



4.5 Illicit drug use

Introduction

Drug use is a serious and complex issue, which contributes to substantial illness, disease and injury, many deaths, social and family disruptions, workplace concerns, violence and to crime and community safety issues (MCDS 2011). The misuse of licit and use of illicit drugs is widely recognised in Australia as a major health problem, and one with wider social and economic costs (Collins & Lapsley 2008). While illicit drug use is a significant issue in the context of Australia's health, tobacco continues to cause more ill health and premature death than any other drug, and alcohol-related hospital separations are higher than those related to illicit drugs (including heroin, cannabis, methamphetamine and cocaine) (Roxburgh and Burns 2013).

Illicit drug use contributed to 1.8% of the total burden of disease and injury in Australia in 2011. This included the impact of injecting drug use and cocaine, opioid, amphetamine and cannabis dependence. Globally, illicit drug use contributed 0.8% of the total burden of disease in 2010 and has increased since 1990—moving from the 18th to 15th ranking risk factor (IHME 2014). It is estimated that illicit drug use costs the Australian economy \$8.2 billion annually through crime, productivity losses and health care costs (Collins & Lapsley 2008).

Illicit drug use is associated with many risks of harm to the user and to their family and friends. It has both short-term and long-term health effects, which can be severe, including poisoning, heart damage, mental illness, self-harm, suicide and death (NRHA 2015).

The first part of this article profiles illicit drug use and looks at the four most commonly used illegal drugs. As there is currently a substantial community and policy interest in the use and effects of 'ice,' (see Box 4.5.1) the second part of this article focuses in more detail on methamphetamine and explores recent trends in availability, use and treatment, and highlights the current evidence about this drug.

What do we know about the prevalence of illicit drug use?

According to the 2013 National Drug Strategy Household Survey (NDSHS), around 2.9 million people in Australia aged 14 and over were estimated to have used illicit drugs in the previous 12 months, and 8 million were estimated to have done so in their lifetime (AIHW 2014b). Both nationally and internationally, the proportion of people using illicit drugs has remained relatively stable over the last 10 years—around 15% of adults in Australia, and around 5% of the global adult population (AIHW 2014a; UNODC 2015).

However, over time, changes occur in the use of specific drugs, in the forms of drugs used and in the way drugs are taken. In Australia, changes in the use of methamphetamine have been one area of increasing concern among the community (see Box 4.5.1).



Box 4.5.1: Strategies, legislation and other activities

Since 1985, the National Drug Strategy (NDS) has provided an overarching framework for a consistent and coordinated approach to addressing licit and illicit drug use in Australia. The NDS is guided by the principle of harm minimisation. Harm minimisation encompasses three components (pillars): demand reduction, supply reduction and harm reduction. The aim of the NDS is to prevent the uptake and misuse of drugs and to reduce the production and supply of illicit drugs and the negative social, economic and health consequences of drug use. The NDS also continues to support and develop essential partnerships between the law enforcement, health and non-government sectors, communities, and all levels of government (MCDS 2011).

Research undertaken by the Drug Policy Modelling Program revealed that Australian governments spent approximately \$1.7 billion in 2009–10 on illicit drug programs and estimated that 64% was spent on law enforcement, 22% on treatment, 9.7% on prevention and 2.2% on harm reduction (Ritter et al. 2013).

The NDS recognises illicit drug use as a health and social issue, while acknowledging the role of law enforcement in detecting and deterring drug-related crime. Legislative and regulatory provisions relating to illicit drugs, precursor chemicals and proceeds of crime exist at the national level (for example, border protection and compliance), but most action (including expenditure) in relation to illicit drugs rests with the states and territories (Ritter et al. 2013).

Many national initiatives are implemented under the NDS, including the National Drugs Campaign. This is a media campaign aimed at reducing illicit drug use among young Australians, by increasing their knowledge of the negative consequences of drug use. The campaign has been running since 2001 and the focus varies, depending on trends in drug use and emerging drugs. The most recent campaign focused on crystal methamphetamine (Department of Health 2015).

The National Ice Taskforce

The Australian Government established a National Ice Taskforce in April 2015 and released its final report in December 2015. The Government will provide almost \$300 million over 4 years from 1 July 2016 to improve treatment, education, prevention, support and community engagement, and to capture better data to identify emerging trends on illicit drug use (PM&C 2015). The *Final Report of the National Ice Taskforce* made 38 recommendations across five key areas:

- support families, communities and frontline workers
- target prevention
- tailor services and support
- strengthen law enforcement
- improve governance and build better data (PM&C 2015).



Illicit drug use and trends

Among the 15% of people aged 14 and over in Australia who are illicit drug users (see Box 4.5.2 for a definition of illicit drug use), 4 in 5 reported using illegal drugs such as cannabis and cocaine, or other substances such as inhalants (Figure 4.5.1). The remaining 1 in 5 reported misuse of a pharmaceutical drug (without use of any other illicit drug) (AIHW 2014b).

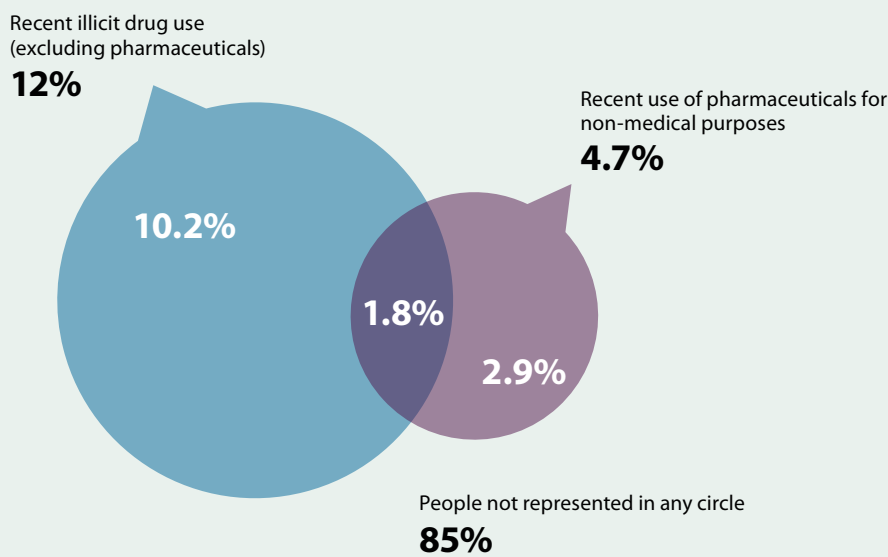
Box 4.5.2: Definition of illicit drug use

'Illicit drug use' can encompass a broad range of substances including:

- illegal drugs—drugs that are prohibited from manufacture, sale or possession in Australia (for example, cannabis, cocaine, heroin and amphetamine-type stimulants)
- pharmaceuticals—drugs that are available from a pharmacy, over the counter or by prescription, which may be subject to misuse (when used for purposes, or in quantities, other than medical purposes for which they were prescribed)—for example, opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine and steroids
- other psychoactive substances—legal or illegal, potentially used in a harmful way—for example, kava, synthetic cannabis and other synthetic drugs, or inhalants such as petrol, paint or glue (MCDS 2011).

Each data collection cited in this article uses a slightly different definition of illicit drug use; please refer to the relevant report for additional information.

Figure 4.5.1: Relationship between recent illicit drug use and pharmaceutical use, people aged 14 and over, 2013



Notes
 1. Components may not sum to totals due to rounding.
 2. Illicit use of at least 1 of 17 drugs.

Source: AIHW 2014b.



According to the 2013 NDSHS, there was no change in the overall use of any illicit drug between 2010 and 2013 (15% of people reporting they had used at least 1 of 17 illicit drugs). However, there were significant changes for a few specific drugs. There were falls in the reported use of ecstasy (from 3.0% to 2.5%), heroin (from 0.2% to 0.1%) and gamma hydroxybutyrate (GHB). Longer-term trends, since 2001, show that use of cannabis, ecstasy and methamphetamine have all declined, but use of cocaine and misuse of pharmaceuticals have increased (AIHW 2014b). Although methamphetamine use has declined over the last 12 years, and remained stable between 2010 and 2013, there was change in the main form used, with ice replacing powder (discussed in further detail in the 'Methamphetamine use, availability and treatment' section).

This section focuses on key findings from the 2013 NDSHS for the four most commonly used illegal drugs—cannabis (10%), ecstasy (2.5%), methamphetamine (2.1%) and cocaine (2.1%). Box 4.5.3 then highlights the increasing misuse of pharmaceuticals, which is an important and emerging issue in relation to illicit drug use in Australia.

Cannabis

According to the 2013 NDSHS, an estimated 6.6 million (or 35%) people aged 14 and over had used cannabis in their lifetime and about 1.9 million (or 10%) had used cannabis in the previous 12 months. About 1 in 20 Australians (5.3%) had used it in the month prior to the survey and 3.5% had used it in the previous week.

About one-third (32%) of recent cannabis users used the drug as often as weekly, and older people (50 and over) were more likely than younger people to use cannabis regularly, with at least 4 in 10 recent users in these age groups using it as often as once a week or more. Among people aged 14–24, the average age for first cannabis use increased between 2001 and 2013 (from 15.5 to 16.7 years).

Ecstasy

In 2013, ecstasy was the second most commonly used illicit drug in a person's lifetime, with 2.1 million (10.9%) people aged 14 and over reporting having ever used the drug and 500,000 having done so in the past 12 months, representing 2.5% of the population. Ecstasy use had been gradually increasing since 2001, before peaking in 2007 at 3.5%. It then declined in 2010 (3.0%) and again in 2013 (2.5%).

The majority of recent ecstasy users only took ecstasy once or twice a year (54%). The average age for first trying ecstasy has remained relatively stable, since 2001, at 18 years.

Methamphetamines

In 2013, about 1.3 million (7.0%) people had used methamphetamines in their lifetime and 400,000 (2.1%) had done so in the last 12 months. Methamphetamine use had been declining since it peaked at 3.7% in 1998 but remained stable at 2.1% between 2010 and 2013. While there was no increase in methamphetamine use in 2013, there was a change in the main form of methamphetamines used, with crystal replacing powder as the preferred form of the drug. Among recent users, powder decreased from 51% to 29%, while the use of crystal more than doubled, from 22% in 2010 to 50% in 2013. This is discussed in further detail in the 'Methamphetamine use, availability and treatment' section.



Cocaine

Of people aged 14 and over, 8.1% (or 1.5 million) had used cocaine in their lifetime, and 2.1% (or about 400,000 people) had used it in the previous 12 months. While use of drugs such as cannabis, ecstasy and methamphetamines has generally declined since 2004, the proportion of people using cocaine has been increasing since 2004. This is particularly so among those aged 20–29 and 30–39. Cocaine use in Australia is currently at the highest levels seen since the survey collection commenced.

However, recent users used cocaine less often in 2013 than in previous years, with a lower proportion using it every few months (from 26% to 18%) and a higher proportion using it once or twice a year from 61% to 71%.

Box 4.5.3: Opioids and misuse of pharmaceuticals

According to the 2013 NDSHS, an estimated 900,000 Australians aged 14 and over (4.7%) used a pharmaceutical drug for non-medical purposes in the previous 12 months. This represents a significant rise from 4.2% in 2010, and is the highest proportion reported since 2001 (AIHW 2014b).

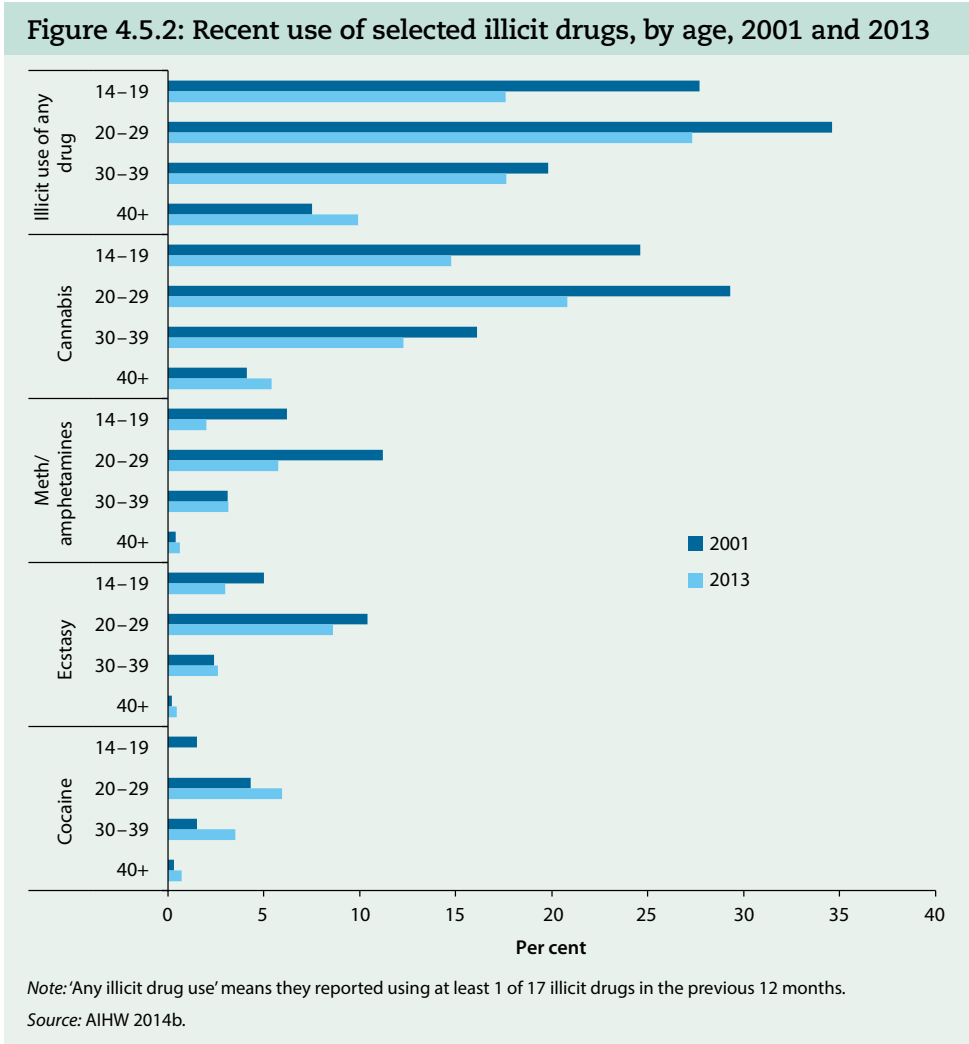
Australia has seen an increase in mortality and morbidity associated with prescription drugs, from opioids in particular. From 2002 to 2011, the rate of accidental overdose deaths due to opioids increased from 32.3 to 49.5 per million people aged 15–54. In the 10 years since 2004–05, hospital separations for opioids also increased from 292 to 362 separations per million people (Roxburgh & Burns 2015; AIHW National Hospital Morbidity Database).

The AIHW will undertake further exploration and analysis on this emerging trend in 2016–17 and will publish results in a future report.

Age comparisons

According to the 2013 NDSHS, people in their 20s were the most likely of all age groups to report using an illicit drug in the previous 12 months (27%) (Figure 4.5.2). Recent cannabis use was by far the most common illicit drug use reported by this group in 2013; however, since 2001, recent use of cannabis decreased (from 29% to 21%).

While people aged 40 and over generally have the lowest rate of illicit drug use, this was the only age group in which a statistically significant increase was found in recent illicit drug use, increasing from 7.5% to 9.9% between 2001 and 2013. This was mainly driven by an increase among people in their 50s and people aged 60, and the largest relative rise in illicit drugs use was reported among people in their 50s (from 6.7% in 2001, to 8.8% in 2010 and 11% in 2013).



Secondary students

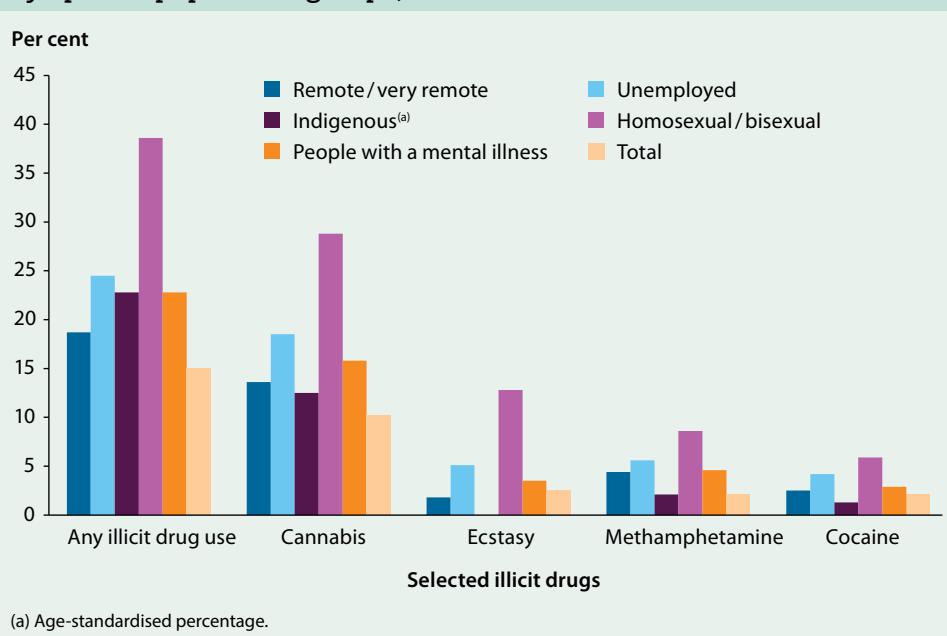
Analysis of the 2011 Australian Secondary Students' Alcohol and Drug Survey suggests that an estimated 16% of 12–17 year olds had used an illicit drug, down from 20% in 2005. Illicit drug use was more common for older teenagers, with 27% of 16–17 year olds using an illicit drug in their lifetime, but again this declined from 33% in 2005. Among secondary students, misuse of tranquillisers (misuse of a specific pharmaceutical) (17%) was the most common behaviour of concern reported to have occurred in their lifetime, followed by marijuana/cannabis use (15%) (White & Bariola 2012).

Use among specific population groups

Illicit drug use varies across different population groups in Australia and Figure 4.5.3 focuses on those groups that show some of the largest disparities in illicit drug use compared with the general population—Indigenous people; people who were unemployed; people identifying as homosexual or bisexual; people with a mental illness; and people living in remote areas.



Figure 4.5.3: Proportion of illicit drug users, people aged 14 and over by specific population groups, 2013



Methamphetamine use, availability and treatment

Methamphetamine (generally referred to by the street names of its two main illicit forms, 'ice' or 'speed'—see Box 4.5.4 for methamphetamine terminology) is a drug of national concern, with the Australian Crime Commission assessing it to be the illicit drug posing the greatest risk to the Australian community (ACC 2015). A number of indicators suggest that the Australian methamphetamine market has grown since 2010, as there have been increases in the detected importation, manufacture and supply of the drug. Use of crystal methamphetamine has also increased among some population groups; the number of people seeking treatment for amphetamines is increasing; and there are more hospitalisations for amphetamine-related problems. Methamphetamine comes in a number of forms and can be administered in different ways (see Box 4.5.5).



Box 4.5.4: Terminology for methamphetamine

Methamphetamine is commonly referred to as methamphetamine or 'meth' or by one of the forms in which it is purchased, such as its crystalline form 'ice', and the terminology varies across data sources. Where possible, the crystalline form of methamphetamines has been referred to as 'crystal' throughout this feature article, rather than its street name, 'ice'. Not all data sources collect data on methamphetamine specifically; some use the broader classes of drugs—amphetamines, amphetamine-type stimulants, or 'meth/amphetamines'—to which methamphetamine belongs. This diagram provides a description of the various terms used.

Amphetamine-type stimulants (IDDR)			Class of drugs
Amphetamines (AODTS NMDS); meth/amphetamines (NDSHS)		Phenethylamines	Class of drugs
Amphetamine	Methylamphetamine (methamphetamine)	Dexamphetamine	MDMA (ecstasy), MDA etc.
Powder (speed), tablet	Powder (speed), base, crystal (ice), liquid	Tablet, e.g. Ritalin	Types of drugs
			Forms of drugs

Notes

1. IDDR: Illicit Drug Data Report.
2. AODTS NMDS: Alcohol and Other Drug Treatment Services, National Minimum Data Set.
3. NDSHS: National Drug Strategy Household Survey.

Box 4.5.5: Forms of methamphetamine and route of administration

Methamphetamine comes in many forms, and changes in the use of methamphetamine have been one area of increasing concern among health professionals and the Australian community.

- Methamphetamine forms include powder/pills ('speed'), crystal ('crystal meth' or 'ice') and a sticky paste ('base').
- Powder/pills are generally snorted or ingested and crystal is usually smoked or injected.
- Dependence on methamphetamine is more commonly associated with people who inject the drug or who smoke crystalline methamphetamine, rather than among those who prefer oral or intranasal routes of administration.
- Injecting and smoking methamphetamine are both associated with more frequent use patterns, treatment demand, higher levels of risky behaviour and other health and psychiatric consequences (McKetin et al. 2008).

Production and supply

Since 2009, the global market for amphetamine-type stimulants (ATS—see Box 4.5.4) has increased substantially. An upsurge in seizures since 2009 point to a rapid expansion of the global ATS market, with ATS seizures almost doubling to reach over 130 tonnes in 2011 and 2012—the highest amount since the United Nations Office on Drug Crime systematic monitoring began—before decreasing slightly in 2013 (UNODC 2015). The increase from 2009 is primarily attributable to the growing amount of methamphetamine seized, which increased from 31 tonnes in 2009 to 80 tonnes in 2013.



Arrests, seizures and detections

Over the last 5 years, the total number of arrests for ATS increased—accounting for 16% of illicit drug arrests in 2009–10 (12% were for consumers; 4.6% for providers) and 23% (18% for consumers; 5.6% for providers) in 2013–14 (Figure 4.5.4). Consumers apprehended for possessing or using illicit drugs accounted for more than three-quarters (76%) of all ATS arrests in 2013–14 (ACC 2015).

In Australia, the number of ATS (excluding MDMA) detections at the Australian border has increased dramatically since 2009–10 (ACC 2015) and was the highest number on record in 2013–14 (from 672 in 2009–10 to 2,367 in 2013–14). The total mass of these detections also increased from 67 kg in 2009–10 to 1,812 kg in 2013–14, although the national mass of seizures decreased by 326 kg between 2012–13 and 2013–14 (ACC 2015). The number of national seizures followed similar trends, increasing from 10,543 in 2009–10 to 26,805 in 2013–14. The national mass of seizures also increased over this period (from 671kg to 4,076kg).

Figure 4.5.4: Selected key trends in methamphetamine use, availability and treatment, 2009–10 to 2013–14

Key trends			
From 2009–10 to 2013–14, criminal activity, use and treatment relating to methylamphetamine rose to their highest levels since 2003–04			
	2009–10	2013–14	% change
Arrests	14,000	26,300	95%
Seizures	10,500	26,800	155%
Detections	700	2,400	243%
Recent users reporting lifetime crystal use	190,000	280,000	47%
Treatment episodes	10,000	28,900	189%

Percentage change of number, 2009–10 to 2013–14.

Notes

1. Each data source has different reference periods, counting units and sample sizes, see 'Data sources'.
2. The specific timing of when these increases occurred may vary due to the overlap between reference periods used across data sources (that is, calendar versus financial year).
3. Numbers are rounded to the nearest 100, except for use numbers, which are rounded to the nearest 10,000.



In addition to increased seizures and detections at the Australian border, the number of clandestine laboratories detected (also known as 'clan' labs—sites where illegal drugs are manufactured in secret, usually with improvised materials and methods) also increased, which is another indicator of the size of the ATS market. The number of clandestine laboratories detected in Australia more than doubled from 2003–04 to 2013–14—from 358 to 744. Of these, the majority were identified as producing ATS (excluding MDMA) (ACC 2015), and given the ease of access of precursor chemicals, such as pseudoephedrine, methamphetamine is reported as the most common ATS produced in Australia (AIC 2015).

Price and purity

In 2014, around three-quarters of people using powder, base and crystal forms of methamphetamine reported stable prices (Stafford & Burns 2014) and have reported a relatively stable price of all three forms (powder, crystal and base) since 2009.

However, using a purity-adjusted price of both powder and crystal, based on Victorian data, Scott et al. (2015) argue that the increasing purity of crystal means the price of both powder and crystal are effectively on par and the price of both has decreased over time.

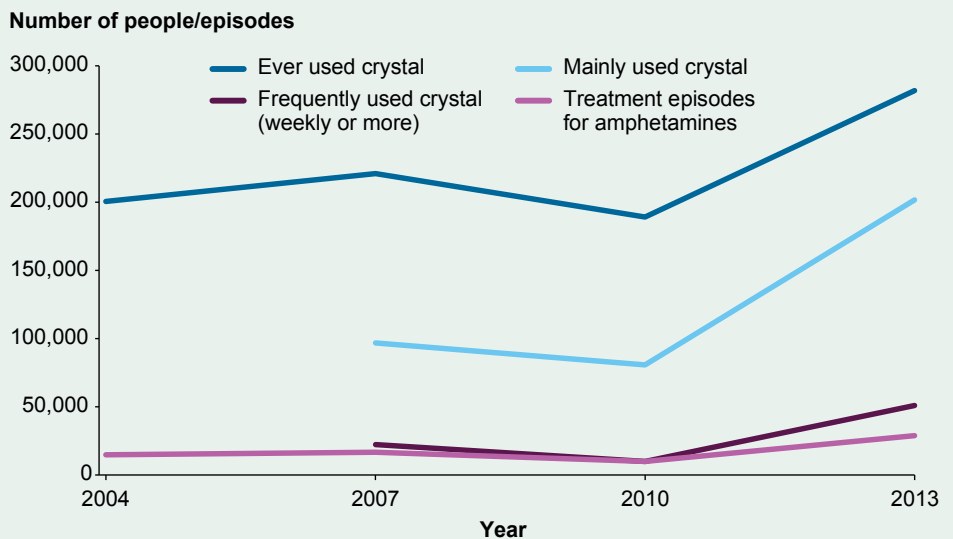
Current use and trends

Despite the apparent increases in supply (see the 'Production and supply' section), lifetime and recent use of methamphetamine has declined over the last decade and remained stable in recent years. There was, however, a change in the main form of methamphetamine used between 2010 and 2013, with crystal methamphetamine being the preferred form and used more often than powder. In addition, there were consistent increases across a number of data sources between 2010 and 2013. For example:

- the proportion of recent methamphetamine users who reported smoking the drug increased significantly (from 19% to 41%), and the proportion swallowing the drug decreased significantly (from 36% to 26%), probably reflecting the shift in main form used from powder to crystal
- among recent meth/amphetamine users, the number who 'mainly' and 'ever' used crystal, and the number who 'frequently' used crystal (at least once per week) all increased (Figure 4.5.5)
- it was estimated that there were around 120,000 more recent methamphetamine users who used crystal as their main form in 2013, compared with 2010 (AIHW 2015d) (Note, this only represents those people who reported that they used crystal as their main form in the previous 12 months; the number is likely to be higher as it does not represent all crystal users.)
- the number of treatment episodes for amphetamines increased from around 10,000 in 2009–10 to 28,900 in 2013–14 (AIHW 2014b)
- the reported availability of crystal also increased, with people who inject drugs, psychostimulant users and police detainees all claiming that crystal was easier to obtain in 2013 (Coghlan & Goldsmid 2015; Sindicich & Burns 2014; Stafford & Burns 2014).



Figure 4.5.5: Recent methamphetamine users who 'ever used', 'mainly used', and 'used crystal at least weekly', and closed episodes for clients receiving treatment for amphetamines, 2004 to 2013



Notes
 1. Treatment data relates to episodes; a person may have multiple treatment episodes in a reporting year.
 2. Information on crystal specifically is not available prior to 2007 for main form used and frequency of use.
 Sources: 2004 to 2013 National Drug Strategy Household Surveys; 2003–04 to 2013–14 Alcohol and Other Drug Treatment Services National Minimum Data Set.

Frequency of use

High doses and frequent use of methamphetamine can cause amphetamine-induced psychosis (characterised by symptoms similar to paranoid schizophrenia and other psychoses); increased risk of suicide; violent behaviour; diminished effects over time (leading to users increasing their dose to achieve intoxication); and methamphetamine dependence (Campbell 2001). Dependent users have been found to be three times as likely to experience psychotic symptoms as non-dependent users (McKetin et al. 2006). Results indicate that those using methamphetamine, particularly ice, are doing so with increased frequency. Between 2010 and 2013:

- there was an increase in the reported frequency of methamphetamine use—daily or weekly use rose from 9.3% to 16%
- daily and weekly use among people who reported mainly using crystal more than doubled—from 12% in 2010 to 25% in 2013 (AIHW 2014b).

Data from the Illicit Drug Reporting System (IDRS) indicates that this trend in increased frequency of crystal use has also been observed among the population of people who inject drugs, and it has continued past 2013. Between 2010 and 2015, the reported median number of days crystal was used in the last 6 months surpassed the median number of days for powder use—7 days for crystal and 10 days for powder in 2010, compared with 20 days for crystal and 11 days for powder and in 2015 (Stafford & Burns 2014).










Who uses methamphetamines?

In 2013, males were more likely than females to have reported the use of methamphetamine in their lifetimes (8.6% and 5.3% respectively) and recently (2.7% and 1.5% respectively), and this pattern is consistent with previous years. Recent users of methamphetamine were most commonly aged 20–29, and this age group has consistently accounted for the largest prevalence of recent methamphetamines users. However, the proportion of recent users in this age group has been steadily decreasing since 2001 (from 11% in 2001 to 5.7% in 2013) (AIHW 2014b).

Which population groups are most likely to use methamphetamines?

Certain groups within the population are more likely to use drugs and to experience drug-related harms, with some population groups in the 2013 NDSHS far more likely to report having used methamphetamines recently than the general population. For example, methamphetamine use was 6.1 times as high among people experiencing high or very high levels of psychological distress as among the general population (AIHW 2014b).

More likely to have used meth/amphetamines recently than the general population

	Those living in <i>Remote/Very remote</i> areas	2.1 times
	Aboriginal and Torres Strait Islander people	1.5 times
	Unemployed people	2.7 times
	Homosexual/bisexual people	4.1 times
	Males aged 20–29	3.2 times
	Single people with dependent children	2.4 times
	People with high or very high levels of psychological distress	6.1 times

Prison entrants

For the first time since the National Prisoner Health Data Collection began in 2009, in 2015 methamphetamine was the most commonly reported illicit drug used among prison entrants in the previous 12 months (AIHW 2015c). More specifically:

- use increased by 35% (from 37% in 2012 to 50% in 2015) and surpassed cannabis (41%), which has traditionally been the most common drug used among this population group as well as among the general population (10%)



- a prison history was both more common and more extensive among prison entrants who reported having used illicit drugs, particularly methamphetamine
- use of methamphetamine was more common among non-Indigenous entrants than Indigenous entrants (54% and 38%, respectively)
- the youngest entrants (aged 18–24) were the age group most likely to report methamphetamine use (59%) (AIHW 2015c).

Treatment patterns

Alcohol and other drug treatment services (AODTS) play an important role in efforts to respond to the recent trends in methamphetamine use. Information on publicly funded alcohol and other drug (AOD) treatment services in Australia, and the people and drugs treated, are collected through the AODTS National Minimum Data Set (NMDS). In 2013–14, amphetamines were the third most common principal drug of concern (17% of all treatment episodes), behind alcohol (40%) and cannabis (24%). Since 2003–04, the proportion of episodes where amphetamines were the principal drug of concern has increased (from 11% in 2003–04 to 17% in 2013–14) (AIHW 2015a).

Treatment episodes for clients using amphetamines in 2013–14 typically involved males aged 20–29—the same profile seen for methamphetamine users in the general population (AIHW 2015a).

Information on the different forms of methamphetamine is not captured in the AODTS NMDS, but the client's usual method of administration is captured. This can provide an indication of the form a client used. For example, clients smoking (report either smoking or inhaling amphetamines in vapour form) will largely be using the crystal form and clients ingesting or snorting are most likely to be using the powder form. For clients injecting amphetamines it is less clear, as each of the base, crystal, powder, or liquid forms can be injected. But, according to the most recent data from the IDRS, for injecting users who were injecting methamphetamine, crystal was the form most often used in the month preceding interview (Stafford & Burns 2014).

Since 2009–10, the number of episodes for clients injecting and smoking amphetamines has increased, while use via other methods remained relatively stable. In 2003–04, injectors accounted for 4 in 5 (79%) episodes for amphetamines and just 3.0% involved smoking the drug. However, the proportion of clients reporting they smoked amphetamines had increased, over the 11-year period to 2013–14, to 41%, while clients injecting fell to 44% (AIHW 2015a).

These trends in method of use for treatment episodes parallel those seen in the population of recent methamphetamine users from the NDSHS, where there was a substantial change in the main form of methamphetamine used—from powder to crystal—between 2010 and 2013 (AIHW 2014b).

Between 2003–04 and 2012–13, there was an increase in the geographic spread of amphetamine-related treatment episodes across Statistical Local Areas in Australia (AIHW 2015a). Overall, this represented a change of around two percentage points, with an increase in the number of episodes across all regional and remote areas (from 24% to 26%) and a decrease across *Major cities* (from 76% to 74%) (see also 'Chapter 6.16 Specialised alcohol and other drug treatment services').



Amphetamine-related hospital separations have also risen. Between 2003–04 and 2013–14, separations rose from 43 to 348 separations per million people. In addition, the number of methamphetamine-related hospital separations has risen since these data were first collected in 2008–09, from 22 to 131 separations per million people in 2013–14 (note that counts of methamphetamines separations are likely to be underestimated) (AIHW National Hospital Morbidity Database). These increases could partly be attributed to the increase in use of methamphetamines in their purer crystal form—crystal generally being recognised as the highest in levels of purity of methamphetamine (DoHA 2008)—which is generally considered to cause more potential harm.

What is the AIHW doing?

As with previous iterations of the NDSHS, the AIHW has established a Technical Advisory Group to provide advice on the survey design and content for the 2016 survey. Refinements to the 2016 questionnaire being considered include an additional question to measure the use of crystal methamphetamine in the previous 12 months, and changes to the pharmaceutical opioid/analgesic questions to better capture the misuse of prescription and over-the-counter opioids/analgesics.

A number of data-development activities have been identified to enhance the AODTS NMDS, including a review of treatment types and settings to better reflect current practice in the AOD sector; analysis of existing data items on pharmaceutical misuse and their involvement in polydrug use; and exploration of options for capturing treatment outcomes.

A data portal with dynamic and interactive data is also being developed.

The AIHW is undertaking a data linkage project to explore the relationship between AOD use and homelessness. This research will inform the development of integrated service approaches to help people with multiple and complex needs to stabilise their lives and reintegrate with the community.

What is missing from the picture?

People who use illicit drugs can be a difficult population to survey, as they may not wish to disclose that they are involved in an illegal activity. Currently, it is not possible to calculate the number of people who used crystal methamphetamine in the previous 12 months, from the NDSHS. From 2007, an additional question about the main form of meth/amphetamine used was added to the survey, which has enabled estimates to be produced for the minimum number of people using, but not for the total number who have used in the previous 12 months.

It is difficult to fully quantify the scope of AOD services in Australia. There are a variety of settings in which people receive treatment for alcohol and other drug-related issues that are not in scope for the AODTS NMDS. In addition, the AODTS NMDS does not cover all agencies providing substance-use services to Indigenous Australians. These agencies provide data to the Online Services Report collection.

Data on the different forms of amphetamines, and methamphetamine specifically, are not separately available in the AODTS NMDS due to the nature of the classification structure used in this collection.



Where do I go for more information?

For more information on illicit drug use and harms in Australia, see AIHW drug-related reports available online at www.aihw.gov.au/alcohol-and-other-drugs-publications/. The *National Drug Strategy Household Survey detailed report: 2013*; *Trends in methylamphetamine availability, use and treatment, 2003–04 to 2013–14*; and other recent publications are available for free download.

Additional research and statistics are available from the [National Drug and Alcohol Research Centre](#); the [Australian Crime Commission](#); [National Drug Research Institute](#); and the [National Centre for Education and Training on Addiction](#) websites.

Two key reports quantify the efforts of such agencies: the *Illicit drug data report*, produced by the ACC, and the *World drug report*, produced by the United Nations Office on Drug Crime.

References

- ACC (Australian Crime Commission) 2015. The Australian methylamphetamine market: the national picture. Canberra: ACC.
- AIC (Australian Institute of Criminology) 2015. Canberra: AIC. Amphetamines. Viewed 20 January 2016, <http://www.aic.gov.au/crime_types/drugs_alcohol/drug_types/amphetamines.html>.
- AIHW (Australian Institute of Health and Welfare) 2014a. Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.
- AIHW 2014b. National Drug Strategy Household Survey detailed report: 2013. Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW.
- AIHW 2015a. Alcohol and other drug treatment services in Australia 2013–14. Drug treatment series no. 25. Cat. no. HSE 158. Canberra: AIHW.
- AIHW 2015b. National opioid pharmacotherapy statistics annual data (NOPSAD) collection. Canberra: AIHW. Viewed 19 January 2016, <<http://www.aihw.gov.au/alcohol-and-other-drugs/nopsad/data-collection/>>.
- AIHW 2015c. The health of Australia's prisoners 2015. Cat. no. PHE 207. Canberra: AIHW.
- AIHW 2015d. Trends in methylamphetamine availability, use and treatment, 2003–04 to 2013–14. Drug treatment series no. 26. Cat. no. HSE 165. Canberra: AIHW.
- Campbell A 2001. The Australian illicit drug guide: every person's guide to illicit drugs—their use, effects and history, treatment options and legal penalties. Melbourne: Black Inc.
- Coghlan S & Godsmid S 2015. Findings from the DUMA program: impact of reduced methamphetamine supply on consumption of illicit drugs and alcohol. Canberra: Australian Institute of Criminology.
- Collins DJ & Lapsley HM 2008. The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004–05. National Drug Strategy Monograph Series no. 66. Canberra: Department of Health and Ageing.
- Department of Health 2015. The National Drugs Campaign. Viewed 8 October 2015, <<http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/home-1>>.
- DoHA (Department of Health and Ageing) 2008. Understanding the broad context of methamphetamine use. Canberra: DoHA. Viewed 11 March 2016, <<http://www.health.gov.au/internet/publications/publishing.nsf/Content/phd-npi-methamphetamine-report-feb09-l~context>>.
- IHME (Institute for Health Metrics and Evaluation) 2014. Data visualizations. Seattle: IHME. Viewed 16 October 2015, <<http://www.healthmetricsandevaluation.org/tools/data-visualizations>>.
- MCDS (Ministerial Council on Drug Strategy) 2011. The National Drug Strategy 2010–2015. Canberra: DoHA.
- McKetin R, McLaren J, Lubman DI & Hides L 2006. The prevalence of psychotic symptoms among methamphetamine users. *Addiction* 101(10):1473–78.



McKetin R, Ross J, Kelly E, Baker A, Lee N, Lubman DI et al. 2008. Characteristics and harms associated with injecting and smoking methamphetamine among methamphetamine treatment entrants. *Drug and Alcohol Review* 27(3):277–85.

NRHA (National Rural Health Alliance) 2015. Illicit drug use in rural Australia. Fact sheet 33, June 2015. Canberra: NRHA. Viewed 28 September 2015, <<http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-illicit-drugs-0615.pdf>>.

PM&C (Department of the Prime Minister and Cabinet) 2015. Release of the final report of the National Ice Taskforce. Canberra: PM&C. Viewed 10 December 2015, <<http://www.dpmc.gov.au/taskforces/national-ice-taskforce>>.

Ritter A, McLeod R, & Shanahan M 2013. Monograph no. 24: Government drug policy expenditure in Australia—2009/10. DPMP Monograph Series. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

Roxburgh A & Burns L 2015. Accidental drug-induced deaths due to opioids in Australia, 2011. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

Scott N, Caulkins JP, Dietze P & Ritter A 2015. Understanding and describing Australian illicit drug markets: drug price variations and associated changes in a cohort of people who inject drugs. Monograph series no. 58. Canberra: National Drug Law Enforcement Research Fund.

Sindicich, N & Burns, L 2014. Australian trends in ecstasy and related drug markets 2013. Findings from the Ecstasy and Related Drugs Reporting System (EDRS). Australian Drug Trends Series No. 118. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

Stafford J & Burns L 2014. Australian drug trends 2013. Findings from the Illicit Drug Reporting System (IDRS). Australian Drug Trend Series No. 109. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

White V & Bariola E 2012. Australian secondary school students' use of tobacco, alcohol, and over-the counter and illicit substances in 2011. Melbourne: Cancer Council of Victoria.

UNODC (United Nations Office on Drugs and Crime) 2015. World drug report 2015. Vienna: United Nations.