Chapter 1

Introduction

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Overview

1. This chapter provides an introduction to drug use in Australian society.
2. Drugs are psychoactive substances and include alcohol, tobacco, heroin, cocaine, cannabis, methamphetamine, LSD and ecstasy (MDMA) to name a few.
3. We are reminded that drug use has occurred over millennia and there are many reasons that people consume drugs. These include for pleasure, to manage aspects of living, to manage emotions, to reduce pain, to increase a sense of belonging, to expand consciousness, and/or to counteract the effects of another drug.
4. While most drug use is not harmful, there are harms associated with more intensive drug use. These include health, social and economic consequences. Harm can also vary for different parts of Australian society, and we summarise issues for specific sub-populations, such as young people, Indigenous populations, women, elderly people, those from culturally and linguistically diverse backgrounds, and others.
5. Terminology matters, and many terms used to describe drug use and the people who use drugs can be stigmatising. Terms such as 'addict', 'alcoholic' and 'injecting drug user' are not benign and can result in discrimination, stigma and prejudice.

6 What should society do about drug use and harms? In Australia, harm minimisation is the overarching policy goal, and it comprises three pillars: supply reduction, demand reduction, and harm reduction. There are many ways governments and the community try to prevent or reduce drug-related harms: in supply reduction through laws and regulations, in demand reduction through drug treatment and prevention programs, and through specific harm reduction strategies.

7 This chapter concludes with an overview of the rest of the book, covering the history of drug use (Chapter 2), the rates of drug use in Australia (Chapter 3), the frameworks and governing images of drug use (Chapter 4), drugs in popular culture (Chapter 5), drugs and the internet (Chapter 6), prevention responses (Chapter 7), harm reduction responses (Chapter 8), the pharmacology of drugs (Chapter 9), psychological treatment responses (Chapter 10), laws and regulation (Chapter 11), policing (Chapter 12) and finally policy development (Chapter 13).

Key terms and concepts

- What drugs are being used by whom
- Why people use drugs
- Only some drug use is harmful
- Terminology can create stigma
- Society responds to drug use in a variety of ways – some are effective

Introduction

This book brings together and outlines all the relevant concepts, theories and practices pertinent to understanding alcohol and other **drug** use in Australian society. This introductory chapter provides an overview of some basic **drug use** issues prior to more in-depth analyses in subsequent chapters. It explores the benefits of drug use, including use for pleasure, to help cope with stress and to provide a sense of belonging. It also considers the short- and long-term harms associated with drug use (including **dependence** for a small proportion of people who use drugs) and introduces the reader to some of the societal responses or controls designed to prevent or reduce drug-related harm.

Drug use is not new. It has been a widespread phenomenon in most societies for at least the last 10 000 years (see Chapter 2 for discussion of the history of drug use). Over time, cultural differences have influenced the kinds of drugs used and the ways they are taken in different societies. They clearly provide benefits, but are also associated with a wide range of health and social problems.

Box 1.1

What do we mean by 'drugs'?

'Drugs' include:

- alcohol
- tobacco
- cannabis (dope, hash, pot, weed, reefer, ganja)
- heroin (smack, junk, H, dope)
- methamphetamine and amphetamine (meth, crystal, speed, ice, base, whiz, goey)
- **MDMA** (ecstasy, E, pills, eccy)
- **LSD** – lysergic acid diethylamide (trips, acid, blotters)
- cocaine (coke, charlie, blow)
- **new psychoactive substances** (NPS), such as **synthetic cannabinoids** (brand names include **Kronic**, **Spice**, Northern Lights), synthetic cocaine (alpha-PVP, bath salts), and others like **mephedrone** (meow meow), cathinone (flakka) and N-methoxybenzyl (**NBOMe**)
- **khat** (qat, kat, chat)
- **pharmaceutical drugs**, developed to treat medical conditions and symptoms but known to be sometimes misused, such as barbiturates (barbs, blockers, sleepers), benzodiazepines (benzos, downers, tranx, moggies, normies), analgesics like codeine, ibuprofen, paracetamol, methadone and other **opioids** such as fentanyl and morphine, and dexamphetamine (dexies, uppers)
- **GHB** – gamma hydroxybuterate (also incorrectly called grievous bodily harm, G, fantasy)
- inhalants, such as amyl nitrate (amyl, poppers), aerosols, paint and petrol
- ketamine (special K, K)
- other **hallucinogens**, such as PCP (angel dust), psilocybin (magic mushrooms, shrooms, mushies), mescaline (cactus, buttons, peyote).

These drugs are all '**psychoactive**'; that is, they are mood-altering because they can change the way we think, feel or act. **Psychoactive substances** interact with the function of our central nervous system, comprising the brain and spinal cord, and change subjective experience, behaviour, or both (Muller & Schumann, 2011).

This list is not comprehensive, and cannot be. There are new and emerging substances all the time (European Monitoring Centre for Drugs and Drug Addiction, 2016a) and our internet-saturated environment has provided another platform for development, sale and discussion about drugs, as detailed in Chapter 6.

In general, drugs are classified as legal (licit), such as alcohol and tobacco, or as illegal (illicit), such cannabis, heroin, or cocaine. There is also a group of drugs that are legal, but are used for nonmedical purposes: pharmaceutical medications, particularly pharmaceutical opioids (see Chapter 9).

The classification of drugs as legal or illegal is not especially related to the level of harm that can result from their use or the potential for dependence (see Chapter 11 for more discussion on this point).

In Australia we have demonstrated great propensity to consume a range of psychoactive drugs (see Chapter 3 for details about drug use rates). Many of us use drugs as part of our day-to-day lives: caffeine is a psychoactive drug and present in tea and coffee as well as cola drinks and most chocolate, so it is likely that there are very few people in this country who do not consume some sort of psychoactive drug on occasion.

Around 80% of Australians consume some alcohol each year (Australian Institute of Health and Welfare, 2014). The National Health and Medical Research Council (NHMRC) has developed guidelines for what is considered risky drinking (NHMRC, 2009). The NHMRC guidelines stipulate that lifetime low-risk levels include drinking up to two **standard drinks** per day. In relation to risk of injury, the NHMRC guidelines stipulate people should drink no more than four standard drinks on any single occasion. Among people who drink, around 28% of men and 10% of women drink at risky levels. Despite these high rates of risky drinking, alcohol consumption has been decreasing in Australia. A decline in consumption that was evident from the mid-1970s reached a plateau by around 1990 and, according to published estimates for Australia from the Australian Bureau of Statistics (ABS), increased through to 2007 and now has started to decline again. This decline has been driven largely by changes in alcohol consumption among young people (Livingston, 2014; Livingston & Dietze, 2016). For more detailed analysis of alcohol consumption in Australia, see Chapter 3.

In what is a continuing good news story in Australia, the number of people smoking tobacco on a daily basis shows a continuing downward trend that commenced in 1993. The population prevalence of smoking in Australia is now less than 20% for both men (18.3%) and women (13.4%) (Australian Institute of Health and Welfare, 2014).

Cannabis is our most commonly used illegal drug, with over a third of Australians using it in their lifetime and between 10% and 13% using it in the past year (Australian Institute of Health and Welfare, 2014). Ecstasy is the next most commonly used illegal drug, with 10% of people over 14 years of age indicating that they have tried it and 2.5%, mostly people in their 20s, using the drug once or more in the previous year. Heroin use is low, with 0.1% of the population in 2013 reporting use in the previous year. However it is worth noting that the rate of heroin and other illegal drug use is probably under-reported for a variety of reasons, discussed in depth in Chapter 3.

The nonmedical use of pharmaceutical drugs such as pain killers and sleeping pills is rising. In 2013, over 4% of the population used pharmaceutical drugs in this way (Australian Institute of Health and Welfare, 2014).

Why do people use psychoactive drugs?

There are many reasons that people take drugs initially, and reasons for continued use. These reasons are summarised in Box 1.2

Box 1.2

Reasons that people consume drugs

For pleasure

We know that most people who take psychoactive drugs on a regular basis do so because the drug produces pleasurable effects and enhances aspects of their lives, such as improving social interaction, or they believe that it will facilitate sexual activity. Somewhat surprisingly, as noted by Kane Race, the concept of drug use for pleasure is largely absent from contemporary **public health** discourse (Race, 2009).

To manage aspects of living, and physical pain

Some people use drugs to maintain particular roles or to assist them to work. Examples are long-haul truck drivers or student using **stimulants** to fight fatigue and exhaustion. This is sometimes called 'functional use' (Muller & Schumann, 2011). Some people use drugs to reduce physical pain and discomfort.

To manage emotions

Since drugs can affect the way we feel, they are used to counter some feelings and to enhance others. This might include calming down, relieving stress or reducing anxiety. In those experiencing distressful psychological states, drugs are used as a compensatory means to 'self-soothe'; this is referred to as the **self-medication hypothesis** (Khantzian, 1997).

To increase the sense of belonging

Young people who are still forming their own ideas and identity are often singled out as being highly influenced by peers in both positive and negative ways (Lee & Lok, 2012). However, people of all ages use drugs because others they know, like, or want to be like, use them. We are influenced by our peers and those we admire, and if they use or are portrayed as using drugs, we are more likely to do so.

To do what is regarded as 'normal' or 'usual'

Related to the previous point, sometimes people use drugs because they think that it is the norm or normal to use drugs. Research has found that many young people believe their peers are using drugs, even when the majority of them are not (Perkins, 2012). This builds on peer pressure and a desire to join in, and is sometimes called **normative drug use**.

To expand consciousness

Hallucinogens such as LSD are used to change sensation and perception, and it has been claimed that they can increase self-understanding and self-discovery (Boys & Marsden, 2003).

To counteract the effects of another drug

Sometimes a person who uses drugs will want to change or reverse the effects of a drug; for example someone may drink caffeine to try to counteract the effect of drinking alcohol. Sometimes people use sedative or depressant drugs, including alcohol, to **'come down'** after using strong stimulants such as ecstasy. Some people also use drugs to manage the side effects of prescribed medications.

To maintain physiological dependence and/or avoid withdrawal

For those people who become dependent upon drugs, it is necessary to continue use to maintain equilibrium and avoid a **withdrawal** state.

This brief overview highlights the fact that psychoactive drugs are used for specific purposes, and for most this is an enjoyable, sometimes euphoric, experience. In addition to these psychological and social reasons for drug use, the cultural and economic milieu in which we live is a powerful determinant of our patterns of drug use. Issues such as the supply and availability of drugs, and the extent of advertising or promotion, influence drug choice and the extent and nature of consumption.

What are the harms associated with psychoactive drugs?

The first point to make is that there is an important distinction between drug use and drug harm. Not all drug use is harmful. This is why experts in drug responses focus more on the harms arising from drug use, rather than on the use itself. In addition, there is a distinction between short-term harm (which can arise from a single occasion of use) and longer term harm (such as health consequences) arising from long-term or chronic consumption. For example, a single episode of heavy drinking is likely to result in **intoxication** when the drinker may experience

immediate problems, including involvement in motor vehicle accidents, assaults, injury or domestic violence. These kinds of harm are distinguished from harms arising from a pattern of regular, high-level consumption of alcohol, such as cirrhosis of the liver or heart and circulatory problems. Descriptions of both short-term and long-term harms arising from consumption of drugs are given in Chapter 3.

One harm arising from drug use is the development of dependence. Dependence typically involves regular drug use, increased **tolerance**, experience of withdrawal when the use of the drug is reduced or ceased, and a strong desire or compulsion to take the drug in the face of clear evidence of harmful consequences (for more details, see Chapter 9). Despite the widespread belief that regular use of psychoactive drugs leads to dependence, the epidemiological data show that the majority of people who consume drugs will not become dependent. However, it has been well established that commonly used psychoactive drugs do carry varying risks for the development of dependence – referred to as **dependence liability**. For example, epidemiological research has shown that within the first ten years of use, 8% of people who use cannabis will become dependent, as will 13% of people who drink alcohol and 16% of people who use cocaine (Wagner & Anthony, 2002). It is also important to note that while dependence is often associated with serious harmful health and social consequences, many people who are dependent on drugs do not have any observable physical or social effects. The stereotypical picture of health and social disintegration in a person's life is often not the result, even after many years of **drug dependence**.

Until the last 10 years or so, the focus on harms has largely been on the person consuming the drug – whether the harm be infection with **hepatitis C** for someone who injects drugs, or the development of a mental health problem associated with cannabis consumption, or chronic liver disease in a person who consumes alcohol. More recently, however, it has become acknowledged that harms also occur to third parties – the people around someone who drinks. Australian research highlighted that almost three-quarters of all adults in Australia, or around 11 million people, were negatively affected by someone else's drinking. The issues ranged from minor annoyance, such as street noise and minor property damage, to physical violence or death. It included more than 70 000 Australian victims of alcohol-related assaults (24 000 were cases of domestic violence). In 2007–08, there were approximately 20 000 Australian children who were victims of substantiated alcohol-related child abuse (Laslett et al., 2010).

Drug-related harms represent a significant economic burden. The most commonly referenced cost of drug harm is the healthcare costs associated with drug-related illness. This includes emergency department services for acute harm, and mental health and drug rehabilitation services. The costs associated with drug-related crime are also significant. These include costs associated with policing, courts, prisons and customs services. Then there are general costs that accrue, such as lost productivity, failure to achieve expected educational levels and, for some, lack of engagement in

work. There are other, hidden costs, such as the loading on insurance premiums to cover alcohol-related motor vehicle accidents, and theft and damage. The total social costs associated with legal and illegal drug use in Australia in 2004–05 were over $55 billion, of which crime costs accounted for approximately $7.1 billion (Collins & Lapsley, 2008). The estimated annual cost of heavy drinkers to those around them in 2007–08 was $14 billion (Laslett et al., 2010).

The economic costs and harms are not distributed equally across society. While everyone who uses drugs is vulnerable to the harms, there are particular groups who may be at higher risk of harm.

Young people

Many young people like to experiment with drugs and engage in other risky and potentially harmful activities, making them at disproportionate risk of short- and long-term harm. Although alcohol, tobacco and other drug use among young people has been declining, young adults still consume all drugs at a higher rate than other groups, and the effects on teenagers can be substantial.

Young people are more likely to **binge drink** than other groups, with 20% reporting that they deliberately drink to get drunk (Australian Institute of Health and Welfare, 2011a) and young adults (20–29 years old) have the highest rate of use of illegal drugs compared to any other age group (Australian Institute of Health and Welfare, 2014). Alcohol and other drug consumption in adolescence is also associated with risky sexual behaviour and poor academic performance. In addition to the harms associated with intoxication, there is also evidence that alcohol and many **illicit drugs** may cause damage to the developing brain. Early initiation of alcohol, for example, is associated with episodes of memory loss and problematic drinking patterns, including dependence later in life (Hingson, Heeren, & Winter, 2006).

Experimenting with tobacco appears to still be attractive for many adolescents, with initiation commencing at around 16 years of age on average. Almost 4% use occasionally and 2.5% report smoking daily. The daily smoking rate for girls is almost twice that for boys (Australian Institute of Health and Welfare, 2014). There is evidence that smokers who commence early are less likely to give up than those who start later in life (British Medical Association, 2007). Therefore many are likely to experience the now well-known health and social consequences of smoking.

The vulnerability of young people to the immediate and long-term harms associated with drug use provides compelling grounds for introducing evidence-based strategies to prevent or delay the uptake of drug use or reduce the associated harms (see Chapter 7 for a detailed analysis of these strategies). As Wayne Hall so eloquently put it, 'Individual choices about drug use are not always made wisely by young people with temporal myopia, a sense of personal invulnerability, scepticism about their elders' advice and an exquisite sensitivity to adult hypocrisy about drug use' (Hall, 2006, p. 1531).

Aboriginal and Torres Strait Islander people

The use of psychoactive drugs combined with high levels of Aboriginal **socio-economic disadvantage** results in a high disease burden and is a major contributor to the longevity gap of 12 years for males and 10 years for females when compared to non-Aboriginal Australians (Australian Institute of Health and Welfare, 2010). (Note that the general term 'Aboriginal' is used throughout this book to refer to Aboriginal and Torres Strait Islander people.) Aboriginal people experience almost double the general population's **burden of disease** associated with alcohol use. The burden comprises long-term harms such as strokes and cancer and events including homicide, violence, suicide and road traffic accidents. The proportion of Aboriginal people who abstain from drinking has been consistently shown to be higher than in the general population. This may be partly explained by the numbers who have given up due to the harmful consequences of its use. The number of Aboriginal people who drink in a risky manner may be at least double that of the general population (Wilson, Stearne, Gray, & Saggers, 2010).

Tobacco contributed to the deaths of one in five Aboriginal people in 2003. They experience high rates of cardiovascular disease, stroke and chronic respiratory tract diseases. It is concerning that the downward smoking trend seen in the general population is not replicated in Aboriginal populations. In 2012–13, they were still 2.6 times as likely to smoke daily as non-Aboriginal people (Australian Institute of Health and Welfare, 2016a).

In some of the more remote parts of Australia, Aboriginal people are also vulnerable to the harmful use of other psychoactive drugs, such as **kava**. Although Aboriginal people make up only 2.6% of the Australian population, they are over 17 times more likely to be imprisoned. One study showed that of those imprisoned, almost 70% were under the influence of alcohol at the time of arrest, compared to 27% of non-Aboriginal prisoners (Putt, Payne, & Milner, 2005).

Women

Although fewer women than men drink or use illicit drugs, they may be exposed to greater risk because they suffer greater levels of personal drug-related harm after fewer years drinking or drug use compared to their male counterparts (Wilsnack, Wilsnack & Kantor, 2014). Women in their 40s and 50s are more likely to use pharmaceuticals for nonmedical purposes than men in the same age group (Australian Institute of Health and Welfare, 2014).

Women are particularly affected by third-party harms, including interpersonal violence, domestic incidents and sexual victimisation, and they spend more time caring for people who experience alcohol-related problems (Laslett et al., 2010). The experience of violence is particularly frequent for Aboriginal women where alcohol-related assaults are 33 times higher than for women in the general population (Australian Institute of Health and Welfare, 2008).

Older people

The proportion of people in their 60s drinking at lifetime and single occasion risky levels has been increasing since 2007 (Australian Institute of Health and Welfare, 2014). The proportion of daily drinkers 70 years and over is higher than for any other age group (14.7%). Nearly 19% of 60–69-year-olds and 10% of 70–79-year-olds drink alcohol at levels placing them at risk of long-term harm, and the 60+ age group is the third-highest user of pharmaceuticals for nonmedical purposes after those in the 20s and 30s (4.7%), a figure that has been increasing since 2001 (Australian Institute of Health and Welfare, 2014). Tobacco is used by approximately 8% of this group on a daily basis and is the drug most associated with serious harm.

Harms for older Australians include accidents and injuries, which for this age group carry a higher risk of permanent disability or death. In the 65–74 age group, almost 600 die every year from injury and disease caused by drinking above recommended levels and a further 6500 are hospitalised (Chikritzhs & Pascal, 2005). An estimated 25% of older Australians consume up to five prescribed medications at any given time (Australian Institute of Health and Welfare, 2007). There is increased risk of falls-related injury associated with drug interactions, particularly when combined with alcohol or unprescribed medications. Psychoactive drug use by the elderly is an under-researched area and will need greater attention as we face the challenges of an ageing population.

People from culturally and linguistically diverse backgrounds

As of 30 June 2015, 28% of the Australian population (6.7 million) was born overseas (ABS, 2016a). The 2011 census found that almost half (49%) of longer-standing migrants and 67% of recent arrivals spoke a language other than English at home (ABS, 2012). The health status of most migrants is as good as, if not better than, that of the Australian-born population (Australian Institute of Health and Welfare, 2010). People from culturally and linguistically diverse *(*CALD) backgrounds in Australia have different drinking cultures and behaviours, which result from their differing circumstances. People whose main language spoken at home is not English are more likely to either abstain from alcohol or to be ex-drinkers (43%) compared to English speakers (15%). However, certain CALD groups show higher rates of risky consumption than others. For example, people born in Pacific Island nations have slightly higher rates of risky alcohol consumption than people born in Australia (ABS, 2010). There may be specific factors that contribute to riskier drinking among some CALD populations, such as migration, isolation and post-traumatic stress. Although smoking is on the decline in Australia, there is evidence that Australian men born in Europe, North Africa and the Middle East and women born in New Zealand, the United Kingdom and Ireland are more likely to smoke than Australian-born men and women (Weber, Banks, & Sitas, 2011). Public health

messages need to be tailored to CALD subgroups. This goes beyond merely translation into languages other than English and includes understanding the culturally specific determinants of harmful alcohol and other drug use.

Gay, lesbian, bisexual, transgender, intersex and queer (GLBTIQ) people

In relation to tobacco, numerous studies have found significantly higher rates of tobacco use among gay, lesbian and bisexual (GLB) populations. (While the most inclusive term is gay, lesbian, bisexual, transgender, intersex and queer – **GLBTIQ** – the research on substance use among these populations has been limited to gay, lesbian and bisexual people.) A number of studies have shown that people (of both sexes) who identified as bisexual had the highest rates of tobacco use. Alcohol consumption rates are generally higher in GLB populations than in heterosexual populations and, concomitantly, higher rates of alcohol use disorders are found. However, this finding appears to apply strongly for women and is less so for men (Cochran & Mays, 2000). For illicit drugs, a majority of studies show significantly higher prevalence of both drug use and drug use disorders among GLB compared to heterosexual populations (e.g. Bolton & Sareen, 2011). Factors that may account for higher alcohol and other drug problems include cultural factors; self-identification; relationship status; relationships with family and friends; residential context; 'coming out'; abuse and victimisation; and stigma, minority stress and discrimination. Preventing discrimination and stigma is an essential aspect of any comprehensive approach to reducing psychoactive drug problems among GLB people. There is a small but compelling literature that demonstrates that recognition of same-sex marriage is associated with lower rates of alcohol disorders. Measures which reduce the stigma and discrimination against GLB people are likely to have powerful public health impacts.

Terminology: labels matter

Terminology is important because labels can determine how our community understands and responds to drug use and associated problems. Chapter 5 shows the many ways in which drugs are represented in **popular culture** – across news media, film and television, music and social media. This highlights how the representation of different drugs reflects broader social and political debates, as well as how it influences the ways that people use drugs.

The terms that are commonly used include 'use', 'misuse', 'abuse', 'harmful use', 'dependence' and '**addiction**'. 'Drug use' is the general term that refers to any consumption. The term 'misuse' has been introduced because many people use alcohol in non-problematic ways, so there has been a desire to distinguish alcohol use from alcohol misuse. Terms such as 'abuse', 'harmful use' and 'dependence' fall under a general category of '**substance use disorders**' as defined by the

World Health Organization's *International Statistical Classification of Diseases and Related Health Problems: Tenth Revision* (ICD-10)(World Health Organization, 2010), a public health-oriented system of classification. More recently the alternative psychiatric-oriented system of classification by the American Psychiatric Association, known as the *Diagnostic and Statistical Manual of Mental Health Disorders*, released a fifth revision (DSM-5), which considers alcohol and other drug use problems on a continuum from mild to severe and has done away with a discrete category of dependence (American Psychiatric Association, 2013). Clinically, however, the term 'dependence' is still in frequent use, and its features include preoccupation with the behaviour, diminished ability to control the behaviour, tolerance, withdrawal, and adverse psychosocial consequences (Cunningham & McCambridge, 2012).

The very inclusion of substance use disorders within ICD-10 and DSM-5 demonstrates one prevailing view of drug problems as medical problems, with defined **diagnostic criteria**. The term 'addiction' has been largely replaced by the notion of dependence, but it has a long history and persists, especially in media coverage and general community discourse, and within some treatment models based on the disease model.

In this book, we use the term 'dependence' rather than addiction. While some may argue that the meaning of the terms can be differentiated, we treat them as synonymous. Importantly, we have a strong preference not to use terms such as '**alcoholic**' and '**addict**' as these terms refer to the whole person, rather than their drug-using behaviour. This is equivalent to using the term 'schizophrenic' rather than 'a person with schizophrenia'. For the same reason, there has been a trend to refer to 'people who inject drugs' **(PWID)** and 'people who use drugs' rather than (injecting) 'drug users'. Language is important and has the capacity to increase or decrease stigma around drug use.

Responses to drugs

The ways in which society responds to drugs depends to some extent on the prevailing frameworks or images that society has about drugs (Babor, Caetano, et al., 2010; Babor, Caulkins, et al., 2010). These responses have varied over time, but typically have medical, psychosocial or criminal justice underpinnings, and largely ignore images of pleasure. Chapter 4 provides a historical overview of frameworks and images that have categorised drug use as a *sin* (with responses by the clergy), as a *crime* (with policing and court responses) or as a *disease* (with health responses). In Australia, drug **policy** is underpinned by the principle of '**harm minimisation**', which seeks a balance between **supply reduction**, **demand reduction** and **harm reduction** (Ministerial Council on Drug Strategy, 2010). **Harm minimisation** is regarded as evidence-based and pragmatic, and encompasses policies directed towards reducing the supply and availability of drugs, reducing the use of drugs, reducing the harmfulness of drug use and preventing the uptake of drugs. Australia has also taken a comprehensive approach to drug policy, directing its strategy towards the harmful use of **licit drugs** (tobacco, alcohol and pharmaceutical drugs), as well as illicit

drugs (heroin, cannabis, cocaine and amphetamine-type stimulants, including ecstasy) and other **psychoactive substances** (inhalants and kava). This has allowed better integration across sectors such as treatment services, policing and even research. Partnerships and coordination of agencies across all levels of government, including health, education and law enforcement, have been essential to the development and implementation of the national drug strategy. Importantly, the Australian approach to drug policy has also featured a commitment to 'evidence-informed practice', with research and evaluation being a high priority.

For more than 30 years Australia has taken this consistent approach to drug policy. However, after 'leading the way' in the development of harm minimisation approaches to drug policy in the mid-1980s and 1990s, it has been said that Australia is now a less vocal advocate for these approaches in international discussions. Where we were once at the forefront of policy innovation, we are now falling behind. The examples of this include the lack of implementation of heroin maintenance programs, the lack of multiple **drug consumption rooms** in high injecting areas where people who use drugs can access sterile equipment and a safer place to use their drugs, and poor drug treatment coverage within Australian prisons.

The 'three pillars'

A good way of conceptualising the array of drug policy options available is to categorise them into three domains or pillars: supply reduction, demand reduction and harm reduction. Using the **three pillars** as a classification system, Table 1.1 provides examples of the variation in policy responses available for currently licit and illicit drugs.

Table 1.1 Policy options and the three pillars of drug policy

	Description	Licit (e.g. alcohol, tobacco)	Illicit (e.g. cannabis, heroin, ecstasy)
Supply reduction	Supply reduction is focused on removing or reducing the supply of drugs within the community. This includes laws, the regulations and policing activity to reduce the supply and availability of drugs. Chapter 11 covers drug laws and regulation; Chapter 12 covers drug law enforcement to reduce the supply of drugs.	Restrictions on sales to minors or intoxicated persons; restricted opening/sales hours, lock-outs; restrictions or bans on advertising and promotions.	Arresting dealers, manufacturers and traffickers for sale and supply. Police detaining people who use drugs and referring them into education, information and treatment. Drug-detection dogs.

(Continued)

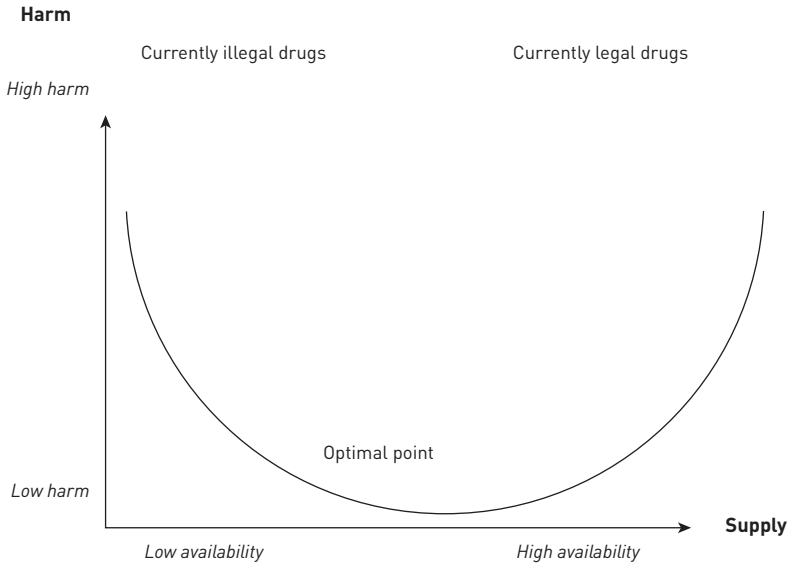
Table 1.1 *(Continued)*

	Description	Licit (e.g. alcohol, tobacco)	Illicit (e.g. cannabis, heroin, ecstasy)
Demand reduction	Demand reduction covers reducing the likelihood that someone will commence drug use (prevention); and providing treatment for people to reduce or cease their drug use. Chapter 9 covers pharmacotherapy treatments; and Chapter 10 covers psychosocial treatments. Chapter 7 covers prevention.	School-based drug education programs; social marketing and media campaigns (e.g. 'Don't turn a night out into a nightmare'); use of screening tools in primary health settings for early identification of risky drinkers. Residential alcohol treatment programs (therapeutic communities). Smoking cessation 'Quit' lines.	School-based drug education programs; social marketing and media campaigns (e.g. 'Speed catches up with you'). Drug treatment programs such as detoxification, residential rehabilitation and pharmacotherapy maintenance treatment (such as methadone or buprenorphine).
Harm reduction	Harm reduction responses seek to minimise the harmful consequences of drug use to the individual, families and the community at large, and adopt a value-neutral position with regard to drug use per se. Chapter 8 covers harm reduction.	Plastic glasses at hotels and venues; designated driver programs; collapsible roadside signage/poles.	Needle syringe programs; supervised injecting facilities; peer-education; **drug checking**.

Reconciling licit and illicit drug policies?

A frequently asked question is how to reconcile the policy trends for licit drugs (increasing restrictiveness) with the trend in illicit drugs (decreasing restrictiveness). One way to understand this apparent contradiction is to consider the relationship between harm and availability. O'Malley and Mugford (1991, pp. 67–8) suggest that the relationship between harm and availability is a U-shaped curve. Imagine increasing rates of harm on the vertical axis, and increasing rates of availability on the horizontal axis. At the top left of the curve is prohibition, and high on the right of the curve is legalisation. O'Malley and Mugford argue that **prohibition** and legalisation

Figure 1.1 The relationship between harm and availability



Source: Adapted from O'Malley & Mugford (1991)

share two common features: high profits in drug sales (whether licit or illicit) and increased harm. However, at the centre of the U-shape rests the bottom of the curve, which moves away from both complete prohibition and legalisation. In this space, **regulation** that reduces the harms is possible – for example, limiting advertising of legal substances and thus reducing harms arising from increased consumption in the population, as well as limiting the harms caused by the operation of **black market** networks.

Other versions of this U-shaped curve have been suggested – for example, demonstrating the relationship between social and health harms (vertical axis) and the drug policy spectrum from prohibition to legalisation (horizontal axis). What these models offer are ways of conceptualising the relationship between harm and availability; they can guide our thinking about the balance between these elements in drug policy. The actual development of policy, however, is not necessarily straightforward, and often politics, opinion and media play a large role in determining how governments respond to drugs (see Chapter 13 for a detailed discussion on policy development processes).

Book overview

The authors contributing to the book provide multidisciplinary perspectives and understandings that cross research, practice and policy domains. They were selected because they are leaders in this field with expertise that is acknowledged nationally and internationally.

In Chapter 2, Wayne Hall and Adrian Carter give an account of the very long history of alcohol and opiate use in human agricultural societies, with emphasis on patterns of use in Australia since European colonisation in the late eighteenth century. They describe the medicinal, religious and recreational roles that psychoactive drugs have played over time, and note changes in use from medicinal to recreational and, in some cases, changes in the status of these drugs from legal to illegal. They also consider the long-standing recognition of drug-related harm and the more recent emergence of concepts of dependence, and how these have affected Australian society generally and Aboriginal populations specifically.

In Chapter 3, Paul Dietze, Mark Stoové and Anne-Marie Laslett consider the **epidemiology** of drug use (rates of use) and well as rates of drug-related harm. They also consider the various data collection methods and highlight their strengths and weaknesses. The authors detail the evidence that the harms associated with the legal use of drugs such as tobacco and alcohol far outweigh that associated with illegal drugs such as cannabis, **psychostimulants** and heroin. They discuss the challenges for epidemiologists, including the need to present realistic pictures of drug use harms and benefits.

In Chapter 4, Robin Room and Wayne Hall challenge us to think about how drug use and societal responses have been framed over the years. They argue that there are a number of '**governing images**' that determine whether we consider problems arising from psychoactive drug use as sin, crime or disease. With these images come the institutions and professions that are positioned to respond to them: the church with clergy and pastoral workers; the criminal justice system with police and judges; and the health system with doctors, nurses and other healthcare professionals.

In Chapter 5, Amy Pennay and Sarah MacLean present images of drugs in popular culture, through examination of news media, film and television, music and social media. They explore how the representation of different drugs reflects broader social and political debates. Historically, the news media has depicted drug use negatively. Drug use is both glamorised and demonised in film and television, reflecting and challenging conventional ideologies about drug issues. Drug use is strongly endorsed through music via the lyrics and content of songs, the biographic accounts of musicians, and the cultural practices of musicians and audiences.

In Chapter 6, Monica Barratt and Simon Lenton provide an overview of internet technologies and how they increasingly shape drug use practices and responses to drug problems. The authors describe the emerging role of the internet as a drug marketplace for anonymous drug sales and purchases, and a source of peer information and advice about drugs and drug use. The internet is also used in the delivery of drug and alcohol **screening** and treatment interventions.

In Chapter 7, Katrina Champion, Nicola Newton, Louise Birrell and Maree Teesson provide an overview of **primary prevention** activities, particularly in relation to halting or delaying the onset of drug use among adolescents and preventing related harms. They provide a rationale for primary prevention, outline the evidence about when prevention should be delivered for optimal benefit, and summarise the different settings for intervention delivery, including schools, media, **primary care**, community, and the family. They discuss the early findings for internet-based interventions for students and their parents.

In Chapter 8, Craig Rodgers and Ingrid van Beek discuss harm reduction: interventions designed to reduce the adverse health, social and economic consequences of drug use without necessarily reducing drug consumption. They provide an overview of strategies and the associated evidence base for **needle and syringe programs**, **supervised injecting facilities** and **opioid maintenance therapy**, and cover strategies to address both legal and illegal drugs. The authors go on to consider where harm reduction approaches fit in an ongoing debate between prohibition and legalisation and the many positions in between.

In Chapter 9, Suzanne Nielsen and Natasa Gisev outline key drug **pharmacology** processes, noting the complex neurochemical structures, proteins and **receptor** systems that underpin the biological basis of psychoactive drugs. This chapter also covers the use of medications to treat drug use disorders (known as pharmacotherapy treatments). Pharmacotherapy for both withdrawal and dependence is discussed in detail.

In Chapter 10, Nicole Lee and Amanda Baker provide an overview of psychosocial treatments for those who have experienced harms or developed dependence. This chapter takes a clinical perspective and considers what is known of 'evidence-based practice'. They examine a range of interventions from non-clinical interventions (such as **case management**) to **low intensity interventions** and briefer treatments to intensive clinical interventions. Settings include residential and non-residential. They look beyond the treatments themselves to look at how utilising a **stepped care** model, developing a sound formulation, therapist effects and good supervision can facilitate treatment outcomes.

In Chapter 11, David McDonald and Caitlin Hughes consider drug laws and those regulations, and challenge us to reflect on why governments choose to legislate to control some drugs and not others, when it is apparent that these decisions are not based on the potential for harm. The international treaties that form the basis for Australian drug laws are described, as well as our current drug laws and law enforcement patterns. Although important and beneficial incremental changes to drug laws have been implemented across Australia in recent decades, drug law reform advocates are calling for a broader reconsideration of the prohibition policy that underlies the way we deal with illegal drugs.

In Chapter 12, Lorraine Mazerolle and Jenna Thompson focus on the enforcement of illicit drug laws through strategies such as policing, border control and customs agency controls. These strategies are designed primarily to prevent, disrupt or reduce the production and supply of drugs. The authors describe various policing approaches including standard, unfocused,

community-wide policing; more strategic **hot spots policing** in areas where crime is concentrated; and **problem-oriented policing** where the problem may be people or places and police responses are typically provided in partnership with other community organisations.

In the final chapter, Chapter 13, Alison Ritter and Kari Lancaster discuss drug policy: how we understand the term and the different policy theories and strategies. Where research evidence fits in **policy processes** that are typically influenced by many other factors is explored. The authors describe the policy process as complex and 'messy', with a wide range of vested interests working to exert influence on policy processes. Given that drugs are a complex, multi-determined social problem, the authors argue that official drug policy cannot 'solve' the problem of drug use and related harms. But they argue that better research evidence and improved understanding of policy processes can lead to better drug policy.

The editors hope that this book highlights some of the complexities associated with psychoactive drug use and the challenges that societies face balancing benefits and harms; freedoms and controls; and intended and unintended policy outcomes. We urge readers to question assumptions about drug use and how we respond, and more specifically to ask to what extent these assumptions and responses are based on good quality evidence.

Discussion questions

- Where do you sit with a focus on drug *use* versus a focus on *harms*? How do your views about drugs influence which measures you would support in both public health policy and clinical practice?
- How do different terms create more or less stigma about drug use and the people who use drugs? What are the possible impacts of stigma on the people who use drugs, their families and the general community?
- Think about the balance between public safety and civil liberties in the application of alcohol policy. Which side do you lean towards? Would you place public safety over civil liberties or vice versa?
- The balance between availability and harm is an important consideration for policy makers. Can you identify the ways in which alcohol is available in Australia today, and how this availability influences harms?

Further reading

Australian Institute of Health and Welfare. (2014). *National Drug Strategy Household Survey Detailed Report 2013* (Vol. AIHW cat. no. PHE183). Canberra: Author.

Australian Institute of Health and Welfare. (2016). *Australia's Health 2016.* Australia's Health No. 15. Catalogue No. AUS 199. Canberra: Author.

Muller, C., & Schumann, G. (2011). Drugs as instruments: A new framework for non-addictive psychoactive drug use. *Behavioral and Brain Sciences, 34*, 293–347.

National Health and Medical Research Council. (2009). *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*. Canberra: Author.

Race, K. (2009). *Pleasure Consuming Medicine: The Queer Politics of Drugs*. Durham, NC: Duke University Press.

Useful websites

Australian Government National Drug Strategy: http://www.nationaldrugstrategy.gov.au
Australian Institute of Health and Welfare: http://www.aihw.gov.au
European Monitoring Centre for Drugs and Drug Addiction: http://www.emcdda.europa.eu
Lowitja Institute: http://www.lowitja.org.au