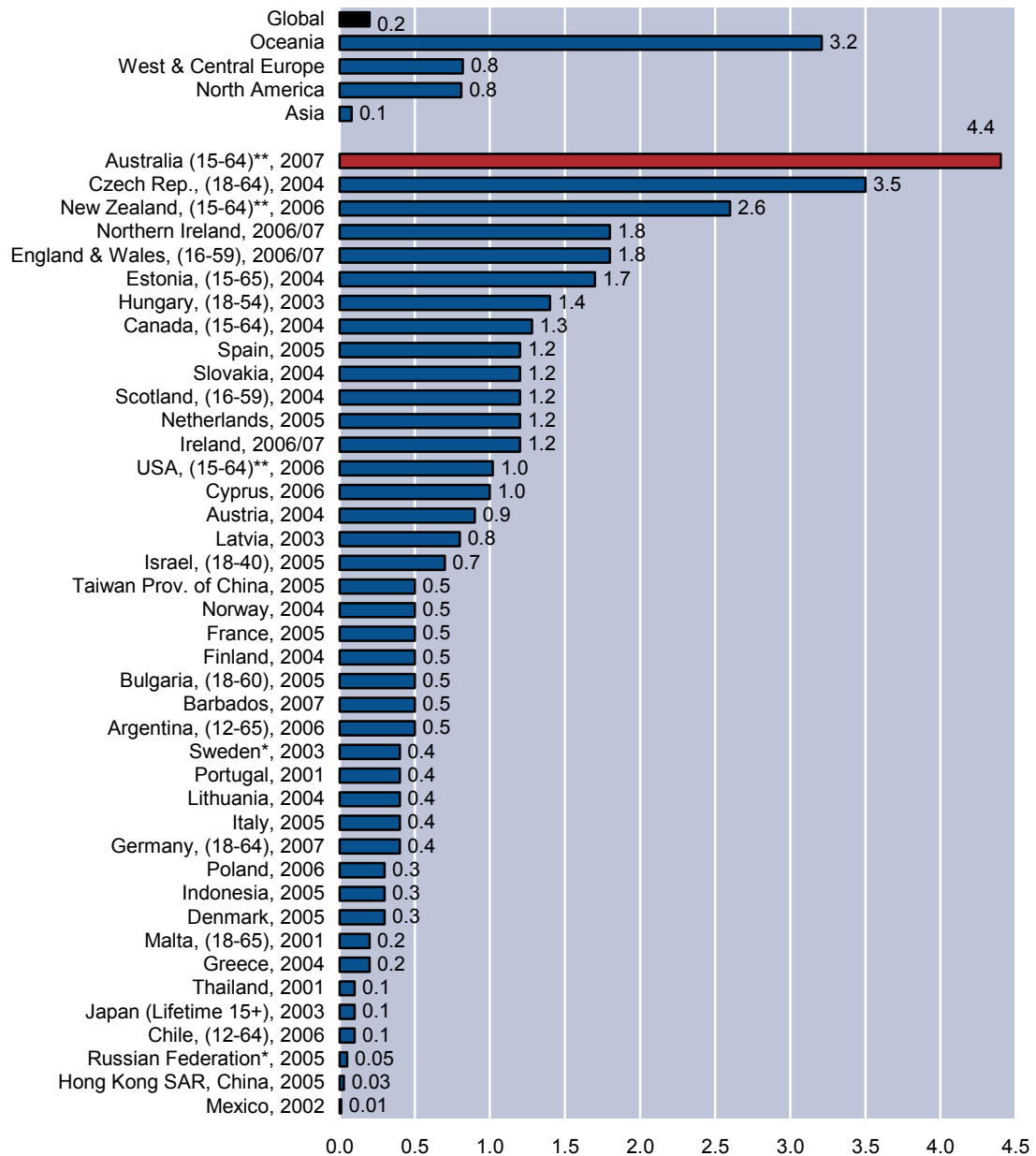
Figure 38: Clandestine ecstasy laboratory seizures by region, 2001 – 2006



Source: UNODC, *Amphetamines and Ecstasy: 2008 Global ATS Assessment*.

However, imported ecstasy still accounts for the majority of consumed ecstasy. In 2006, Australia had the third highest ecstasy seizures globally and accounted for 12% of the world’s total ecstasy seizures, behind the USA (26%) and the Netherlands (24%). For 2007, Australia reported the world’s largest ever ecstasy seizures – 4.4 metric tons, similar to the entire world’s ecstasy seized for 2006. The size and sophistication pointed to the lucrative market for transnational organized crime, but also to the efficacy of the country’s intelligence led policing approach.

Figure 39: Annual prevalence of ecstasy use in selected countries, standardized for ages 15-64 in 2006/07 or latest year available



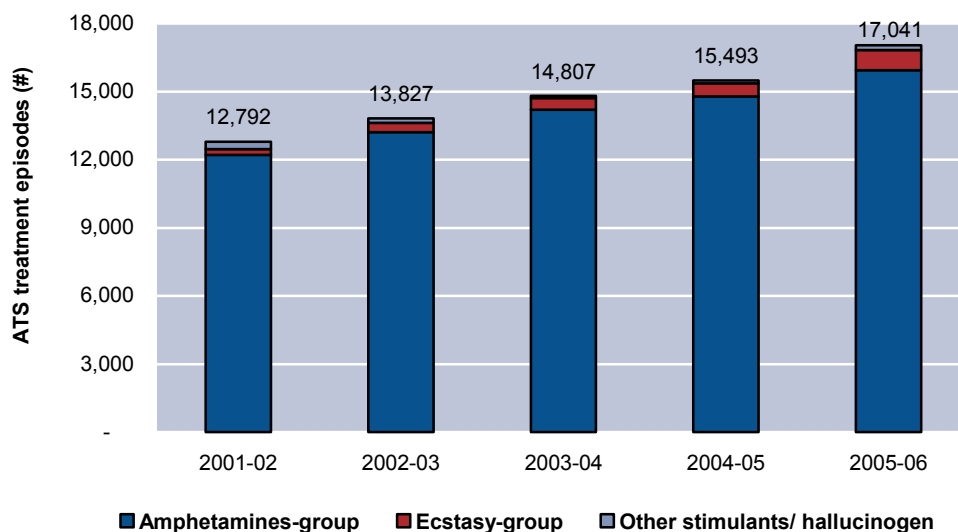
*UNODC estimate; ** Age adjusted 15-64 years

Source: UNODC, 2008 World Drug Report.

There has been an increase in the number of amphetamines related treatment episodes, from 12,211 in 2001/02 to 15,935 in 2005/06, and an even stronger increase in ecstasy related treatment admissions, from 253 to 897 over the same period.²² Expressed as a proportion of all treatment episodes, amphetamines-related treatment remained, however, stable at 11%, or excluding alcohol at 18%; ecstasy-related treatment demand was less than 1% of the total.¹³⁴

²² Treatment for other related stimulant/ hallucinogens remained stable at about 200 cases annually.

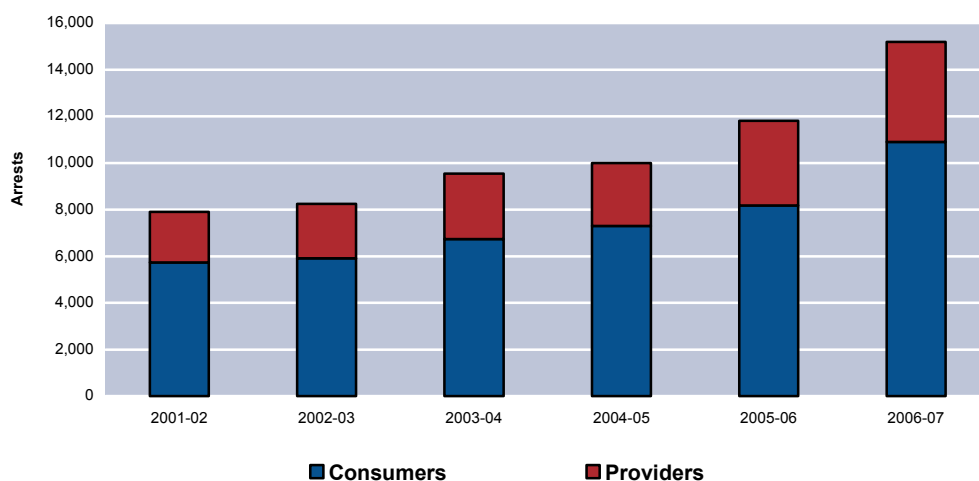
Figure 40: Amphetamine-type stimulant treatment episodes 2001-02 to 2005-06, by type



Source: UNODC, *Amphetamines and Ecstasy: 2008 Global ATS Assessment*.

Arrest data also showed an upward trend for ATS, i.e. amphetamines and ecstasy taken together. The upward trend is among both consumers—who account for about 71% of arrests—and providers. The total number of ATS related arrests amounted to 15,216 in the financial year 2006-07 -- 29% higher than a year earlier and have nearly doubled since 2001-02. The largest number of ATS related arrests took place in Queensland (29% of the total), followed by New South Wales and Victoria (22% each) and Western Australia (20%). Viewed against Australia’s population distribution (Qld 20%; Vic 25%; NSW 33%; and WA 10%), ATS related arrests seem to be particularly high in Queensland and in Western Australia.

Figure 41: Arrests of consumers and providers of amphetamine-type stimulants, 2001/02 – 2006/07



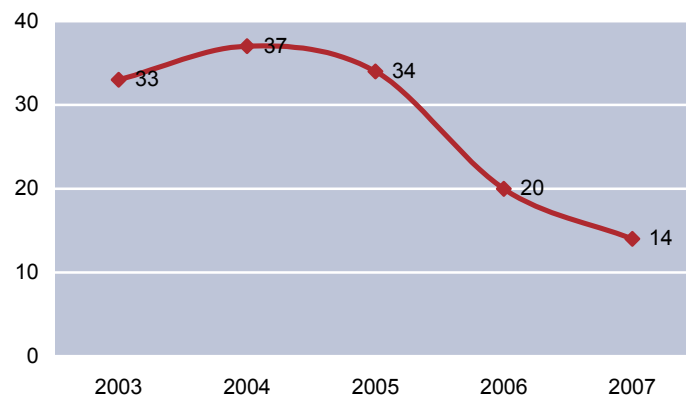
Source: Australian Crime Commission, *Illicit Drug Data Report 2006-07, June 2008 (and previous years)*

Thus, there are indications that overall use of ATS has somewhat decreased since the beginning of the new millennium. The decrease was driven by lower amphetamines use, partially off-set by increases in ecstasy use. Annual prevalence of ecstasy use among the population age 14 and above rose from 2.9% in 2001 and 3.5% in 2007 while use of amphetamines declined from 3.4% to 2.3%.¹³⁵

The quantities of ecstasy consumed by the group of regular ecstasy users also increased. While in 2000 less than 50% of regular ecstasy users in New South Wales consumed more than 1 pill per occasion, the proportion rose to 84% by the year 2007, and 71% nationally. The number of pills taken per occasion increased from an average of 1½ tablets per occasion in 2003 to 2 tablets in 2004, but stabilized thereafter at 2 tablets in 2005-2007.

Data suggest, however, that the frequency of ecstasy use has already surpassed its peak and has started to decline, from 37% of regular ecstasy users using ecstasy on a weekly basis (or more often) in 2004 to 14% in 2007. In parallel, the number of days, on which ecstasy was used, declined among regular ecstasy users from a median of 15 days in 2004 to 12 days in 2007.¹³⁶ Thus, while increases in annual prevalence of ecstasy use were noted in the general population, the frequency of such use has declined, suggesting increasing experimentation but fewer regular users.

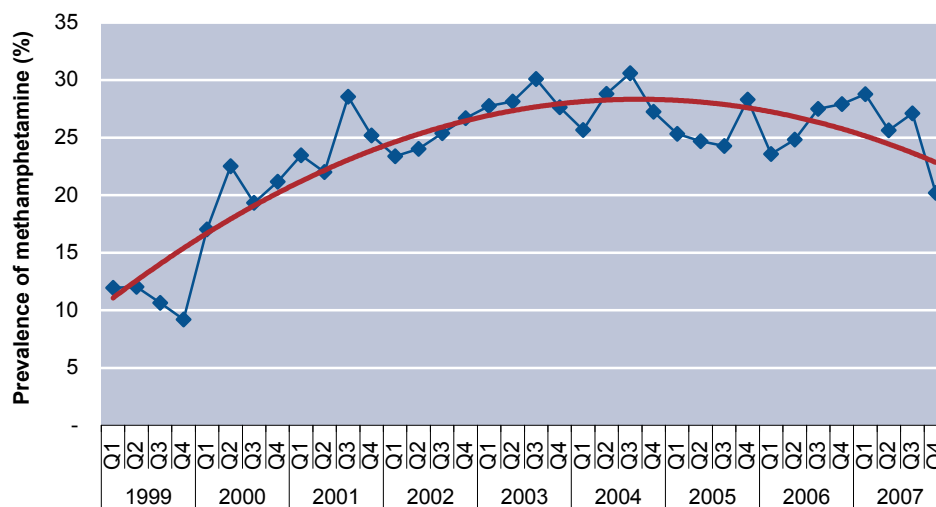
Figure 42: Use of ecstasy: weekly use (or more often) among regular ecstasy users, 2003-07



Sources: NDARC, *Australian Trends In Ecstasy And Related Drug Markets 2007 (and previous years): Findings from the Ecstasy and related Drugs Reporting System (EDRS)*, 2008.

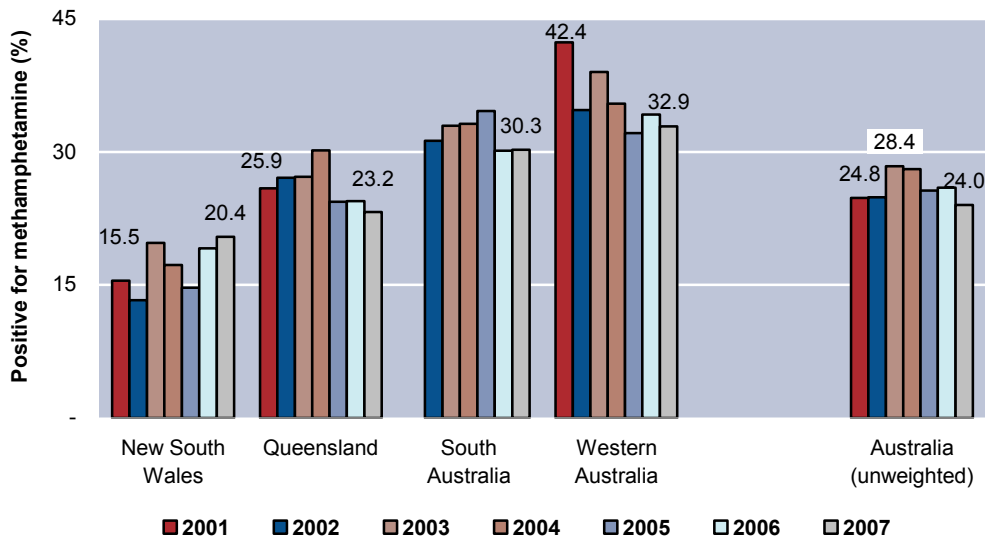
The trends towards stabilization and subsequent decline can also be seen with arrestees. The Drug Use Monitoring Data (DUMA) indicate that the percentage of detainees testing positive for methamphetamine increased until 2003. Thereafter it stabilized and began showing a small decline.¹³⁷

Figure 43: Detainees testing positive to methamphetamines in Australia*, 1999-2007



* unweighted average of results from Western Australia (East Perth), South Australia (Adelaide and Elizabeth), New South Wales (Parramatta and Bankstown (Sydney)) and Queensland (Brisbane and Southport).
Source: Australia Institute of Criminology, *Drug Use Monitoring in Australia (DUMA)*.

Figure 44: Detainees testing positive to methamphetamine in Australia*, 2001-2007

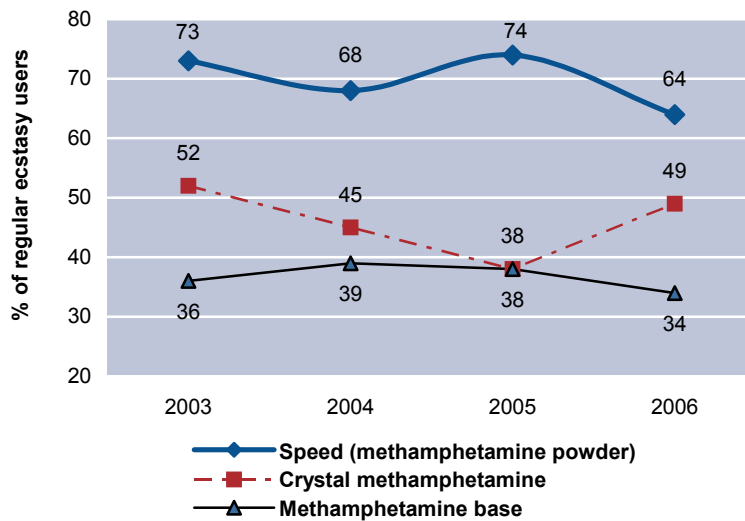


* unweighted average of results from Western Australia (East Perth), South Australia (Adelaide and Elizabeth), New South Wales (Parramatta and Bankstown (Sydney)) and Queensland (Brisbane and Southport).

Source: Australia Institute of Criminology, Drug Use Monitoring in Australia (DUMA).

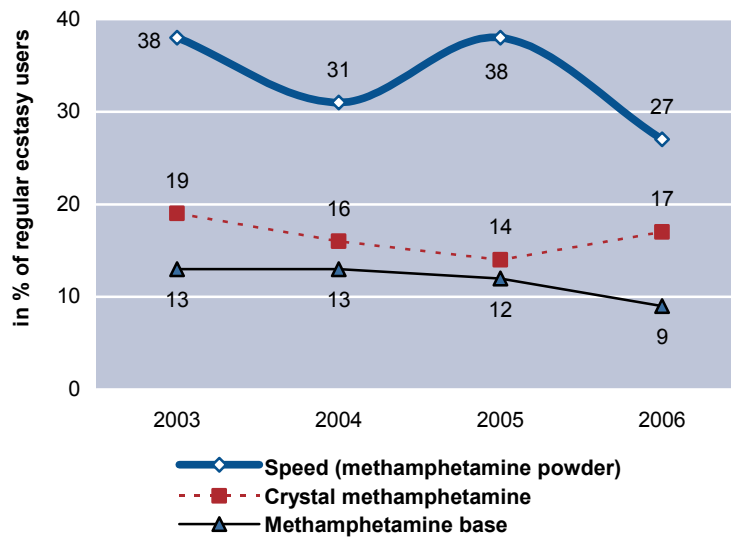
Similarly, data collected among regular ecstasy users showed a decline of methamphetamine use between 2003 and 2006. This applied to all forms of methamphetamine consumption, irrespective of whether the question related to the use of such substances over the last six months prior to the survey, or to the use by poly-drug users. The downward trend became more pronounced in 2006 for ‘speed’ (methamphetamine powder) and the use of methamphetamine base, while crystal methamphetamine showed upwards. The latter could reflect increasing imports of this substance from East Asia and declining local production of methamphetamine. However, poor awareness of these substances by users may mean that other forms of ATS are being sold as crystal methamphetamine, which would case some doubt on the reliability of self-reporting of crystal methamphetamine use.

Figure 45: Methamphetamine use during previous 6 months among regular ecstasy users, 2003-2006



Sources: NDARC, Australian Trends in Ecstasy and related Drug Markets 2006 (and previous years): Findings from the Ecstasy and related Drugs Reporting System (EDRS).

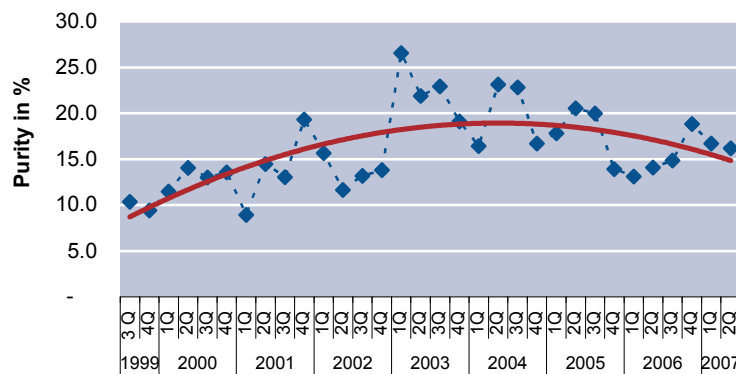
Figure 46: Methamphetamine usually used in combination with ecstasy as a percentage of regular ecstasy users who also consume other drugs, 2003-2006



Sources: NDARC, *Australian Trends in Ecstasy and related Drug Markets 2006 (and previous years): Findings from the Ecstasy and related Drugs Reporting System (EDRS)*.

Such a trend is also reflected in purity data. Overall methamphetamine purity, as analyzed by the forensic laboratories of the state police forces, showed an upward trend from 10% over the last two quarters of 1999 to 23% in 2003, followed by a downward trend in subsequent years to 16% over the first two quarters of 2007.¹³⁸ As traffickers often adjust the purity by adding more or less adulterants depending on market conditions, purity data are, in general, a good indicator for underlying changes in the supply structure. Purity data thus suggest that supply of methamphetamine increased until 2003 before gradually falling again until 2006. In parallel, the unweighted average price of methamphetamine increased slightly, from AUD\$169 per gram (street purity) in 2003 to AUD\$209 in 2006, also suggesting that supply has started to decline. Significant price increases were reported, *inter alia*, from Queensland - for many years the largest methamphetamine producing jurisdiction of Australia - rising from AUD\$80 per gram (street purity) in 2000 to AUD\$200 per gram in 2006.¹³⁹ The median purity of analyzed seizures amounted to 29% in Queensland in 2000 far higher than in any other jurisdiction at the time; by 2005 it had fallen to 17% and by 2006 to 10% (first two quarters), suggesting that methamphetamine production in Queensland is increasingly facing difficulties. Higher purity levels are now reported from Western Australia (20%), Victoria (16%) and South Australia (15%).¹⁴⁰

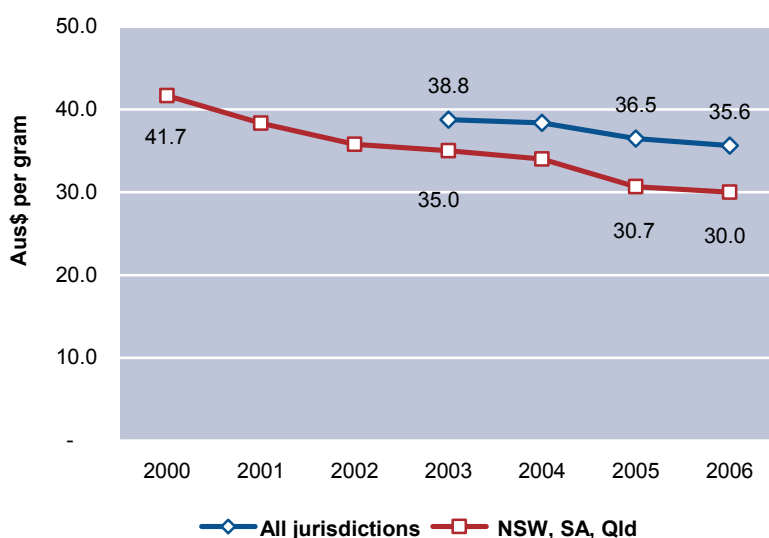
Figure 47: Average methamphetamine purity in Australia*, 1999-2007



* Unweighted average of median purities of methamphetamine per jurisdiction reported by state police.
 Source: UNODC calculations based on Australian Crime Commission, *Illicit Drug Data Report 2006-07*, June 2008 and previous years

Ecstasy prices, as reported by the ‘Ecstasy and Related Drugs Reporting System’ (EDRS), showed a decline by some 28% over the 2000-2006 period which lost, however, momentum in 2006.¹⁴¹ Ecstasy purity data, as analyzed by the forensic laboratories of the state police forces, showed a basically stable level since 2002. Thus, price data in combination with purity data suggest that supply of ecstasy grew until 2005 before stabilizing in 2006 followed by slight declines into 2007. Over the July 2006-June 2007 period, reported purity levels of ecstasy seized ranged from 0.1% to 95.5%. The low proportion of MDMA in some samples could also reflect the fact that other substances than MDMA, such as methamphetamine and/or ketamine, are sometimes sold in tablet form as ‘ecstasy’ in Australia. For example, PMA (para-methoxyamphetamine) reappeared in ecstasy tablets in Australia in 2007, and has historically been associated with a number of deaths in that country. Median purities of ecstasy have been rather similar across the jurisdictions, ranging from 23% in South Australia to 30% in New South Wales over the July 2006-June 2007 period.¹⁴²

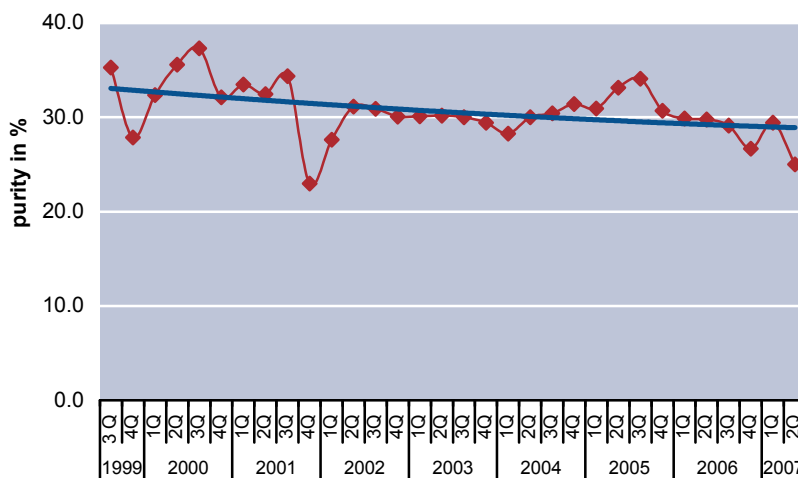
Figure 48: Average ecstasy price in Australia*, 2000-2006



* Unweighted average of reported median prices across jurisdictions.

Source: UNODC calculations based on NDARC, Australian Trends in Ecstasy and Related Drug Markets, 2006. Findings from the Ecstasy and Related Drugs Reporting System (EDRS), Sydney 2007.

Figure 49: Average ecstasy purity in Australia*, 1999-2007



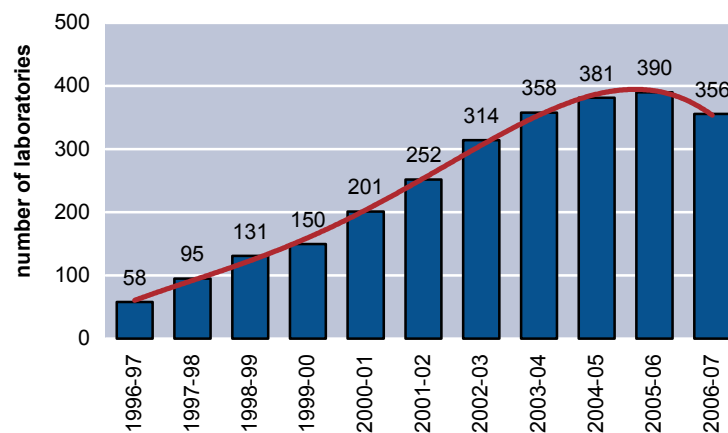
* Unweighted average of median purities of ecstasy per jurisdiction reported by state police.

Source: UNODC calculations based on Australian Crime Commission, Illicit Drug Data Report 2006-06, May 2007 and previous years

Supply of amphetamines is dominated by domestic clandestine production, primarily of methamphetamine. A pre-requisite for such manufacture is the availability of precursor chemicals, notably pseudoephedrine and/or ephedrine. In the past these precursors were smuggled into Australia from South-East Asia. The precursor chemicals typically originated in China. In recent years, precursor chemicals have also been supplied through over-the-counter purchases of pharmaceuticals containing pseudoephedrine. However, controls have improved in recent years, and in 2006 the sale of such pharmaceutical preparations in 2006 became restricted.

This seems to have had a positive impact and led to a stabilization of the market. The number of detected and dismantled clandestine laboratories, which had increased in recent years, showed signs of a stabilization in 2005/06. The total number of dismantled laboratories in 2006/07 amounted to 356 of which 347 (97%) were ATS-related.²³ Of those 347, 249 (72%) manufactured exclusively amphetamines, 19 manufactured ecstasy (5%) and 79 were involved in various combinations of amphetamines, ecstasy and precursor production (23%).

Figure 50: Dismantled clandestine laboratories (all types and sizes) in Australia, 1996-2007



Source: Australian Crime Commission, *Illicit Drug Data Report 2006-07*, June 2008 and previous years

The largest number of clandestine laboratories in 2006-07 and in previous years, has been reported from Queensland (37% of the total), followed by Victoria (20%), New South Wales and South Australia (both with 14%), and Western Australia (10%). Viewed against Australia's population distribution (Qld: 20%; WA: 10%; SA: 8%; Vic: 25%) clearly above average detections of labs can be identified for Queensland and South Australia. While increases in lab detections occurred in most States between 1996-97 and 2006-07, the most notable occurred in notably in Western Australia (from 3 to 37), Victoria (from 9 to 72) and South Australia (7 to 50). Compared with the previous year, seized laboratories declined 9%, with substantially fewer laboratories detected in West Australia and Queensland.

The decline in Queensland, confirmed by other indicators, seems to be associated, *inter alia*, with Project STOP, a real-time online recording system that tracks all sales of preparations containing pseudoephedrine¹⁴³ and thus allows pharmacists to see immediately whether the customer has recently purchased (or has been denied the sale of) pseudoephedrine-based pharmaceuticals at other pharmacies. Following the successful trial of Project STOP in Queensland in 2006—which contributed to a 23% decline in clandestine manufacture in that state¹⁴⁴—is now being implemented throughout the country as part of the *National Strategy to Prevent the Diversion of Precursor Chemicals Into Illicit Drug Markets*.¹⁴⁵

Though there are indications of stabilization of domestic methamphetamine manufacture, there is still a threat of methamphetamine imports, notably of crystal methamphetamine from countries in East Asia. As has been stated in official documents, the rescheduling of pseudoephedrine-based

²³ There were 9 reported heroin home-bake laboratories in 2006-07.

products, and the introduction of offences that prohibit the possession of precursor chemicals, is likely to reduce criminal opportunities for the domestic diversion of these products. But, the decreased availability of pseudoephedrine is feared to increase attempts to smuggle the precursors or the finished ATS products into the country.¹⁴⁶

Significant border detection in the financial years 2005-07 included shipments of crystal methamphetamine from Canada to Sydney as well as liquid meth-amphetamine solutions from China to Sydney, from Hong Kong to Sydney and from Hong Kong to Melbourne. In addition, attempts were made to smuggle significant amounts of pseudoephedrine into Sydney from Indonesia and Vietnam.

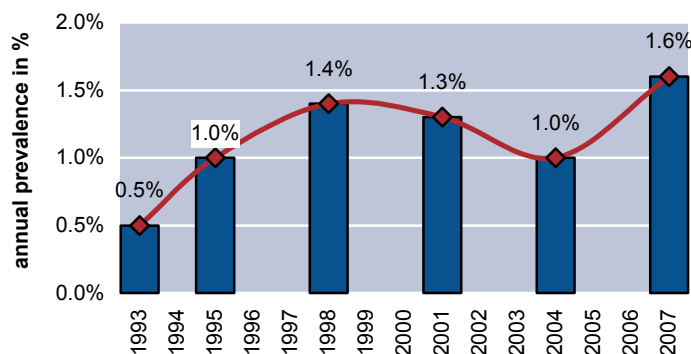
In contrast to methamphetamine, the bulk of the ecstasy continues to be smuggled into the country from abroad. Significant border detections included attempted shipments of MDMA from Canada via Hong Kong to Melbourne and from Belgium to Melbourne. The main countries of embarkation for MDMA shipments in 2005/06, in weight order were Canada and Belgium, followed by the UK and France.¹⁴⁷ More recently, some Israeli groups were caught trying to smuggle huge quantities of ecstasy from Europe into Australia.¹⁴⁸ While in June 2007, authorities seized 4.4 mt of ecstasy - the largest single seizure ever recorded and equal to the total global ecstasy seizures reported for all of 2006 – via a controlled delivery shipped from Italy, resulting in numerous arrests. Given the magnitude of the interception significant increases in ecstasy price and reduction in purity should be seen in the final quarters of 2007 and into 2008. The same criminal organization is also believed to have shipped significant amounts of cocaine into the country.

4.5. Cocaine

Cocaine use showed a strong increase in Australia in the 1990s. This changed in subsequent years. Between 1998 and 2004 the annual prevalence rate of cocaine use amongst people aged 14 years or above fell by 29% according to national household survey data.

However, results from the 2007 national household survey showed a reversal of the downward trend. The annual prevalence of cocaine use among the population aged 14 years and above increased significantly, from 1% in 2004 to 1.6% in 2007. Most of the increase took place in 2007. It appears to have been linked (i) to successes in reducing the supply and the demand for ATS (amphetamines use fell 0.9 percentage points, from 3.2% in 2004 to 2.3% in 2007), prompting some drug users (and potential ATS users) to experiment with cocaine instead, and (ii) to a sudden increase of cocaine supply in Australia. This occurred as the cocaine flow from the Andean countries to the United States, the world's largest cocaine market, got reduced in 2007 due to the increasingly violent fights among the drug cartels in Mexico who control nowadays most of the cocaine trade going to the United States¹⁴⁹. Trafficking groups in the Andean countries were thus investigating alternative outlets, including Western Europe (with trafficking taking place increasingly via countries of Western Africa) and the financially highly lucrative markets in the Oceania region, notably Australia.

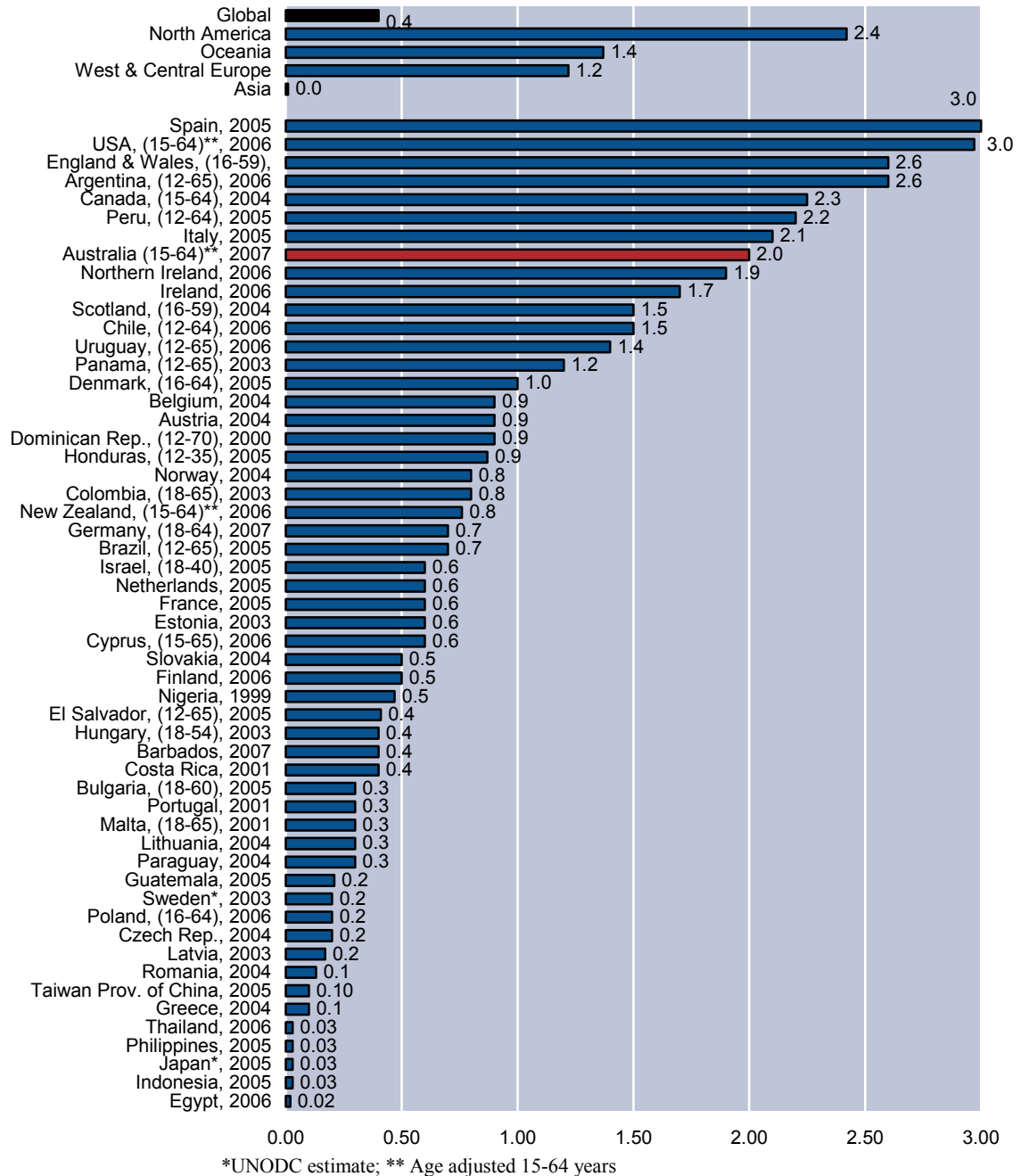
Figure 51: Annual prevalence of cocaine use in Australia, among the population, age 14 and above, 1993-2007



Sources: AIHW, 2007 National Drug Strategy Household Survey.

Expressed as a percentage of the population standardized to age 15-64, Australia’s current cocaine prevalence rate amounts to 2.0%. Cocaine use in Spain, the USA, England and Wales, Argentina, Canada, Peru and Italy is still more widespread than in Australia. But, cocaine use in Australia is far more widespread than in neighbouring New Zealand (0.8%), higher than the global average (0.4%) and higher than the average of West and Central European countries (1.2%). It is only lower than the average in North America (2.4%).

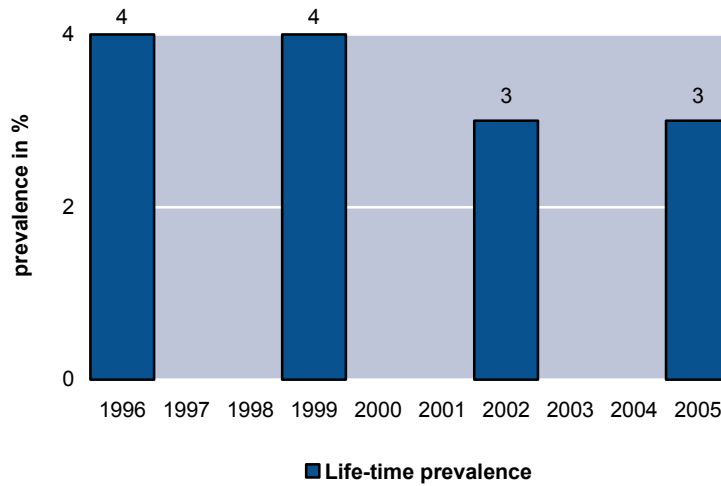
Figure 52: Annual prevalence of cocaine use in selected countries, standardized for ages 15-64 in 2006/07 or latest year available



Prior to 2007, all available data signalled declines in cocaine use. Thus, school survey data among students age 12-17 showed a decline in lifetime prevalence of cocaine use from 4% in 1999 to 3% in 2005. Use of cocaine among Australian students was found to be considerably lower than in the United States (5.6%, on average among 8th, 10th and 12th graders in 2005). However the substantial

increase of cocaine use in the general population occurring since 2006 may potentially result in increased youth uptake as well.¹⁵⁰

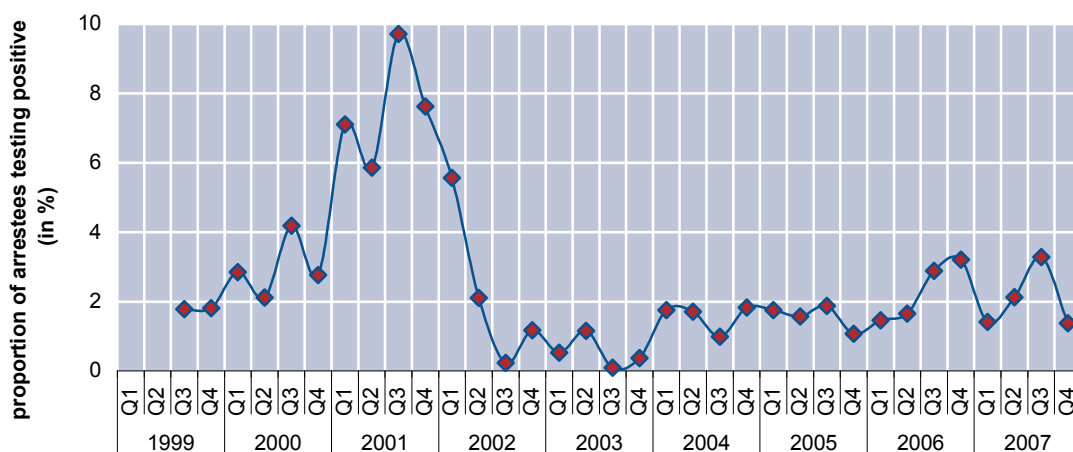
Figure 53: Cocaine use among secondary school students (age 12-17) in Australia, 1996-2005



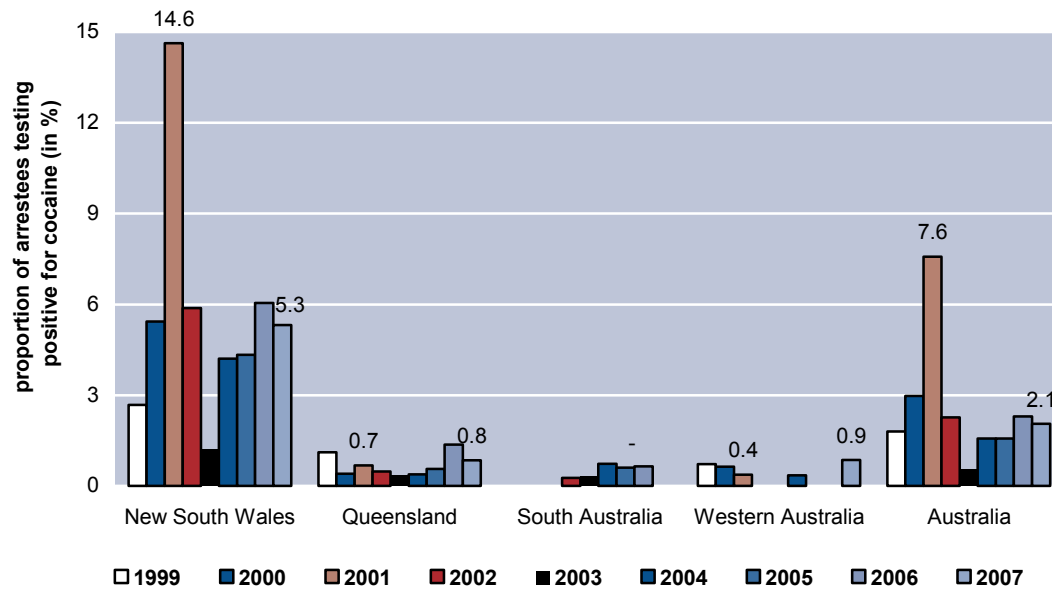
Source: The Cancer Council of Victoria, Australian secondary school students' use of over-the-counter and illicit substances in 2005, June 2006

Drug Use Monitoring in Australia (DUMA) data in relation to detainees testing positive for cocaine suggest that, as a consequence of the heroin shortage in 2001, a number of users switched temporarily to cocaine, notably in the two Sydney sites. But, only a few quarters later, cocaine use levels among detainees fell strongly to rather low levels. DUMA data suggest that cocaine use levels are still substantially lower than in 2001 - though they started to show an increase in 2006. DUMA data also suggest that the cocaine market is largely concentrated in Sydney. In most other locations, cocaine use among detainees is still negligible. Overall about 2% of detainees were found to have consumed cocaine in 2007. This was far less than the corresponding ratios for methamphetamine (24%) or for heroin (10%).¹⁵¹

Figure 54: Testing of arrestees for cocaine use in Australia*, 1999-2007



* unweighted average of results from Western Australia (East Perth), South Australia (Adelaide and Elizabeth), New South Wales (Parramatta and Bankstown (Sydney)) and Queensland (Brisbane and Southport). Source: Australia Institute of Criminology, Drug Use Monitoring in Australia (DUMA).

Figure 55: Testing of arrestees for cocaine use in Australia*, 1999-2007

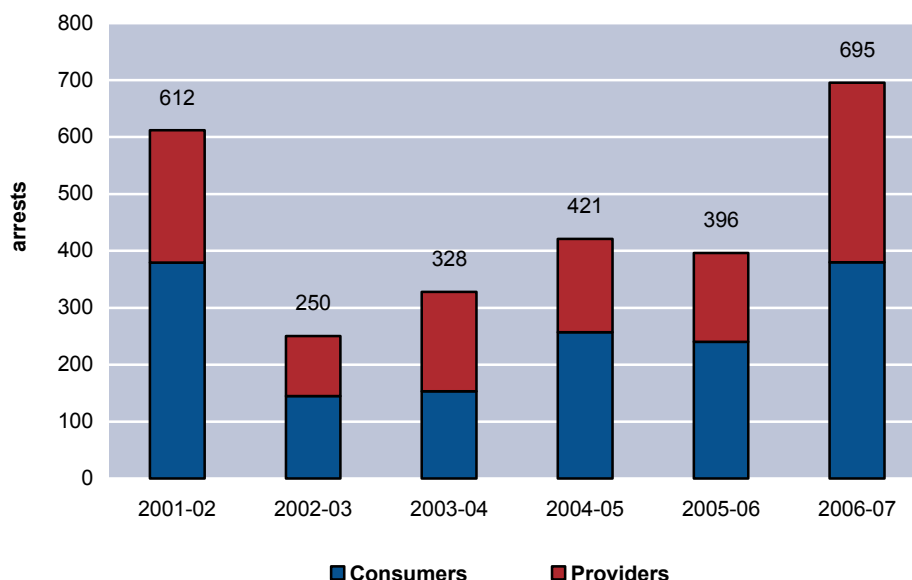
* unweighted average of results from Western Australia (East Perth), South Australia (Adelaide and Elisabeth), New South Wales (Parramatta and Bankstown (Sydney)) and Queensland (Brisbane and Southport).
Source: Australia Institute of Criminology, Drug Use Monitoring in Australia (DUMA).

Cocaine is still far less of a ‘problem drug’ than in the United States and some other industrialized countries, even though annual prevalence rates as such are not low any longer. Available data suggest that cocaine in Australia is primarily consumed by persons that are socially integrated and have a rather high socio-economic status. There is only one major exception. In the Sydney area, cocaine is also injected and used among persons with a low socio-economic status, often unemployed who are involved in sex work, various criminal activities and/or using heroin. Cocaine is also cheaper in New South Wales than in other jurisdictions.

Problematic cocaine use as such remains still limited in Australia. The number of treatment episodes related to cocaine is still low: 434 episodes in 2005/06—the last year data are available—equivalent to less than 1% of all treatment demand. This is in sharp contrast to most other industrialized countries, notably the USA and – starting from lower levels – countries in Europe which have been confronted with rising levels of cocaine use as well as rising levels of cocaine related treatment demand in recent years.¹⁵² In North America, cocaine accounts for 31% of all drug related treatment demand, in Europe for 9% and in Australia for less than 1%. Moreover, cocaine related treatment episodes in Australia declined as compared to 2001/02 (804 episodes). However an increase in the future is likely given the substantial jump in the general population use of cocaine reported for the year 2007.¹⁵³

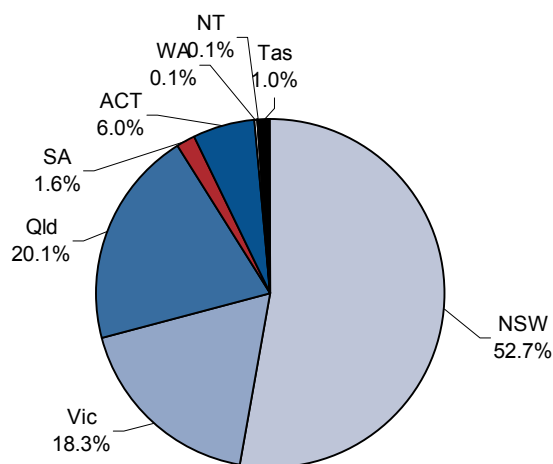
Arrest data show that after a short increase in the financial year 2001-02, cocaine use declined again. However, in 2006-07, cocaine arrests increased by over 75% from the previous year—consistent with the increase in annual prevalence. These were also consistent with the increase in seizures and total weight of cocaine seized at both the border and domestically (more than 600% and 1300% increase over the previous year, respectively). More than half of the total weight of cocaine detected at the Australian border occurred in sea cargo shipments while shipments by post continue to be the most frequently detected method of importation.

Figure 56: Arrests of consumers and providers of cocaine, 2001-2007



Source: Australian Crime Commission, *Illicit Drug Data Report 2006-07*, June 2008 and previous years
 The main arrests related to cocaine occurred in New South Wales (53%) in 2006/07, followed by Queensland (20%) and Victoria (18%).

Figure 57: Regional distribution of arrests of consumers and providers of cocaine, 2006/07



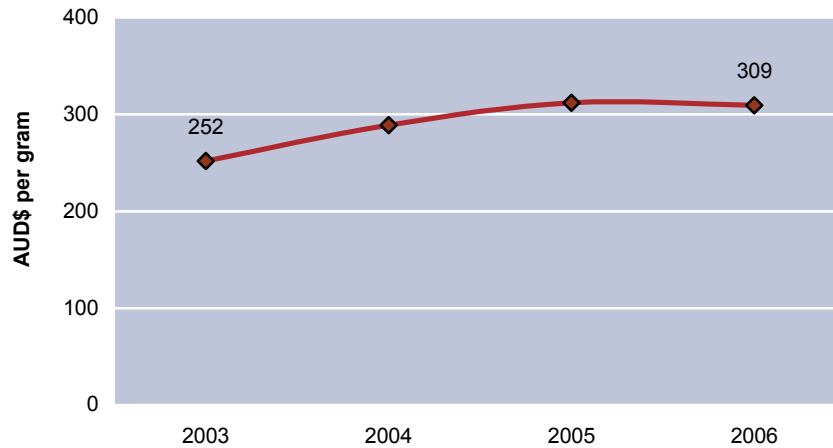
Source: Australian Crime Commission, *Illicit Drug Data Report 2006-07*, June 2008.

Significant embarkation points for cocaine imports into Australia in the financial year 2006-07, listed by weight were: Chile, Canada, the Hong Kong SAR of China, Mexico, the USA, Argentina, Guyana, Brazil, Colombia, Nigeria, Thailand, Costa Rica, the United Arab Emirates and Germany. Methods of importation included sea cargo (350 kg, with 3 notable seizure events over 1 kg), air cargo (204.2 kg, 13 notable events), air passengers (29.6 kg, 11 notable events) and via post (25 kg, 4 notable events).

West African organised crime groups have frequently been involved in the importation of cocaine in postal deliveries, in air cargo as well as by air passengers. The main point of entry for cocaine into Australia is Sydney (New South Wales).¹⁵⁴

Cocaine prices, as reported by ecstasy users, rose over the 2003-2006 period by more than 20% (from AUD\$252 to AUD\$309). Such high prices are an indication that cocaine supply was not abundant prior to 2007. The price increases over the 2003-2006 period are also in sharp contrast to the situation in Europe which experienced ongoing declines in cocaine prices over the last few years, going hand in hand with increases in cocaine consumption.

Figure 58: Average cocaine price in Australia*, 2003-2006



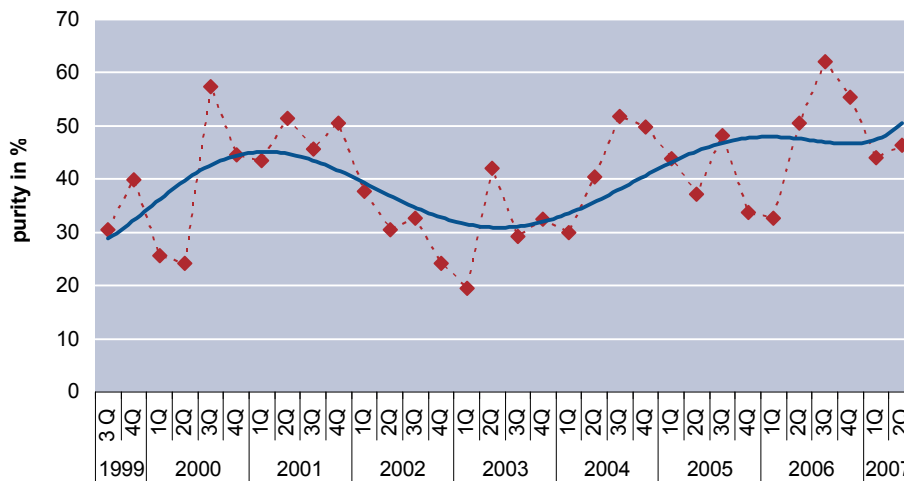
* Unweighted average of reported median cocaine prices across jurisdictions.

Source: UNODC calculations based on NDARC, Australian Trends in Ecstasy and Related Drug Markets, 2006. Findings from the Ecstasy and Related Drugs Reporting System (EDRS), Sydney 2007.

Price increases in Australia were reported across all jurisdictions.¹⁵⁵ Injecting drug users even reported an increase of cocaine prices by 50% in New South Wales over the 2000-2006 period (from AUD\$200 to AUD\$300 per gram).¹⁵⁶ However, prices have remained generally stable (~AUD\$300) over the 2005-2006 period.

Cocaine purity, as analyzed by the forensic laboratories of the state police forces, showed a decline in the first years of the new millennium, followed by increases beginning in 2004. Nonetheless, purity adjusted cocaine prices rose in New South Wales by about a third over the 2000-2006 period.

Figure 59: Average cocaine purity in Australia*, 1999-2007



*Unweighted average of median purities of cocaine per jurisdiction reported by state police.

Source: UNODC calculations based on Australian Crime Commission, Illicit Drug Data Report 2006-07 June 2008 and previous years

The relatively high cocaine prices—cocaine prices are significantly higher in Australia than in Europe or in North America—combined with increased enforcement efforts in North America have made Australia a more tempting and profitable market for cocaine traffickers, partially explaining more recent increases in supply and use. Australia is thus at risk of becoming a significant market – though past experience has shown that the Australian authorities have found ways and means to prevent this.

5. CONCLUSIONS

Australia, like many other industrialized countries, has faced a strong increase in the use of illicit drugs since the late 1960s. Initial responses to the problem, which concentrated primarily on law enforcement activities, did not prove particularly successful.

Subsequent policies of harm reduction – pursued since the mid 1980s, were successful in keeping HIV/AIDS rates low but failed to limit the increase in drug abuse in the 1990s. Australia emerged with one of the highest levels of drug consumption worldwide. All of this was disturbing as Australia had been successful in reducing alcohol and tobacco consumption and many of its economic and social welfare indicators were improving (rapidly improving scores on the human development index, high levels of economic growth, falling levels of unemployment etc.).

The upward trend in drug use changed following the implementation of the *National Illicit Drugs Strategy “Tough on Drugs” (1997)* as of 1998. The basic elements of the policy, as reflected in the *National Drug Strategic Framework (1998/99 – 2002/03)* and the subsequent *National Drug Strategy - Australia’s Integrated Framework (2004-2009)* had not changed much with harm minimization remaining the key concept. The strategy strengthened supply and demand reduction activities, improved and clarified community messaging, and increasingly built on research and evaluations to guide policy development. In parallel, the establishment of the Australian National Council on Drugs helped to incorporate the know-how of the community of experts working in the various fields of drug control at the federal level and in the various States. Significantly, it helped to substantially increase the overall drug budget for the implementation of the Federal Australian Government’s strategy (AUD\$1.3 billion over the 1998-2005 period). The total anti-narcotics budgets of the national and state governments was estimated at AUD\$3.2 bn in the fiscal year 2002/03, equivalent to 0.41% of GDP (up from some 0.1% of GDP a decade earlier), one of the highest such proportions among the industrialized countries (almost three times as much as the West European average (0.15%) and close to the ratios reported from the USA (0.47%). Australia also experimented successfully with rather broad powers of the police and the establishment of drug courts.

The results achieved in recent years have overall been impressive. Overall drug use declined by 40% between 1998 and 2007; cannabis use fell by 38%; use of amphetamines fell by 38%; and heroin use fell by 75%. The number of heroin related overdoses fell by half and the number of opiate related deaths declined by two thirds. In addition to improved treatment and prevention activities, the targeted reduction of supply, notably for heroin and methamphetamine, contributed to this success. There have been, however, also some problems. Ecstasy use continued showing an upward trend, from an annual prevalence rate of 2.4% in 1998 to 3.4% in 2004 and 3.5% in 2007. Cocaine use increased slightly over the 1998-2007 period, from 1.4% to 1.6%, but it rose significantly as compared to 2004 (1%) as internationally operating drug traffickers started to target the lucrative Australian market. The increase of cocaine use over the 2004-2007 period by 0.6 percentage points was, nonetheless, lower than the decline by 0.9 percentage points reported for the use of amphetamines (mostly methamphetamine).

Australia developed a balanced policy mix of demand and supply interventions and seems to have succeeded in implementing harm reduction interventions that are not misinterpreted as being soft on drugs. The Australian Government’s, *National Illicit Drugs Strategy “Tough on Drugs” (1997)*, announced a decade ago led to the clarification that drug production, trafficking and use should be addressed decisively. At the same time, Australia continued with many of its pragmatic harm reduction policies. This combination seems to have contributed to overall harm minimization. One particularly interesting feature in this regard is Australia’s strong reliance on research and the systematic incorporation of research findings in policy formulation, reflecting the view that in the long-run only sound evidence-based policies will result in progress.

Drug use levels are still high in Australia by international standards. But the situation is less alarming than a decade ago. Australia is on the right track. The declines in drug use among the general population, and in particular the ongoing declines of drug use among secondary students are encouraging signs, clearly showing that prevention activities, if supported by law enforcement interventions and built on research, can be successful and that a close cooperation with all sectors

of society can make a change. The bi-partisan orientation of Australia's drug policy (resulting from different political controls at the state and the federal level) also appears to have been an important element in this regard, combining both progress and continuity. The new Australian Government, elected in late 2007, has the opportunity to build on the experiences and successes of previous administrations, at both the state and the federal level.

ENDNOTES:

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- ¹¹ Stephen Milgate (The Australian Doctors' Fund), "Challenging Orthodoxy in Australian Drug Policy", The International Drug Prevention Symposium, University of New South Wales, Sydney, 13-14 July 1998. http://www.adf.com.au/archive.php?doc_id=13
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- ¹⁴ R. MacKay, *National Drug Policy: Australia*, prepared for the Senate Special committee on Illegal Drugs, 20 December 2001.
- ¹⁵ Jennifer Norberry, "Background Paper 12, 1996-97, Illicit Drugs, their Use and the Law in Australia, Parliament of Australia", Parliamentary Library, May 1997. <http://www.aph.gov.au/library/pubs/bp/1996-97/97bp12.htm>
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