

# 1 Introduction

## The National Drug Strategy

The National Drug Strategy (NDS) is a comprehensive, integrated approach to the harmful use of licit and illicit drugs and other substances. The NDS is managed under the direction of the Ministerial Council on Drug Strategy (MCDS) which brings together Commonwealth, State and Territory Ministers responsible for health and law enforcement to collectively determine national policies and programs designed to reduce the harm caused by drugs to individuals, families and communities in Australia (MCDS 1998).

The Strategy aims 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. Both licit and illicit drugs are the focus of Australia's harm-minimisation strategy. Harm minimisation includes preventing anticipated harm as well as reducing actual harm. Harm minimisation is therefore consistent with a comprehensive approach to drug-related harm, involving a balance between demand-reduction, supply-reduction and harm-reduction strategies.

## Drug-related harm

The Institute estimates that nationally in 1997 over 22,000 deaths and more than a quarter of a million hospital episodes were drug-related. The licit drugs (tobacco and alcohol) accounted for over 96% of the drug-related deaths and hospital episodes. The estimated direct health care cost of drug dependence and harmful use in Australia in 1992 was \$1.0 billion: \$833 million for tobacco; \$145 million for alcohol; and \$43 million for illicit drugs (Collins & Lapsley 1996). More recently, the Institute estimates that in 1993–94 the direct health system cost of the management of substance abuse disorders was \$274 million (this does not include the cost of managing other conditions attributable to the use of tobacco, alcohol and illicit drugs).

## About the 1998 survey

The 1998 National Drug Strategy Household Survey was the most comprehensive survey concerning licit and illicit drug use ever undertaken in Australia. It gathered information from over 10,000 persons aged 14 years and over. The sample was based on households, therefore homeless and institutionalised persons were not included in the survey (consistent with the approach in previous years).

The survey comprised questions on drug-related knowledge, awareness, attitudes, use and behaviours. It was the sixth survey conducted under the auspices of the NDS. Previous surveys were conducted in 1985, 1988, 1991, 1993 and 1995. An Indigenous (urban) supplement survey was conducted in 1994. The data collected in these surveys contribute to the development of policies for Australia's response to drug issues.

## Comparisons with 1995 results

This survey introduced a number of methodological enhancements that could potentially affect comparison with previous survey results. A discussion of the main differences between the 1995 and 1998 surveys is in Chapter 5. One of these changes (cross-validation between lifetime and recent use) may have systematically produced marginally higher prevalence estimates than if the 1995 methodology was used. However, the Technical Advisory Committee considered that the slight loss of comparison with 1995 was more than compensated for by the increase in the reliability of 1998 estimates.

Notwithstanding, most of the differences in prevalence estimates between 1995 and 1998 are real differences (within usual statistical tolerance limits).

The results are also consistent with an expectation that overall prevalences will be higher due to the experience of age cohorts that have been successively more exposed to the substantial increases in acceptability of and access to recreational drugs that began in the late 1960s. As these higher-prevalence cohorts are added to the sample, and cohorts with lower experience are removed (due to death corresponding with older age), then the overall prevalence of lifetime use will increase. The reversal of this trend will occur only if there is a radical reduction in the prevalences among younger cohorts introduced into subsequent survey samples.

## About this report

Data presented in this report are based on estimates derived from responses weighted to the Western Australian population aged 14 years and over. Unless otherwise specified, the base for all estimates is the number of respondents who answered the relevant question(s) in the survey instrument.

In the 1995 survey report, some tables included a 'Don't know/not stated' response category. Where these types of responses are compared with 1998, the 1995 results were recalculated to be comparable with the 1998 analysis. Missing cases were excluded and responses were rebased to 100%.

The report contains chapters on summary measures, patterns of consumption, drug-related harm and policy support. A background chapter (Explanatory notes) and estimates of sampling errors (Appendix 2) are also provided. A copy of the survey instrument is provided in Appendix 5. In most instances, the proportions reporting use and knowledge of and attitudes about drugs, or drug-related behaviours, are presented first.

Prevalences are provided for information, regardless of their levels of statistical reliability. For a number of the measures of low prevalence behaviours (e.g. use of injecting drugs), resultant estimates are more likely to be statistically unreliable than the same measures of high prevalence behaviours (e.g. alcohol consumption). In particular, estimates shown by age group and sex are based on very small numbers of respondents, and should be treated with caution. Results in the tables are marked with an asterisk (\*) if the relative standard error (RSE) is greater than 50%. For prevalence proportions, this means that there is only a 5% chance that the result is different from zero, and such results are therefore considered as unreliable for most practical purposes. Results subject to RSEs of between 25% and 50% should be considered with caution (these are not marked in the tables, but can be determined by reference to the tables of standard errors and RSEs at Appendix 2).

Detailed information to estimate RSEs for the 1995 results is not available. As a guide, a prevalence of 1% of persons aged 14 years or more in Western Australia was associated with an RSE of approximately 50% in 1995.