



a quick guide to

DRUGS ALCOHOL

a drug info @ your library publication





by Matthew Dunn and Heather Proudfoot
National Drug and Alcohol Research Centre (NDARC)
with chapter 15 Drugs and the law by Steve Bolt.

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Contents

| | |
|--|-----|
| <i>Introduction</i> | v |
| <i>About the authors</i> | v |
| 1 <i>About drugs</i> | 1 |
| 2 <i>Alcohol</i> | 11 |
| 3 <i>Benzodiazepines</i> | 23 |
| 4 <i>Cannabis</i> | 29 |
| 5 <i>Cocaine</i> | 37 |
| 6 <i>Ecstasy</i> | 43 |
| 7 <i>GHB</i> | 49 |
| 8 <i>Heroin</i> | 53 |
| 9 <i>Ice, speed and other methamphetamines</i> | 61 |
| 10 <i>Inhalants</i> | 67 |
| 11 <i>Ketamine</i> | 73 |
| 12 <i>LSD</i> | 77 |
| 13 <i>Magic mushrooms and other natural hallucinogens</i> | 81 |
| 14 <i>Tobacco</i> | 85 |
| 15 <i>Drugs and the law</i> | 93 |
| <i>Legal information and advice</i> | 125 |
| <i>Drug and alcohol information, support and treatment centres</i> | 127 |
| <i>Online information</i> | 135 |
| <i>References</i> | 137 |



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Introduction

This book is intended for anyone who is interested in finding accurate information about drugs and alcohol—for young people, their parents, teachers and the community. It is not a medical or scientific book, it is set out in easy to read sections so that you can find the information that you require quickly, and read as much or as little as you like.

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National Drug and Alcohol Research Centre (NDARC)

The National Drug and Alcohol Research Centre (NDARC), is an internationally recognised Research Centre of Excellence. The Centre is multidisciplinary and collaborates with medicine, psychology, social science and other schools of the University of NSW, as well as with a range of other institutions and individuals in Australia and overseas.



Image: Age Fotostock



1

About drugs

Drugs are substances that change a person's physical or mental state.

The vast majority of drugs are used to treat medical conditions, both physical and mental. Some, however, are used outside the medical setting for their effects on the mind. These are referred to as **recreational** drugs, and many of them are illegal in Australia.

Psychoactive drugs

Drugs that affect a person's mental state, whether prescribed for a medical condition (for example, antidepressants) or taken for recreational purposes (such as alcohol and heroin), are called **psychoactive** drugs. Psychoactive drugs affect the way a person thinks and feels—which may also affect the way they behave.

The most commonly used legal psychoactive drugs, apart from drugs taken on prescription, are alcohol and tobacco. The most commonly used illegal psychoactive drug is cannabis (marijuana).

Categories of psychoactive drugs

Psychoactive drugs are divided into three categories (some drugs fall into more than one category):

- » **Depressants** slow down the activity of the central nervous system (the brain and spinal cord), which reduces a person's alertness, and also slows down functions such as breathing and heart rate. Examples of depressants are alcohol, heroin, cannabis, the prescription drug group of benzodiazepines and other prescription tranquilisers.
- » **Stimulants** increase the activity of the central nervous system, making the person more alert and aroused. Examples of stimulants are nicotine, caffeine, cocaine, ecstasy and the methamphetamines, speed and ice.
- » **Hallucinogens** make a person see, hear, smell or feel things that aren't there. Examples of hallucinogens are LSD, magic mushrooms, ecstasy and cannabis.

Why do people use psychoactive drugs?

People use drugs for many reasons—for fun or excitement; to feel good, better or different; to counteract negative feelings; because they are bored or curious; because their friends or family do it; or because they have a dependence on the drug. Often people who use drugs associate with other people who use drugs. It is not always clear which comes first—the friends or the drugs.

Drug dependence

Drug dependence may occur when a person continues to use drugs—legal or illegal—even though their drug use causes them significant problems. It is regarded by many as a medical condition or a disorder not directly under the control of the individual. The term 'addict', with its negative implications, is not used any longer.

Drugs & young people

Young people take drugs for much the same reasons as older people, often with the added element of rebellion. However, the consequences can be much worse. Childhood and adolescence are critical times for brain development, and the brain is more sensitive to the influences of drugs and alcohol during these periods. For example, there is evidence that alcohol use in young people can lead to impaired learning and memory which can affect them for the rest of their lives.

In general, drug dependence may be diagnosed if a person:

- » spends a significant amount of time obtaining the drug, using it, and/or recovering from its effects
- » develops a tolerance to the drug (see below)
- » continues using the drug even though they know it is causing them psychological and/or physical harm
- » wants to cut down or control their drug use (and perhaps makes repeated unsuccessful attempts to do so)
- » takes more of the substance, or uses it for longer, than they intend
- » reduces, or gives up entirely, important social, recreational and/or work activities because of their drug use
- » suffers symptoms of withdrawal when they stop using the drug (see below).

Three or more of these symptoms is generally considered sufficient for a diagnosis.

Tolerance

After using a drug for a while, a person may find that:

- » they need to take more of the drug to get an effect that they previously got with less, or
- » the drug simply becomes less effective in producing the desired effect.

This is called **tolerance**.

Withdrawal

When a person who has been using a drug stops taking it, or reduces the dose, they may experience a physical and/or psychological reaction. This is called **withdrawal**. Because the dependent person has become tolerant to the drug's effects, they have been taking the drug just to feel normal. When they stop taking the drug, they may experience the opposite to the highs the drug originally gave them.

Withdrawal can be very unpleasant, producing symptoms such as tremors, sweating and vomiting, as well as extreme craving. For some drugs and some individuals, medical supervision during withdrawal is necessary.

The strength of the withdrawal varies, depending on:

- » the individual person
- » the drug they have been using
- » how much they have been taking
- » how long they have been taking it.

Bad withdrawal symptoms can make it very difficult for a user to stop or reduce their drug intake.

Detoxification

Detoxification is the term that used to be applied to withdrawal management. The process by which the body is purged of the drug and its immediate physical and psychological effects is called detoxification.

Detoxification usually leads to some level of withdrawal, and medical assistance may be required. Anti-anxiety drugs such as benzodiazepines are sometimes prescribed for a short time during medically-supervised withdrawal.

Treatment

Withdrawal is only the first step towards recovering from drug dependence. Most people also need access to effective treatments.

A number of options for treating drug and alcohol dependence are available in Australia. Some seek to help the person achieve a drug-free lifestyle, while others recognise abstinence as one option among others. All treatments have the primary aim of minimising the harm and the risks associated with drug use.

Treatment is most effective if it is tailored to suit a person's circumstances, and it usually involves a combination of methods.

- » For many drugs—including alcohol and tobacco—**psychological interventions** and good **social support** are important elements of recovery.
- » For a few drugs, there are effective medical interventions (**pharmacotherapies**).

- » For some drugs, there has been little or no research on effective treatments, mainly because these drugs are less widely used and have lower impact on society or they have only recently been developed.

Although in most cases a person on treatment lives in their own home during treatment, some residential programs are available. These may be appropriate for people with serious problems who have little social support.

Psychological interventions

Three types of psychological intervention have been found effective for a broad range of drugs.

- » **Motivational enhancement** is an approach used by the therapist to help the client to decide for themselves that they really need to change their behaviour. This can help maintain commitment in people who might otherwise leave treatment before it can be effective.
- » **Cognitive behavioural therapy** seeks to change the thoughts and ideas that led to dependence in the first place, replacing them with more constructive ways of thinking. It can also be used to help a person recognise situations that place them at risk for resuming drug-taking, and to reduce the anxiety often associated with stopping drug use.
- » **Contingency management** typically uses rewards, such as vouchers, to encourage compliance with treatment and reduce drug use (**voucher-based reinforcement**). The vouchers are exchangeable for goods and services in the community, and clients are rewarded if they meet specific treatment goals such as drug-free urine, on-time attendance at treatment or medication compliance.
- » **Social and family support services** provide psychological support as well as helping with medical, financial, housing and legal issues, and are important in maintaining recovery in the community.

Peer support programs

Peer support programs such as Alcoholics Anonymous and Narcotics Anonymous may be helpful for people who can relate to their particular philosophical approach. Other peer support groups use a 'rational recovery' approach.

See pages 127-133 for contact details of drug and alcohol treatment centres and advice lines.

Pharmacotherapy

Pharmacological treatments usually involve replacing the drug with a less harmful alternative; for example, heroin may be replaced by methadone. This allows the person to regain some control over their life, and may ultimately lead to a drug-free lifestyle.

Pharmacological treatments are not available for all drugs, and even when they are available they do not work for everyone. They must be accompanied by good social and psychological support to be effective.

Polydrug use

Polydrug use means:

- » using two or more drugs in combination
- » using one drug to counteract the effects (or the after effects) of another
- » using different drugs at different times over a short period of days or weeks.

Most illegal drug users are polydrug users.

The dangers of polydrug use

Using a single psychoactive drug can be dangerous; using more than one significantly increases the risks. In particular, if two drugs of the same type, such as the depressants heroin and alcohol, are used together, there are greatly increased risks of accidents, overdose and death.

Other common dangerous drug combinations include cannabis with alcohol, ecstasy with alcohol, heroin with sedatives, and amphetamines with sedatives.

Because alcohol is the most widely abused psychoactive drug, it is also the most commonly involved in risky polydrug use.

Drugs and driving

Many psychoactive drugs, including alcohol, have effects on the brain that make operating machinery, and particularly driving a vehicle, more dangerous.

Drugs, driving and the law

It is against the law to drive under the influence of alcohol or any illicit drug (see page 113 for further details).

Random drug testing is used in NSW. Police can administer an oral drug test to any driver. Cannabis, ecstasy and methamphetamines can be detected through roadside testing. A person who tests positive is prohibited from driving for 24 hours. The sample is sent to a laboratory for more precise analysis, and if the presence of an illegal drug is confirmed the driver may be charged. A person can also be arrested and taken to a hospital for a blood and urine test if a police officer has a reasonable suspicion that they are driving under the influence of drugs. The samples will be sent to a laboratory and if they test positive for any drug (including prescribed drugs) NSW Police will decide whether the person's driving would have been impaired by their drug use. The person will then be charged accordingly.

A driver under the influence of an illegal drug who causes the death or injury of another road user can face criminal charges, with the possibility of a prison term if convicted.



Image: Age fotostock

Driving under the influence: the research

A 2007 report from the Australian Drug Foundation summarises the Australian research on driving under the influence of drugs and alcohol.¹

The percentage of drug users who reported driving under the influence of a drug (that is, driving within three hours of using the drug) at least once in the previous 12 months were:

- » cannabis users: 50%
- » methamphetamine (ice and speed) users: 50%
- » ecstasy users: 40%
- » benzodiazepine users: 30%
- » alcohol users who drove over the .05% alcohol limit: 14%.

The percentages were lower for other drug types.

Although in percentage terms the alcohol figure is lowest, in absolute numbers it is highest because of the vastly greater number of drinkers. The report found that alcohol is the single most frequently implicated substance in car crashes, and is involved in around 30% of all road accidents. However, 30% of accidents also involve a drug other than alcohol (including prescription drugs)—much higher than might be expected given the estimated rates of drug-driving in the community.

- » The research also found that polydrug use is a significant factor in road accidents. Alcohol with benzodiazepines, and alcohol with cannabis, were found to be the most dangerous combinations. In particular, around 43% of fatally injured drivers with cannabis in their body were also under the influence of alcohol.

Community perceptions

The report also showed that many people underestimate the risks involved in driving while affected by drugs—particularly with illegal drugs, for which less information is available. For instance, if alcohol users and non-users are asked if driving above the blood alcohol level of .05 is dangerous, over 90% in both groups agree. However, only around 30% of cannabis users (compared with 80% of non-users) think driving under the influence of cannabis is very risky or dangerous. Similar differences in estimating risks are found for users and non-users of methamphetamines and ecstasy.



Image: Age fotostock

Drugs and pregnancy

Most drugs taken during pregnancy cross the placenta and reach the unborn child. Some of these drugs, such as alcohol, can be harmful to the developing child. Premature birth and low birth weight have been linked to the use of heroin, cocaine and methamphetamines during pregnancy.

See the relevant chapter on a particular drug for information about the health risks of drug use during pregnancy.

If a mother uses drugs while breastfeeding, it is possible that the drug will be present in her milk and may have adverse effects on the baby.

Check with your doctor if you are taking or planning to take any drug during pregnancy or breastfeeding, including prescribed and over-the-counter medications.

Drugs and mental health

Some drugs, such as cannabis, LSD, ecstasy, ice and speed, can directly produce effects that resemble symptoms of mental illness, such as hallucinations or paranoia. These effects usually disappear once the drug is out of the person's system.

However, many people who seek treatment for drug or alcohol problems also have mental health problems that are not due to their current drug use. These people tend to be more unwell and are more difficult to treat than people with a single disorder.

It has been suggested both that mental illness can cause drug problems (when a person takes drugs in the hope of escaping their symptoms), and that heavy drug use over time causes mental health problems. Most of the evidence, however, seems to indicate that the same factors can lead to both types of problems; that is, biological, social and/or environmental factors predispose a person to have both a mental health and a substance abuse problem.

Both drug and alcohol and mental health services have become much more aware of this situation, and best practice in both areas is now to treat both disorders if this is appropriate. If you are choosing a drug and alcohol treatment program for a friend or relative, it is important to ask whether they will help with any mental health problems.

If the client is a polydrug user, it is also important that the agency can treat each type of drug.

Prevalence of mental health problems associated with drug use

Statistics from the 2007 National Drug Strategy Household Survey found that around 20% of those who used illegal drugs in the month preceding the survey said they were suffering 'high or very high psychological distress'. This compared with around 9% of those who did not use illegal drugs in that month. While the figure of 20% applied to most illegal drugs, heroin users are much more affected, with 65% expressing high or very high psychological distress.²



2

Alcohol

Grog, booze, hooch, moonshine, goon, vino, piss

Alcohol is a **depressant** (see definition on page 2).

The alcohol that people drink is **ethyl alcohol** (there are other kinds, all very poisonous). It is made from a mixture of yeast and water, fermented with grains, vegetables or fruits. The fermentation process changes natural sugars into alcohol. Beer and whisky are made from grains, wine and brandy from grapes, vodka from potatoes, cider from apples, and rum from sugar, to name just a few of the most popular alcoholic drinks.

Alcohol concentration varies considerably with the type of drink. In Australia, beer contains 0.9 to 6% alcohol, wine 12 to 14%, fortified wines such as sherry and port around 18 to 20%, and spirits such as scotch, rum, bourbon and vodka 40 to 50%.

People have been drinking alcohol for tens of thousands of years, as part of various religious ceremonies, as a painkiller, and for socialisation and fun. It is the most commonly used and socially acceptable recreational drug in Australia.

Alcohol and the law

It is legal to drink and sell alcohol in Australia, provided certain conditions are met.

Consuming alcohol

- » Consumption of alcohol in designated alcohol-free zones is illegal.
- » Police can detain a person who is drunk in a public place and behaving in a disorderly way.
- » It is illegal for a fully licensed driver to drive with a blood alcohol concentration of .05 or over. Learner and provisional drivers must have a blood alcohol concentration of zero. See page 18 for more about alcohol and driving.

Selling alcohol

- » It is illegal to sell alcohol to a person who is already drunk.
- » It is illegal to sell alcohol to anyone under 18.
- » Premises where alcohol is sold must have an appropriate licence. It is also necessary to obtain a licence to serve alcohol at certain events and functions.

People under 18

- » People under 18 are not permitted to drink in pubs, clubs or licensed restaurants.
- » People under 18 can drink in their own home, or a public place where drinking is legal such as a BYO restaurant, as long as they are supervised by:
 - › their parent or guardian, or
 - › another responsible adult with the permission of their parent or guardian.

How alcohol is used

Alcohol is usually drunk in social situations for its relaxing effects, which tend to reduce people's inhibitions (many people believe it is a stimulant rather than a depressant, because of the mood and behavioural effects of reduced inhibition).

How common is alcohol use?

The 2007 National Drug Strategy Household Survey found that alcohol is the most widely used recreational drug in Australia, with 83% of people aged 14 or more having at least one drink in that year. Approximately 18% of 16 and 17-year olds, and 41% of 18 and 19-year olds, reported drinking alcohol on a weekly basis. Young females are reversing a historical trend by engaging in more risky drinking practices than young males.

The survey defined risky or high-risk drinking as having more than five drinks per day for females and more than seven drinks for males.³

Effects

Short-term effects

Alcohol is absorbed rapidly into the bloodstream and affects the brain within about five minutes (absorption may be slower if the person has recently eaten).

Alcohol depresses the central nervous system, slowing down heart rate, breathing and other body functions. Other short-term effects may include:

- » reduced inhibitions
- » a sense of relaxation
- » loss of alertness and coordination, and slower reaction times
- » impaired memory and judgement
- » nausea, shakiness and vomiting
- » blurred or double vision
- » disturbed sleep patterns
- » disturbed sexual functioning (such as difficulty in maintaining an erection).

As consumption continues these effects are increased, which increases the risks involved in driving, using machinery or making decisions affecting safety.

The effects gradually wear off as the alcohol is broken down by the gut and liver. It takes about an hour for the body to break down the alcohol in one standard drink (see page 16), although there is considerable variation between individuals. It takes longer if there is damage to the liver.

Variation in effects

Because of the way alcohol is stored and processed by the body, people with a lower proportion of body fat and a higher proportion of body fluids, and larger people, are generally less affected than others by the same amount of alcohol. This means that some members of the following groups may be more vulnerable to the effects of alcohol:

- » women, who are generally smaller than men and usually have a higher proportion of body fat
- » older people, who tend to have lower levels of body fluids
- » young, physically immature people
- » other relatively small people.

A person's general state of health, and whether they have recently eaten, also has an effect.

Australian Alcohol Guidelines and standard drinks ⁴

The National Health and Medical Research Council (NHMRC) publishes guidelines for reducing the health risks of drinking alcohol.

New guidelines were published in 2009, which differ in important respects from the previous guidelines. There are now only four basic recommendations, which can be summarised as follows:

- » **To reduce the risk of alcohol-related problems over a lifetime** (such as chronic disease or injury), a healthy adult should drink no more than two standard drinks (see page 16) a day. Having alcohol-free days and drinking less per occasion reduces the lifetime risk still further.
- » **To reduce the *immediate* risks associated with drinking** (such as injuries under the influence of alcohol), a healthy adult should drink no more than four standard drinks on any one occasion. (No distinction is made between men and women in this recommendation. Although women may become intoxicated more easily, men are at greater risk because they are more likely to engage in risky behaviour.)
- » **There is no safe drinking level for people under 18.** Young people should delay drinking at least until they turn 18. The risk is particularly high for those under 15. If younger people do drink it should be at a low risk level, in a safe environment and supervised by adults.

- » **Women who are *pregnant, planning a pregnancy or breast feeding*** should not drink at all. The greatest harm to the foetus or breastfeeding infant occurs when drinking is at high and frequent levels, but no level of drinking is considered safe. The guidelines do not mean that any drinking is recommended. In fact they suggest that there is no universally safe level of drinking.



Image: Age fotostock

Standard drinks

The amount of alcohol in a can, bottle or glass of an alcoholic drink is often expressed in terms of **standard drinks**. One standard drink contains 10g of alcohol.

How many standard drinks?

The illustration shows some common alcoholic drinks, and how many standard drinks each typically contains.⁵



These are only an approximate number of standard drinks.
Always read the container for the exact number of standard drinks.

Image: Department of Health and Ageing

The hangover

On the day following a drinking session a person may experience more or less severe nausea, headache and fatigue. These are symptoms of dehydration. Alcohol is a diuretic; that is, it causes increased fluid loss. The fluids must be replaced by non-alcoholic drinks if dehydration is to be avoided.

Some alcoholic drinks, including brandy, bourbon and red wine, contain substances called **congeners**, which can also cause symptoms associated with hangover.

Smoking, drinking on an empty stomach, and drinking quickly, add to the severity of the hangover.

Drink spiking

Risky drinking in women is often associated with unwanted sex and rape. Apart from knowingly drinking too much, women can also be victims of **drink spiking** (adding alcohol or other drugs to a person's drink without their knowledge). Most drink spiking involves adding extra alcohol to ordered drinks.

However, despite the emphasis on drink spiking in the media, women (and men) are far more likely to have unwanted sex as a result of the loss of inhibition and judgement caused by knowingly drinking to excess.

Long-term effects

Heavy use of alcohol over a lifetime increases the risks of:

- » some oral, throat and breast cancers
- » liver cirrhosis
- » brain damage and dementia
- » some forms of heart disease and stroke.

There is some evidence that drinking at low risk levels may help reduce the risk of heart disease in older people. However, it is important to remember that heavy drinking is always risky.

In terms of death and injury, alcohol is second only to tobacco in causing preventable harm in Australia. For example, in 2003 alcohol was considered to have caused 1100 deaths. In 2004-5, 37% of Australians attending drug and alcohol treatment services said that alcohol was their main problem—more than for any other substance.⁶

Alcohol and driving

The effects of alcohol on both physical and mental functioning make driving hazardous—alcohol is involved in around one-third of all road deaths. The risk increases with the amount of alcohol in the bloodstream. For this reason it is against the law to drive with a blood alcohol concentration over a prescribed limit.

Blood alcohol concentration is measured in grams per 100ml (g/100ml)

- » For most fully licensed drivers, the limit is 0.05.
- » For drivers with a learners or provisional licence—L or P-plate drivers—the limit is zero.
- » For people driving heavy vehicles or public passenger vehicles—trucks or buses—and people driving vehicles containing dangerous goods, the limit is 0.02

The amount of alcohol that can be drunk before a person reaches the legal limit varies considerably from one person to another, and for the same person in different circumstances (see box on page 14).

Generally speaking, a guide for keeping below the 0.05 limit is:

- » for men, no more than two standard drinks in the first hour of drinking, and no more than one per hour after that
- » for women, no more than one standard drink in the first hour of drinking, and no more than one per hour after that.

See page 16 for the definition of a **standard drink**.

Learner and provisional licence holders should not drink at all if they intend to drive.

Binge drinking

Drinking to the point where the more severe negative effects of drinking alcohol occur, especially intentionally, is called **binge drinking**.

Because being drunk stops a person thinking clearly and acting sensibly, a person who drinks to excess may put themselves and others at risk from injury due to falls, physical assault and dangerous behaviour. This is why alcohol is closely associated with road accidents, fights, violence, unwanted sexual activity and unprotected sex. Alcohol use has also been found to be associated with suicide and self-inflicted harm.

Driving with a blood alcohol concentration over the legal limit is a serious offence. A drunk driver who causes the death or injury of another road user can face criminal charges, with possible imprisonment if convicted.

Alcohol and pregnancy

Heavy drinking during pregnancy increases the risk of miscarriage, stillbirth, and perinatal death. It may also cause **foetal alcohol spectrum disorder** in the unborn baby, a condition leading to developmental defects, which can range from less to more serious.

After birth, the babies of alcohol dependent mothers can suffer withdrawal symptoms, including tremors, irritability and fits.

The Australian National Health and Medical Research Council suggests that there is no safe level of drinking during pregnancy, and that, if possible, a pregnant woman (or a woman planning a pregnancy) should not drink at all. However, low levels of drinking appear to carry a correspondingly low risk.

Alcohol and breastfeeding

Alcohol in the mother's bloodstream passes into breast milk. It can reduce the milk supply, and can cause irritability, poor feeding, sleep disturbance, and poor psychomotor development in the baby.

Alcohol and mental health

Many people who have alcohol-related problems also have mental health problems. For example, people with posttraumatic stress disorder (such as war veterans and people who have experienced violence) are more likely to develop problems with alcohol.

There are also strong associations between alcohol problems and anxiety and depression, as well as severe mental disorders (schizophrenia, bipolar disorder and major depression).

The use of alcohol, like other self-administered drugs, makes problems arising from mental illnesses worse.

As breastfeeding has many advantages for a young baby, it is recommended that a mother who does choose to drink should continue to breastfeed her baby, but keep her alcohol consumption to a low level, not drink before feeding the baby, and not drink at all until the baby is one month old. Expressing milk before drinking may be an option.⁷

Using alcohol with other drugs

Because alcohol depresses brain activity it should not be used with other drugs or medications that have similar effects on the brain, such as benzodiazepines, cannabis and heroin. Drinking alcohol while using these drugs can cause bodily functions to slow to the point where death occurs. Many heroin overdoses are associated with heavy alcohol use.

A person taking a prescription medication should always find out about the possible effects of drinking alcohol at the same time by reading the information that comes with it, and discussing the matter with their doctor or pharmacist.

Dependence

Heavy or regular alcohol use can lead to dependence (see definition on page 2).

Withdrawal

When a dependent drinker suddenly stops or reduces their drinking they are likely to experience withdrawal symptoms—which makes stopping more difficult. Withdrawal symptoms can be quite mild or quite severe, ranging from insomnia and shakiness to severe seizures and **delirium tremens**—often called the DTs—which is characterised by gross trembling of the whole body, fever and delirium.



Image: iStockphoto

Most people do not suffer delirium tremens, but there can be significant risks in withdrawing from alcohol, and people undergoing withdrawal should be monitored.

Reducing the harm

Alcohol use and abuse pose a high cost to society through the impact on individual health and workplace productivity. There are also costs related to drink driving and community violence. Research has estimated that in Australia during 2004-05 the social cost of alcohol related harms to the individual was \$15.3 billion.⁸ Research by the Alcohol, Education and Rehabilitation Foundation (AERF) published in 2010 looked at the cost of alcohol abuse to those other than the drinker. This cost has been estimated at over \$20 billion, putting the total cost per year of alcohol-related harms in Australia at \$36 billion.⁹

Some suggestions for reducing costs are:

- » higher alcohol taxes, with higher taxes for drinks that are most often abused
- » partial or complete bans on the advertising and promotion of alcohol
- » increased measures to reduce drink driving
- » a greater involvement by GPs in explaining risks and risk-reduction strategies to their patients.

The 2005 research also recommended:

- » greater control of drinking environments such as clubs and pubs
- » alcohol ignition locks on vehicles driven by convicted drink-driving offenders
- » guidelines to help people drink at low risk levels
- » standard labelling and health warnings on bottles and cans.

Most people who are going through withdrawal are treated on an outpatient basis; that is, they are not hospitalised, but they do have medical support. Sometimes medications such as benzodiazepines are prescribed to help reduce the severity of symptoms.

Overdose

If drinking continues for an extended period, bodily functions can decrease to such an extent that the person loses consciousness (blacks out), which can lead to death by suffocation if the person vomits while unconscious.

In rare cases, a person's physical functioning may decrease to the point where they stop breathing. This is called **alcohol poisoning**.

Treatment

Advice from a GP or other health professional can be effective, especially with people who have milder alcohol problems.

For those with more serious problems, other forms of treatment may be required. This may involve withdrawal under medical supervision, followed by psychological or medical treatments to help prevent the person going back to their risky behaviour.

Psychological treatments such as motivational interviewing, cognitive behavioural therapy and contingency management (see page 5) have been found to be effective in treating alcohol disorders. More recent research has found that naltrexone, acamprosate and/or disulfiram in conjunction with psychological treatment can improve recovery.

Support groups may also be an option.



Image: Age fotostock



Benzodiazepines

benzoes, downers, sleepers, rohies, roofies, moggies, sarahs, footballs, normies

Benzodiazepines belong to a group of central nervous system depressants (see definition on page 2) called **minor tranquilisers**. They come as pills in a variety of colours and shapes, according to the brand.

The first benzodiazepine (chlordiazepoxide) was synthesised in 1954 in Austria. It was discovered by chance during research on chemical dyes, and found to be a very effective tranquiliser. It was marketed in 1959 under the brand name Librium.

Valium, which became a very popular drug, was released in 1963, and since then many other benzodiazepines have been developed.

Benzodiazepines and the law

Benzodiazepines can be prescribed by doctors, and are legal if used as prescribed.

It is illegal:

- » to use benzodiazepines without a prescription, or to give or sell them to other people
- » to drive if you are using unprescribed benzodiazepines.

How benzodiazepines are used

Benzodiazepines are widely prescribed in Australia for problems such as anxiety and insomnia. They can also be prescribed for epilepsy, alcohol withdrawal, and agitation in severe psychiatric disorders. Prescribed benzodiazepines are taken orally as pills. Because there is a high risk of dependence, benzodiazepines are usually prescribed for short-term use only.

Benzodiazepines are also used illegally as recreational drugs. In this case they may be ground to a powder, mixed with water and injected, as well as being swallowed as pills.

Effects

Short-term effects

The immediate effects of taking benzodiazepines include:

- » a feeling of relaxation, sleepiness and lack of energy
- » dizziness
- » euphoria
- » confusion
- » visual distortions
- » moodiness
- » short-term memory loss.

Some common benzodiazepines and their trade names

diazepam—Valium, Ducene, Antenex, Valpam
oxazepam—Serepax, Murelax, Alepam
nitrazepam—Mogadon, Alodorm
temazepam—Normison, Temaze, Temtabs
lorazepam—Ativan
flunitrazepam—Rohypnol, Hypnodorm
bromazepam—Lexotan
clonazepam—Rivotril, Paxam
alprazolam—Xanax, Kalma

How common is illegal benzodiazepine use?

The 2007 National Drug Strategy Household Survey found that 8% of injecting drug users had recently injected benzodiazepines.¹⁰ Australian Drug Trends 2006, which surveys injecting drug users across Australia, found that between one-third and one-half of those interviewed had obtained benzodiazepines illegally in the past six months.¹¹

There is little information about non-injecting illegal use of benzodiazepines.

Benzodiazepines take around 30 minutes to work when they are swallowed as pills, because they have to be digested before the drug can enter the blood stream. Injected benzodiazepines have an almost immediate effect.

Like other depressants, benzodiazepines affect both physical and mental performance, reducing coordination, slowing reaction times and impairing memory. There is increased risk of accidents and falling, and impairment of performance in tasks such as driving.

Different benzodiazepines are processed by the digestive system and eliminated from the body at different rates. For example, the effects of one of the more common short-acting benzodiazepines, temazepam, reach a peak after two or three hours; the drug ceases to be effective after about six to eight hours. The effects of diazepam (Valium), on the other hand, peak after 30 to 90 minutes, while the drug remains in the blood for up to three days.

There is also considerable variation between individuals, depending on various factors such as age and liver health.



Rohypnol

Image: U.S. Drug Enforcement Administration

Long-term effects

There is a long list of adverse physical and mental effects are associated with long-term benzodiazepine use, including:

- » anxiety, irritability, paranoia, aggression, and depression
- » muscle weakness, rashes, nausea and weight gain
- » sexual problems
- » menstrual irregularities
- » memory loss, confusion, lethargy and sleep problems.

Risks of injecting benzodiazepines

Injecting any drug can lead to serious health problems, including collapsed veins, cellulitis (infection of the deep layers of the skin) and the spread of blood-borne viruses such as HIV and hepatitis. Injecting benzodiazepines can have even more serious effects. Benzodiazepine tablets must be dissolved before they can be injected, and the result is a sticky or lumpy fluid that has the potential to damage the circulation. Possible consequences are organ damage, loss of limbs, stroke and, occasionally, death.

Benzodiazepines and driving

Benzodiazepines can cause drowsiness, confusion, and slowed reaction times. It is dangerous, as well as illegal, to drive while using unprescribed benzodiazepines.

If you have been prescribed benzodiazepines, you should not drive if your doctor has advised you not to, or if you experience symptoms of drowsiness or confusion.

Benzodiazepines and pregnancy

Benzodiazepines cross the placenta to the unborn baby. High doses can cause the baby to be born with poor muscle tone, poor feeding ability, drowsiness and low body temperature.

A woman who is pregnant or is planning a pregnancy, and who has been prescribed benzodiazepines, should discuss this with her doctor.

Using benzodiazepines with other drugs

The 2007 National Drug Strategy Household Survey found that for recent users of tranquillisers, mainly benzodiazepines, 42.5% used alcohol, 34.1% used no other drug at the same time, and 25.2% used marijuana/cannabis.¹²

Using benzodiazepines with alcohol, which, like benzodiazepines, is a depressant, has been shown to increase the risk of dying from sedative overdose.

Heroin users sometimes use benzodiazepines as a substitute for heroin if it is unavailable. Benzodiazepines can also be used both to help withdrawal from heroin, and to increase its effects. Since heroin is another depressant, however, combining the two drugs greatly increases a person's risk of dying from a heroin overdose; benzodiazepines are involved in about a quarter of heroin overdose deaths.¹³

People who use amphetamines and ecstasy often use benzodiazepines to help them relax or sleep when they are recovering from the effects of these stimulant drugs.

Dependence

Benzodiazepines are highly addictive, and are therefore prescribed only for short-term use. Tolerance can develop quickly; this means that dosage must be increased to get the same effect, increasing the chances of dependence (see definition on page 2). It is possible to become dependent and suffer withdrawal symptoms after only two weeks of regular use.

Withdrawal

Common symptoms of benzodiazepine withdrawal are often those for which the drugs were prescribed in the first place, such as insomnia, anxiety and irritability. Other possible symptoms include headaches, nausea, tremors, sweating, loss of appetite, visual and hearing disturbances, digestive disturbances, hallucinations and fits.

Symptoms can be decreased by gradually reducing the dose rather than stopping suddenly.

Overdose

Overdosing on a benzodiazepine alone rarely results in death; if benzodiazepines are taken with other depressants, such as alcohol or heroin, death is a far more likely outcome.¹⁴

Very high doses of benzodiazepines can, however, lead to unconsciousness or even coma. A person who has taken an excessive dose can die by passing out and suffocating on vomit or mucus.

Treatment

Treatment for benzodiazepine dependence involves a gradual withdrawal of the drug under medical supervision. The longer the process of withdrawal, the more effective the treatment is likely to be in the long term.

Psychological treatments aimed at keeping the person motivated and improving their coping skills (see page 5) are recommended to maintain recovery. Good social support can also be very helpful.



Benzodiazepine pills

Image: Australian Drug Foundation



4

Cannabis

marijuana, dope, pot, grass, weed, ganga, gunja, mull, doobie, mary jane, bud, hash, bhong, skunk, head, hydro, chronic, yandhi, bush

Cannabis comes from the *Cannabis sativa* plant. The primary active ingredient is THC (delta-9 tetrahydrocannabinol), a central nervous system depressant (see definition on page 2).

THC can also act as a hallucinogen (see definition on page 2).

Cannabis comes in three different forms:

- » **marijuana**, the dried leaves and flowers of the cannabis plant—this is the weakest form
- » **hashish (or hash)**, the dried resin from the cannabis plant, which is stronger than marijuana
- » **hashish oil (or hash oil)**, which is oil extracted from hashish, which is the most potent form.

The cannabis plant has been used for centuries for two very different purposes:

- » its effects as a drug
- » the production of hemp fibre.

Cannabis grows easily in a wide range of environments (hence the name 'weed'), and is a prolific source of hemp, which can be used to make cloth. Rope was usually made from hemp fibre before synthetic fibres were introduced.

Cannabis was first used for medical and religious purposes in China, India and the Middle East. It was introduced to the Western world via India in the early 1800s, and was the most commonly used drug for pain relief before the introduction of aspirin in the late 1800s.

The medical use of cannabis

THC has been trialled for medical use to relieve the discomfort of cancer treatments, for people with spinal cord injuries, and for people with damage to their gut lining. This use is controversial both because it is an illegal substance in Australia and most other countries, and because of the harm associated with smoking—the usual way of taking cannabis. Inhaling the cannabis using a vaporiser (oral spray) has been found to be a suitable alternative for medical purposes.

The medical use of cannabis is legal in some countries, and under review in Australia.¹⁵



Cannabis buds

Image: U.S. Drug Enforcement Administration

Cannabis and the law

The use, possession and supply of cannabis is illegal in all states and territories in Australia. It is also illegal to possess items used to take cannabis, such as bongs. In NSW, first offenders with a small amount of cannabis may be issued with a formal caution, which can include information about the harm associated with cannabis use and a number to call for drug-related information or referral. A person can receive up to two cautions.

More serious or subsequent offences may lead to a period of imprisonment.

How cannabis is used

Marijuana is usually smoked, rolled up in a cigarette paper (a **joint**), usually, but not necessarily, with tobacco. A water pipe (a **bong**) may also be used.

Hashish oil can be soaked into cigarette papers and smoked with tobacco.

All types of cannabis can be cooked into food and eaten.

Effects

Short-term effects

When cannabis is smoked the active ingredient is absorbed directly from the lungs into the blood stream, and the effect is almost immediate. Cannabis eaten in food takes longer to have an effect (up to 60 minutes), as it must be digested before it can enter the blood stream. This method does not carry the risks associated with smoking, but the time lapse between consumption and effect makes it hard for the user to judge how much to take.

The effects of cannabis vary considerably from one person to another; relevant factors include mood, body weight, the person's previous



*Bong
Image U.S. Drug Enforcement
Administration*

experience with cannabis and the type being used. In some cases there may be no noticeable effects at all.

Short-term effects may include:

- » a feeling of being 'stoned'—relaxed, euphoric and uninhibited
- » enhanced sensory perceptions, particularly enjoying food, for example, or music
- » feelings of hunger (having 'the munchies')
- » panic reactions, confusion and feelings of paranoia
- » nausea, headaches and reddened eyes
- » dizziness, with impaired balance and coordination.

When the active ingredient is particularly strong, psychotic symptoms such as hallucinations can occur.

Cannabis intoxication can impair a person's ability to perform tasks requiring coordination, judgement and quick reactions, such as driving.

The short-term effects of cannabis can last from two to four hours, but the drug is stored in fatty tissue for anything up to four weeks.

How common is cannabis use?

Cannabis is the most commonly used illegal drug in Australia.

The 2007 National Drug Strategy Household Survey found that almost one in eight teenagers (people aged from 14 to 19) had used cannabis in the previous 12 months, while people in the 20-29 age group were the main users, with one in five reporting use in the previous 12 months.

The survey found that there had been a steady decline in the use of cannabis across most age groups since 1998. In 1998, 17% of the population aged 14 and over reported using cannabis in the previous 12 months. By 2004 this had decreased to 11%, while by 2007 it was 9%.¹⁶

Long-term effects

Ongoing heavy use may:

- » increase the risk of lung cancers
- » cause chronic bronchitis and permanent damage to the airways

- » damage the cardiovascular system (the heart and circulation)
- » lead to mental health effects—see box page 34.

Babies whose mothers smoke cannabis in pregnancy (like those whose mothers smoke tobacco) are more likely to be born prematurely and at a low birth weight.

Cannabis and driving

It is dangerous, and illegal, to drive under the influence of cannabis. Research suggests that a driver affected by cannabis is two to three times more likely to have an accident.¹⁷

Random drug testing of drivers for cannabis (an 'oral fluid' test) has been introduced in NSW (see page 114 for further information).



Cannabis plant
Image: Age fotostock

Cannabis and mental health

Cannabis use can have serious consequences for the mental health of particularly vulnerable people. It increases the frequency of episodes of psychosis in those with a disorder such as schizophrenia or bipolar disorder. Whether it can cause a psychotic illness is not known, but it appears that heavy use at a young age can bring about a psychotic episode in susceptible individuals.

Heavy use from an early age is associated with an increase in the risk of depression later in life. A relationship between cannabis use and anxiety disorders, or between cannabis use and lack of motivation, has not been established.

Cannabis and pregnancy

If a pregnant woman smokes cannabis with tobacco—the most common way of using cannabis—the unborn baby is exposed to the risks presented by tobacco smoking (see page 89). Cannabis-smoking in pregnancy also increases the risk that the baby will be born prematurely.

Cannabis also passes into breast milk, which means that it is likely to affect a breast-fed baby.

Using cannabis with other drugs

Cannabis is often used with other drugs.

Using cannabis with any other drugs (illegal or prescription) is more dangerous than using cannabis alone. Cannabis and tobacco are a common combination. The risks to the respiratory and cardiovascular systems of using both drugs appear to be higher than for using either cannabis or tobacco alone.

It is also common to mix alcohol and cannabis, and there is evidence that even small doses of the two drugs together can impair driving performance to a greater extent than either alone.



A joint

Image: Age fotostock

Dependence

Heavy users of cannabis can become dependent (see definition on page 2).

Withdrawal

Symptoms of cannabis withdrawal tend to be milder than those of withdrawing from alcohol and from drugs such as heroin. They include increased anxiety, moodiness and sleep problems, which can persist for up to three weeks.

Overdose

There has been no evidence of a person dying from a cannabis overdose.

Treatment

Treatment for cannabis dependence and withdrawal is generally on an outpatient basis: the person is not hospitalised, but receives support and advice from a health professional.

Cognitive behavioural therapy, focussed on improving the person's coping skills to prevent relapse, has been found to be effective. Motivational enhancement and contingency management may also be useful (see page 5).



Cannabis plants
Image: Age fotostock

Is cannabis a gateway to hard drugs?

There has been ongoing debate about whether cannabis acts as a 'gateway' to the use of other illegal drugs such as heroin or speed. It is true that many people who take these drugs previously used cannabis. On the other hand, many of them previously used tobacco and alcohol, which are not generally regarded as gateway drugs.

People who consider cannabis a gateway drug argue that the cannabis affects the body and mind in a way that makes an individual more susceptible to other drug use. However, there may be other reasons for an association; for example, the person may have a tendency to engage in risky behaviour, which leads to experimentation with a variety of drugs.¹⁸

The 2007 National Drug Strategy Household Survey found that 33.5% of people 14 and over had ever smoked cannabis, while only 1.6% had ever used heroin. This means that only a small proportion of cannabis users go on to use heroin. Overall, research suggests that if cannabis does act as a gateway to heroin use, it is for a small number of people; most people who try cannabis do not go on to heavy drug use.¹⁹



Cocaine

coke, crack, charlie, blow, toot, snow, nose candy, white dust

Cocaine is obtained from the leaves of the coca plant, but it can also be chemically synthesised. It is a stimulant drug (see definition on page 2), as well as a potent local anaesthetic.

Coca leaves have been used for thousands of years in South America for religious, mystical, social and medicinal purposes.

The active chemical was isolated in 1855, and purified and named cocaine in 1860. By the end of the 1800s, cocaine was used in a number of medicines, as well as being an ingredient in the soft drink Coca-Cola.

The drug was banned from use in medicines and beverages in the United States in 1914.

In its pure form, cocaine is a white crystalline powder called **cocaine hydrochloride**. Cocaine hydrochloride cannot be smoked effectively because it is destroyed at high temperatures; however, if the hydrochloride is removed through a chemical process the drug is converted into **freebase**, which can be smoked.

Crack is a particularly pure form of freebase cocaine. It often comes in the form of small lumps known as 'rocks'. Crack cocaine is rarely seen in Australia.

Cocaine sold on the street is often cut or diluted with other substances, such as glucose, lactose or baking powder.

Cocaine and the law

It is illegal to use, possess, supply or manufacture cocaine in New South Wales.

How cocaine is used

Cocaine is usually snorted, though it can also be swallowed, smoked or injected.

Effects

Short-term effects

Short-term effects include:

- » a sense of euphoria and wellbeing
- » increased blood pressure, heart rate and body temperature
- » increased alertness and energy
- » sexual arousal
- » loss of appetite.

The effects depend on the amount taken, its purity and how it is taken.

The effects are generally short-lived (less than 30 minutes).

How common is cocaine use?

The 2007 National Drug Strategy Household Survey found that 5.9% of Australians aged 14 and over have ever used cocaine (up from 4.7% in 2004, 4.4% in 2001, 4.3% in 1998 and around 3% between 1993 and 1995), while 1.6% reported use in the year preceding the survey. Generally, reported previous year use was higher among males than among females, and among people aged 20 to 29 than those in other age groups.²⁰

Long-term effects

Long-term effects include:

- » sleep disorders
- » sexual problems such as impotence
- » nose bleeds, sinusitis and damage to the nasal wall from snorting
- » heart attacks, strokes and respiratory problems
- » paranoia, depression and anxiety.



Cocaine
Image: U.S. Drug Enforcement
Administration

Cocaine and driving

It is dangerous, as well as illegal, to drive while taking cocaine. Cocaine can make a person feel overconfident when driving, leading to risk-taking behaviour and poor judgement.

Cocaine and pregnancy

Cocaine use during pregnancy can affect foetal development by increasing the heart rate of both the mother and the unborn baby, reducing the supply of blood and oxygen to the baby. There is also an increased risk of bleeding, miscarriage, premature labour and stillbirth.

Some research indicates that the children of women who use cocaine in pregnancy may experience long-term mental or physical effects.

Babies of mothers who regularly use cocaine during pregnancy may also experience withdrawal symptoms after birth.

It is likely that, if a mother continues to use cocaine while breastfeeding, the drug will be present in her milk, which may have adverse effects on the baby.

Using cocaine with other drugs

Cocaine and alcohol used in the same session combine in the liver to form cocaethylene, which has been shown to produce more adverse effects on the heart and circulation (cardiovascular toxicity) than either cocaine or alcohol alone.

Dependence

Dependence can develop after a relatively short period of use (see definition on page 2). Just how long it takes may depend on the way the drug is used—smoking or injecting may lead to dependence in a matter of weeks or months, while dependence associated with snorting may take months or years to develop.

Withdrawal

Withdrawal from cocaine, unlike withdrawal from drugs such as alcohol and heroin, often produces no visible physical symptoms, instead producing symptoms such as a strong craving for the drug, fatigue, lack of pleasure, depression, anxiety, irritability and agitation.

Overdose

Several toxic reactions can follow the use of cocaine. Cocaine toxicity is often called cocaine overdose, but it can occur with relatively small doses, especially in combination with other drugs or when there are pre-existing medical conditions.

Symptoms of cocaine toxicity may include:

- » nausea and vomiting
- » chest pain
- » tremors
- » increased body temperature and heart rate
- » seizures
- » extreme paranoia, anxiety, panic and agitation
- » hallucinations and delirium.



Cocaine
Image: U.S. Drug Enforcement
Administration



Crack cocaine

Image: U.S. Drug Enforcement Administration

Treatment

There has been research on both psychological and pharmacological treatments for cocaine dependence. However, the high drop-out rate from treatment makes evaluation of individual therapies difficult, and there is little current information on effective cocaine-specific treatments.

Evidence from better-researched drugs suggests that services providing good social support, as well as psychological interventions to help maintain motivation and improve coping skills, are likely to be useful (see page 5).



Cocaine Bricks

Image: U.S. Drug Enforcement Administration



Ecstasy

E, pills, eccy, XTC, MDMA, pingas, Adam, X

Ecstasy is a derivative of methamphetamine (the active ingredient is **3, 4–methylenedioxymethamphetamine**, abbreviated to **MDMA**). It has both stimulant and hallucinogenic properties (see definitions on page 2).

Ecstasy usually comes as a tablet, in a variety of colours and sizes, sometimes marked with a design or logo (brands such as Mitsubishi and Calvin Klein have been found stamped on ecstasy tablets). Pills that look the same, even pills stamped with the same logo, are not necessarily of the same quality—they may contain varying amounts of other substances besides MDMA, including methamphetamine, ketamine, other substances chemically related to MDMA, and legal substances such as caffeine.

MDMA was first synthesised in 1912 and patented in 1914, but it found no widespread use until the 1970s when it was used in psychotherapy to help patients 'get in touch with their feelings'. In a controlled medical environment, it appeared to have only moderate effects and to be relatively safe.



Ecstasy tablets

Image: U.S. Drug Enforcement Administration

By the 1980s, the term 'ecstasy' was coined and the drug was being used recreationally. Around this time it became a prohibited substance.

Currently there is some interest in the potential use of MDMA as a treatment for PTSD (post-traumatic stress disorder).

Ecstasy and the law

It is illegal to use, possess, supply, traffic or manufacture ecstasy in New South Wales.

How ecstasy is used

Ecstasy is sold as tablets (the most common form), capsules or powder. It is usually swallowed, though it can also be snorted, smoked, injected (after being dissolved in water) or inserted into the anus or vagina.

Effects

Short-term effects

The short-term effects of ecstasy include:

- » euphoria and a feeling of wellbeing
- » feelings of intimacy with others
- » confidence
- » a lack of inhibitions
- » nausea
- » sweating
- » increased blood pressure and pulse rate
- » jaw clenching and teeth grinding.

The 'comeup' is a users' term for the stage at which the effects begin to be felt. At the 'peak' the effects are at their most intense. During the 'comedown', the user may feel physically and emotionally drained. Some users may experience a 'crash'—negative feelings associated with coming down from ecstasy.

The effects appear in around 30 to 40 minutes after ecstasy is swallowed, plateau at two to three hours after consumption and diminish in intensity

over the next three to four hours. Snorting or injecting can result in much quicker onset of effects.

How long the effects last may depend on how the drug is taken, how much is taken, and whether the person has recently eaten, as well as the person's individual metabolism.

As ecstasy may cause an increase in body temperature, a serious health concern is dehydration. Sipping water can help prevent this (although it is possible to drink too much water, leading to water intoxication).

Long-term effects

Little is known about the long-term effects of ecstasy. Some long-term users appear to experience depression and some memory and cognitive impairment.

Ecstasy and driving

It is dangerous, as well as illegal, to drive while taking ecstasy. Ecstasy can make a person feel overconfident when driving, leading to risk-taking behaviour and poor judgement.

Ecstasy and pregnancy

It is possible that using ecstasy when pregnant increases the risk of miscarriage. The use of amphetamine-like substances such as ecstasy during

How common is ecstasy use?

According to the 2007 National Drug Strategy Household Survey, the proportion of Australians who have ever tried ecstasy has increased from 3.1% in 1993 to 8.9% in 2007, while the proportion who used ecstasy in the year preceding the study has increased from 1% to 3.5% over the same period.

Generally, reported previous year use was higher among males than among females, and among people aged 20 to 29 than those in other age groups.²¹



Ecstasy tablet

Image: U.S. Drug Enforcement Administration



Ecstasy tablet

Image: U.S. Drug Enforcement Administration

pregnancy has also been associated with delayed development and subtle abnormalities in newborn babies.

It is possible that if a mother uses ecstasy while breastfeeding the drug will be present in her milk, and may have adverse effects on the baby.

Interaction with other drugs

Ecstasy can be dangerous when combined with any of the prescription antidepressant drugs called monoamine oxidase inhibitors (there are many brands of these).

Dependence

There is limited research on dependence associated with ecstasy (see definition on page 2). Studies suggest that dependence is possible.

Withdrawal

Heavy or regular users may go through a period of anxiety and depression when they stop taking the drug.

Ecstasy-related deaths

There have been some ecstasy-related deaths in Australia, some linked to PMA (paramethoxyamphetamine) an amphetamine-type drug with both stimulant and hallucinogenic properties. It is more potent than most of the other drugs of this type, and far more toxic. Users may experience hallucinations, delirium, restlessness, agitation, muscle contractions, thrashing around, sweating, high fever, seizures, coma and death.

In Australia, research suggests that people who have died after taking PMA took pills that they thought were ecstasy (MDMA).²²

Overdose

High doses of ecstasy may lead to users experiencing a non-fatal stimulant overdose. Symptoms may include:

- » nausea and vomiting
- » chest pain

- » tremors
- » increased body temperature and heart rate
- » seizures
- » extreme paranoia, anxiety, panic and agitation
- » hallucinations and delirium.

Treatment

People do not generally seek treatment for ecstasy use, and there has been little ecstasy-specific research.

Evidence from better-researched drugs suggests that services providing good social support, as well as psychological interventions to help maintain motivation and improve coping skills, are likely to be useful (see page 5).



Ecstasy tablets

Image: Australian Drug Foundation



GHB

G, grievous bodily harm, fantasy, liquid E, liquid ecstasy, blue nitro, GBL, 1,4-B

GHB stands for **gamma-hydroxybutyrate**, which is a depressant (see definition on page 2). Although it is sometimes called liquid ecstasy it is not chemically related to ecstasy, which is a stimulant.

GHB is a naturally occurring substance found in the body. It was first synthesised in the 1960s and developed as an anaesthetic, and has been used as a treatment for a number of medical conditions, including insomnia, depression, narcolepsy and alcoholism. It has also been used by bodybuilders and athletes in the belief that it raises growth hormone levels; however, there is no evidence that this is the case. More recently, it has been associated with the nightclub and rave scenes.

GHB usually comes as a liquid, and is sold in vials, bottles or fish-shaped soy sauce containers. It is colourless, but may have colour added to stop it being mistaken for water or other clear liquids. It is odourless, and can have either a bitter or a salty taste.

Less often, GHB is found in the form of a white powder.

GHB and the law

It is prohibited to use, possess, supply or manufacture GHB in New South Wales.

How GHB is used

GHB is usually swallowed.

Effects

Short-term effects

The short-term effects of GHB include:

- » feelings of euphoria and increased wellbeing
- » increased libido
- » drowsiness
- » nausea and vomiting
- » visual disturbances
- » agitation and dizziness.

More serious effects can include respiratory distress, seizures and death.

Different stages include the 'comeup', where the user gradually starts to feel the effects, the 'peak', when the effects are at their most intense, and the 'comedown', when the user may find themselves physically and emotionally drained.

GHB, GBL and 1,4-B

Some other chemicals, including gamma-butyrolactone (GBL) and 1,4-butanediol (1,4-B) are converted to GHB by the body when they are ingested. GHB is reported to have a salty taste, while GBL and 1,4-B are said to have a 'chemical' taste.

How common is GHB use?

The 2007 National Drug Strategy Household Survey found that 0.5% of Australians aged 14 and over have ever tried GHB, while 0.1% used GHB in the year preceding the survey. Reported previous year use was higher among males than among females, and among people aged 20 to 29 than those in other age groups.²³

How long the stages last may depend on the person's metabolism, whether they have recently eaten, the quantity consumed and whether the drug consumed was GHB, GBL or 1,4-B.

GHB starts to have an effect in around 10–15 minutes, reaching a plateau in around 45–90 minutes and diminishing over the next 15–30 minutes.

Long-term effects

Little is known about the long-term effects of GHB due to the short time it has been used as a recreational drug.

GHB and driving

The short-term effects, including drowsiness, visual disturbances and dizziness, mean that it is dangerous, as well as illegal, to drive while taking GHB.

GHB and pregnancy

Little is known about the effects of GHB on the unborn child. However, it is possible that GHB crosses the placenta in pregnancy, and has some effect on the baby. It is also possible that GHB will be present in breast milk if taken during breastfeeding.

It is generally risky to take any drug while pregnant or breastfeeding without medical advice.

Using GHB with other drugs

When GHB is mixed with other depressants, such as alcohol or benzodiazepines, it increases the depressant effects of both drugs, which may lead to respiratory distress and even death.



*GHB can come as coloured liquid
Image: Age fotostock*

Dependence

Dependence (see definition on page 2) can develop when GHB is taken on a regular basis.

Withdrawal

Withdrawal symptoms may include insomnia, restlessness, anxiety, tremors, sweating, and chest pain and tightness. How long the symptoms last depends on the dosage and frequency of use.

Drink spiking

It is often suggested that GHB is used in drink spiking, because it can be tasteless, odourless and hard to detect. However, users report that GHB can have an unpleasant taste which would be difficult to disguise. Also, as GHB has powerful depressant effects, many experts believe that if it were often used in drink spiking there would be many more deaths than actually occur, particularly if a victim had been consuming alcohol beforehand.

Overdose

Overdosing is a serious danger with GHB. The difference between a dose that produces the desired effects and a dose that produces dangerous effects is very small. Analysis of different vials of GHB has shown that the concentration varies considerably, so users can never be sure of how much they are taking.

Treatment

Evidence from better-researched drugs suggests that services providing good social support, as well as psychological interventions to help maintain motivation and improve coping skills, may be effective (see page 5).



Heroin

smack, H, horse, Harry, boy, junk, shit, skag, brown

Heroin is a drug manufactured from morphine, which is obtained from the opium poppy. Its effects are similar to those of morphine. Both are central nervous system depressants (see definition on page 2), and very effective painkillers.

Heroin was first manufactured in England in 1874. It was rediscovered in Germany 23 years later, and named heroin. It was marketed as a substitute for morphine, which was used as a painkiller, and as a cough suppressant. It has the same exhilarating and pain relieving effects as morphine, but fewer side effects.

Heroin is highly addictive, and for this reason its use has been severely restricted. Despite the fact that it is a very effective pain killer and often better tolerated than morphine, it is not prescribed for any medical purpose.

Heroin can come in several forms, but the two most common in Australia are **white powder** and **brown rock**. The powder form is dissolved and injected. Dealers normally cut it with other substances, typically caffeine, paracetamol, sugars or starch.

The 'brown rock' form of heroin is less pure; it is usually heated and the vapours inhaled.

Unrefined heroin (**heroin base**) is rarely found in Australia.



*Heroin
Image: U.S. Drug Enforcement
Administration*

Heroin and the law

Heroin was banned from legal prescription in Australia in 1953. Bans were brought about through international pressure.

The use of heroin for any purpose is illegal in all states and territories in Australia. Supply is much more severely punished than other activities associated with heroin use.

How heroin is used

Heroin can be injected, smoked, swallowed or snorted, or its fumes inhaled (this is called 'chasing'). It is usually injected. Smoking heroin is becoming more popular, but it has been found that people who smoke heroin usually end up injecting it.

Australian research has found that people can die from smoking, snorting or swallowing heroin, as well as injecting it.

How common is heroin use?

The 2007 National Drug Strategy Household Survey found that 0.2% of Australians aged 14 and over had used heroin in the preceding year—a total of 36,200 individuals. More than twice as many males as females used heroin, and the largest group of users was in the 20–29 age group. Interestingly, females in the 30–39 age group reported using heroin at close to the male rate, while females in the youngest age group had relatively low use rates.²⁴

A positive finding is that overall percentages are slightly lower than those found in previous surveys.

Effects

Short-term effects

Heroin suppresses nerves that signal pain, making it an especially effective painkilling medication. It also suppresses the centres in the brain that control breathing and coughing.

The initial effect of heroin, when injected, inhaled or smoked, is a surge of pleasurable feeling called 'the rush', which is usually accompanied by warm flushing of the skin, a dry mouth and a heavy feeling in the hands and feet. Other immediate symptoms can include nausea, vomiting and a severe itch. The effects are almost immediate following injection or inhaling.

After the initial rush, users become drowsy for several hours, with slowing of the heart and breathing, as well as reduced mental alertness and response to pain.

Long-term effects

Many of the physically damaging effects of heroin are associated with injecting, rather than with the drug itself. Constant injection can lead to collapsed veins, bacterial infection and abscesses (boils) at injection sites. If a person shares needles or uses dirty equipment they are also vulnerable to blood-borne viruses such as HIV and hepatitis B and C.

Heroin itself can cause:

- » severe constipation
- » tooth decay (from lack of saliva)
- » difficulty getting and staying pregnant
- » impotence in males
- » loss of appetite and weight.

Heroin use and psychological problems

Heroin users suffer high levels of depression and anxiety, and are more likely to have an antisocial personality disorder. Suicide rates amongst heroin users are estimated at 14 times that in the general population. They are also found to have high rates of post-traumatic stress disorder (PTSD) and borderline personality disorder.²⁵

The 2007 National Drug Strategy Household Survey found that around 65% of heroin users reported high or very high psychological distress, as measured by the Kessler 10 Scale. This compared with 20% of other drug users, and around 9% of those who did not use illegal drugs in the preceding month.²⁶

Heroin users are often in poor general health, which, along with suppression of the respiratory system, makes them vulnerable to lung infections such as pneumonia and tuberculosis.

Heroin and driving

Heroin causes drowsiness and impairs alertness, concentration and reaction times. It is dangerous, as well as illegal, to drive under the influence of heroin.

If heroin is used with alcohol, the risk is greatly increased.

Heroin and pregnancy

Heroin taken by a pregnant woman crosses the placenta, and can affect foetal development. It increases the risk of miscarriage, premature birth, low birth weight and sudden infant death syndrome (SIDS).

The baby of a heroin-dependent mother may also be born dependent, and have to go through a withdrawal following birth (this is called neonatal abstinence syndrome). In severe cases, medication may be necessary. If the mother has a blood-borne virus such as hepatitis B or C, or HIV, the baby may become infected pre delivery or at childbirth.

Heroin passes into breast milk, and can cause further adverse effects on a breast-fed baby.

Using heroin with other drugs

Heroin users frequently use other depressant drugs such as alcohol and tranquillisers at the same time. Combining heroin with these drugs greatly increases the risk of overdose.

Dependence

Research suggests that around one in four of those people who ever try heroin actually become dependent on it (see definition on page 2). Daily heroin use over several weeks is probably necessary to develop dependence. Daily use typically occurs after a one or two-year period from first use.



*Discarded syringe
Image: Age fotostock*

Australian research has found that people can develop a dependence through smoking heroin as well as injecting it.²⁷

Withdrawal

Within the first 12 hours after their last dose a dependent user can experience withdrawal symptoms, including:

- » runny eyes and nose
- » excessive sneezing and yawning
- » sweating.

These symptoms may be followed by:

- » agitation and irritability
- » goose bumps
- » hot and cold flushes
- » loss of appetite.

After about 24 hours very strong cravings develop, which may be accompanied by:

- » stomach cramps
- » diarrhoea
- » nausea and vomiting

- » headaches
- » poor sleep
- » lethargy
- » pains in the back, joints and/or legs and arms
- » continuation of the earlier symptoms.

Symptoms reach their peak in two to four days; by the fifth to seventh day most physical symptoms have begun to settle down. Over the following weeks, general health and mood improve, but the former user may experience ongoing problems related to sleep and appetite, as well as drug cravings.

Overdose

The risks of overdose and death are high. Heroin is a very effective nervous system depressant. It can be difficult for a person to control the dose they are taking, since purity cannot be measured directly when the drug is purchased on the illegal drug market.

A person returning to heroin after a break or a significant reduction in their use is at particular risk. They will have lost their tolerance to the drug; if they then take the amounts that they used before stopping, they can overdose.

The risk of death is increased if other depressants such as alcohol or tranquillisers are used at the same time. In fact, most overdose deaths occur when heroin has been mixed with another depressant.²⁸

Treatment

The most effective treatments for heroin dependence are **substitution therapies**. These involve substituting other less harmful drugs for heroin, usually on a long-term basis. Doses must be high enough to prevent withdrawal symptoms.

People in treatment also need good psychological and social support, addressing motivation and coping skills, if they are to succeed in giving up heroin (see page 5).

Methadone

Methadone maintenance

treatment is the most commonly used substitution therapy. The methadone is typically swallowed as a syrup.

While its effects on the brain are similar to those of heroin, methadone lacks many of the negative side effects associated with heroin use. Because it is swallowed, the risks associated with injecting drug use are removed. When stabilised on methadone, a person is able to undertake usual life activities, including driving. Since the methadone is prescribed by a doctor, problems associated with controlling dosage and using the illegal market are less than with heroin.

Methadone can be injected, and overdose is still possible. However, the evidence suggests that methadone maintenance treatment reduces the risk of death to one-third of the risk for users not in treatment. It also reduces heroin use, other criminal activity associated with the illegal market, and obstetric and foetal complications, while leading to an increase in users' legitimate earnings

Because methadone is not effective for all heroin users, other drug therapies have been developed, including buprenorphine and naltrexone.

Heroin, opiates and opioids

The term **opiate** is used to describe naturally occurring drugs obtained from opium poppies.

Opium is the resin taken from the poppies, from which the opiates morphine and codeine are extracted.

Opiates act on nerve cells in the brain called **opioid receptors** to depress the activity of the nervous system and act as very effective pain killers.

Heroin is not derived directly from the opium poppy—it is manufactured from morphine. It is called an **opioid agonist** because it activates the brain in the same way as the opiates.

Methadone is a synthetic opioid agonist that affects the brain in the same way as morphine and heroin.

While the opioid agonists activate the opioid receptors, **naltrexone** acts to block these receptors (so drugs like heroin cannot activate them); it is an **opioid antagonist**.

Buprenorphine is a mixed opioid agonist–antagonist. It activates the opioid receptors to a lesser extent than heroin, methadone and morphine, but it acts at the same time to block the receptors, preventing heroin and other opioids from having much effect.



Heroin poppies

Image: Age fotostock

Buprenorphine

Buprenorphine is taken by dissolving a tablet of the drug under the tongue. Because of its action on the brain, the risk of overdose with buprenorphine is lower than with methadone. It must be prescribed at doses high enough to maintain people in treatment, and should be accompanied by appropriate psychological and social support. It has a similar effectiveness to methadone in terms of retention in treatment and reducing illegal drug use.

Naltrexone

Another treatment that is less common in Australia is use of the blocking agent **naltrexone**. In high enough doses, naltrexone blocks the sites in the brain activated by heroin, so that any heroin taken will have no effect.

Naltrexone brings on a severe withdrawal reaction. Because of this, people planning to enter naltrexone treatment are often required to go through withdrawal before entering treatment. The treatment has a high drop-out rate, and appears to be best suited to highly motivated people with good social support.



Ice, speed & other methamphetamines

base, crystal, ice, crystal meth, meth, shabu, ox blood, whiz, goey

Amphetamine was first synthesised in 1887, and was used in the 1930s to treat asthma. Today, amphetamines and amphetamine derivatives are used in the treatment of narcolepsy (a sleep disorder) and attention deficit hyperactivity disorder (ADHD).

In 1935 a study of the effects of amphetamine in hospital workers found that the most commonly reported effects were a sense of wellbeing and exhilaration, and reduced fatigue, while during World War II amphetamine was extensively used to combat fatigue and increase alertness in soldiers.

Methamphetamine is a man-made stimulant drug (see definition on page 2)—a more potent form of the drug **amphetamine**. It was first synthesised from ephedrine in 1918, and was also used during World War II.

There are different forms of methamphetamine, generally distinguished by their appearance and perceived purity. The three main forms are:

- » crystalline (**ice** or **crystal**)
- » powder (**speed**)
- » **base**.

Crystalline methamphetamine (ice) is a highly purified form of methamphetamine with a crystal-like appearance. The only difference between ice and the other methamphetamines, speed and base, is that ice undergoes additional refinement to remove impurities.

Ecstasy, which is sold as a tablet, is also a methamphetamine derivative (see page 43 for information on ecstasy).



Ice, crystalline methamphetamine
Image: U.S. Drug Enforcement
Administration

How common is methamphetamine use?

The 2007 National Drug Strategy Household Survey found that 6.3% of Australians aged 14 and above have ever tried methamphetamine or amphetamine (including speed, ice, base, prescription amphetamines and liquid amphetamine), and 2.3% used them in the year preceding the survey. For 51.2% of those who used the drug in the preceding year the main form used was powder (speed), followed by ice (26.7%); other forms, such as base (12.4%), tablet (5.1%), prescription amphetamines (3.2%) and liquid (1.3%) were less commonly used.

The use of methamphetamine or amphetamine in the past year was generally higher among males than females. Use was highest among those aged 20–29 compared to other age groups.²⁹

Methamphetamines and the law

It is illegal to use, possess, supply or manufacture methamphetamine in New South Wales.

How methamphetamines are used

Methamphetamine can be swallowed, snorted, smoked or injected. Ice is usually smoked or injected.

Effects

Short-term effects

The short-term effects of methamphetamine include:

- » increased energy
- » a sense of euphoria and wellbeing
- » increased attention and alertness
- » increased talkativeness
- » increased heart rate, breathing and body temperature
- » decreased appetite
- » jaw clenching and teeth grinding
- » nausea and vomiting
- » a dry mouth
- » changes in libido
- » nervousness, anxiety and paranoia.



Amphetamine powder can be referred to as 'speed'

Image: Age fotostock

High doses may lead to aggressiveness, hostility and violent behaviour.

These effects vary from person to person, and are influenced by factors such as the person's weight, how much they have eaten, their general health, how much of the drug they have taken, and whether they have taken any other drugs.

Taking large quantities can intensify some of the effects. Heavy users may also experience effects such as:

- » blurred vision
- » tremors
- » irregular breathing
- » loss of coordination
- » collapse.

The most serious effects of taking large quantities may include stroke, heart failure, seizures and excessively high body temperature.

Long-term effects

Long-term effects may include:

- » agitation or aggression
- » decreased motivation
- » depression and anxiety
- » poor concentration and memory
- » psychotic symptoms such as paranoia and hallucinations
- » disturbed sleep
- » weight loss
- » chest pains.

People who inject methamphetamine may experience problems related to injection such as collapsed veins, abscesses and the spread of blood-borne viruses like hepatitis B and C or HIV, while those who snort may suffer from nasal irritation.

Methamphetamine psychosis

Methamphetamine use can induce a brief psychosis with symptoms of paranoia and hallucinations, and can make people who have schizophrenia or other chronic psychotic symptoms worse. Research conducted at the National Drug and Alcohol Research Centre has found that around three in ten dependent methamphetamine users will experience psychotic symptoms during any given year; these symptoms usually last up to two or three hours, but sometimes they can last longer and lead to the person being hospitalised.³⁰

Methamphetamines and driving

It is dangerous and illegal, to drive while taking any methamphetamines. Methamphetamines can make a person feel overconfident when driving, leading to risk-taking behaviour and poor judgement.

Methamphetamines and pregnancy

There is evidence that methamphetamine use can affect foetal development. Methamphetamine use during pregnancy has been linked with bleeding, early labour and miscarriage, as well as an increased risk of foetal abnormalities. Use of methamphetamines will also increase the heart rate of both mother and baby.

If methamphetamines are used close to birth, the baby may be born with symptoms of methamphetamine use. Babies of mothers who regularly use amphetamines may also experience withdrawal symptoms in the first few weeks after birth.

Not much is known about the effects of methamphetamines on the baby during breastfeeding. It is generally risky to take any drug while breastfeeding without medical advice.

Interaction with other drugs

Methamphetamines can be dangerous when taken with **monoamine oxidase inhibitors**, a type of prescription antidepressant.

Dependence

People who become dependent (see definition on page 2) on methamphetamine typically inject or smoke the drug, and use it at least twice per week.

Withdrawal

Withdrawal symptoms for methamphetamine can include:

- » feeling depressed, irritable, restless and lethargic
- » stomach cramps
- » nausea
- » rapid heartbeat
- » hot and cold flushes.



Glass pipe used for smoking 'ice'

Image: iStockphoto

Overdose

Several toxic reactions can follow the use of methamphetamines. Methamphetamine toxicity is often called methamphetamine overdose, but it can occur with relatively small doses, especially in combination with other drugs or when there are pre-existing medical conditions.

Symptoms of methamphetamine toxicity may include:

- » nausea and vomiting
- » chest pain
- » tremors
- » increased body temperature and heart rate
- » seizures
- » extreme paranoia, anxiety, panic and agitation
- » hallucinations and delirium.

Treatment

Although methamphetamines are used by a large number of people around the world, no research has yet identified effective treatments for methamphetamine-related problems.

Evidence from better-researched drugs suggests that services providing good social support, as well as psychological interventions to help maintain motivation and improve coping skills, are likely to be useful (see page 5).



10

Inhalants

The street names of inhalants depend on the product used. For example, amyl nitrite is sometimes called 'amyl' or 'poppers', while nitrous oxide may be called 'bulbs'.

Inhalants are substances that are sniffed to give the user an immediate 'high'.

These substances are easily absorbed through the lungs and carried to the brain, where they act to slow down the central nervous system, this means they are depressants (see definition on page 2).

Types of inhalants

The main categories of inhalants are:

- » volatile solvents (including aerosols)
- » nitrites
- » gases.

Volatile solvents

Volatile solvents are substances that change rapidly from a liquid or semi-solid state to a gas when exposed to air. They are found in a range of readily obtainable products, including:

- » petrol
- » paint thinner
- » spray paint
- » paint removers
- » hair spray
- » deodorants
- » air fresheners
- » lighter fuels
- » the propellant gases used in aerosol spray cans.



Aerosols

Image: Age fotostock

Aerosols

Some volatile solvents that come in an aerosol spray can, such as hair spray and many deodorants, are inhaled for the effects produced not only by the product's main ingredient, but by the aerosol's propellant gases.

'Chroming'

Gold, silver and other metallic spray paints are sniffed mainly for the effects caused by the solvents used to suspend the metallic particles in the spray. Sniffing metallic paints is called 'chroming'.

Nitrites

Nitrites have historically been used to enhance sexual experience. The most popular are amyl nitrite and butyl nitrite.

Amyl nitrite relaxes most of the muscles involved in non-conscious processes, such as digestion and breathing. Among other things, it dilates blood vessels, increasing their diameter, which leads to increased heart rate and body temperature (the 'rush').

These drugs are occasionally used for their muscle-relaxing rather than their psychoactive properties, in particular in conjunction with anal sex.

Nitrous oxide ('laughing gas') is the most popular anaesthetic inhalant, and is often associated with the dance and rave scenes.

Gases

Inhalants that come in a gaseous form include products used in medical anaesthetics (such as ether or chloroform).

Inhalants and the law

Most inhalants are common products and are readily available.

The sale of amyl nitrite is prohibited by law; however, it is sold in some adult stores under the guise of room deodorants, video head cleaners or leather cleaners.

How common is inhalant use?

The 2007 National Drug Strategy Household Survey found that 3.1% of Australians aged 14 and over have ever tried inhalants, while 0.4% used them in the year preceding the survey. More males than females reported using them during the preceding year.³¹

In another survey, 17% of Australian high school students reported having deliberately sniffed inhalants at some point in their lives, while 13% reported having done so in the preceding year.³²

How inhalants are used

Inhalants are usually inhaled directly from the container or sprayed onto a cloth or into a plastic bag, and then inhaled.

Petrol fumes are sniffed from a can or a bottle, or from a cloth soaked in petrol and held over the nose and mouth.

Effects

Short-term effects

Some of the short-term effects of using inhalants are similar to those of alcohol, such as:

- » slurred speech
- » blurred vision
- » dizziness
- » nausea
- » euphoria
- » loss of coordination.

Other short-term effects may include:

- » irritation of the eyes and throat
- » hallucinations
- » loss of memory
- » headaches
- » nose bleeds.

Some inhalants, such as amyl nitrite, can cause enhanced sensual awareness and a loss of inhibitions.

Amyl nitrate is immuno-suppressive; a person's immune response dips immediately on inhaling it, and stays down for about 96 hours.

Long-term effects

Little research has been done on the long-term effects of most inhalants. Possible health problems may include:

Petrol-sniffing

Long-term petrol-sniffing has many serious effects. Chronic use may cause irreversible brain damage. Lead poisoning, which can result in liver, kidney and brain damage, is also a major problem.



*A range of household products
Image: Age fotostock*

- » brain damage affecting coordination, movement and memory
- » weight loss
- » fatigue and tremors
- » paranoia, hostility and depression
- » social and psychological delays in development.

Inhalants and driving

It is not safe to drive while using inhalants, given their effects on vision and coordination.

Inhalants and pregnancy

It is generally risky to take any drug while pregnant or breastfeeding without medical advice.

Using inhalants during pregnancy may increase the risk of miscarriage, premature birth, birth defects, seizures, and sudden infant death syndrome (SIDS).

Using inhalants with other drugs

Combining amyl nitrate and Viagra is particularly problematic. It may cause loss of consciousness and, in extreme cases, even death.

Dependence

Psychological dependence—that is, using inhalants to help cope with the problems of everyday life—may develop with prolonged use. Physical dependence (see definition on page 2) can also occur, as the person develops a tolerance to the substance they are using.

Withdrawal

Chronic users may have withdrawal symptoms such as hand tremors and headaches when they stop using the drugs.

Overdose

The possibility of death from using inhalants is rare, however it is a risk. ‘Sudden sniffing death’ has followed the use of a range of inhalants including aerosols and correction fluids. It is believed that chemicals in these products can cause heart failure, particularly if the user is stressed or does heavy exercise after inhaling.

If nitrites are swallowed they can interfere with the blood’s ability to transport oxygen. Death from a lack of oxygen, pneumonia, cardiac failure or cardiac arrest, or from breathing in vomit, is a possible consequence.

Treatment

Little research has been carried out on treatments for inhalant abuse.

Evidence from better-researched drugs suggests that services providing good social support, as well as psychological interventions to help maintain motivation and improve coping skills, are likely to be useful (see page 5).



Ketamine

K, special K, vitamin K

Ketamine is a short-acting general anaesthetic for human and veterinary use. It is usually a powder, though it can also come in liquid form.

Ketamine was first synthesised in the 1960s as part of an effort to find a safer alternative to the anaesthetic phencyclidine, and it is still widely used as an anaesthetic.

Its use as a recreational drug began to increase around the beginning of this century.

Ketamine and the law

It is illegal to use, possess, supply, or manufacture ketamine in New South Wales. There are exceptions under the law, for example authorised use by medical practitioners.

How ketamine is used

Ketamine is usually manufactured as a liquid, which is then evaporated to form a powder that can be snorted or dissolved in other liquids and swallowed. A few users have reported injecting it. It can also be smoked, mixed with tobacco or cannabis, in a joint or pipe.

Effects

Short-term effects

Ketamine produces a feeling of detachment from one's body and the external world. It does this by reducing or blocking signals to the conscious mind from other parts of the brain, typically the senses. The short-term effects of ketamine include:

- » a sense of euphoria and wellbeing
- » increased libido
- » drowsiness
- » slurred speech
- » impaired motor coordination
- » hallucinations
- » a sense of floating
- » nausea and vomiting.

How common is ketamine use?

The 2007 National Drug Strategy Household Survey found that 1.1% of Australians aged 14 and over have ever tried ketamine, while 0.2% used it in the year preceding the survey.³³ Other research has found that around two-thirds of those who have ever tried ketamine had not used it in the year preceding the study.³⁴

The effects of even a small amount of ketamine can resemble an out-of-body experience. Many who take large amounts are convinced that their experiences are real, even though they accept that they have taken a drug. Users may fall into an anaesthetised state, a 'k-hole'. In fact, one of the more serious effects of using ketamine

is that a user may harm themselves while anaesthetised. There are stories of people burning or cutting themselves unknowingly while using the drug.

Some users have such unpleasant experiences with ketamine that they never try it again.

The effects of ketamine may come on quickly, from between 10 to 20 minutes, and may last from 45 to 90 minutes.



Ketamine
Image: U.S. Drug Enforcement
Administration

Long-term effects

Some regular users experience 'flashbacks'—the spontaneous recurrence of an experience that occurred while the user was under the influence of the drug.

Ketamine and driving

It is not safe to drive while using ketamine. Drowsiness, impaired motor coordination and hallucinations, can affect the ability to drive include drowsiness and impaired motor co-ordination.

Ketamine and pregnancy

Little is known about the effects of ketamine on an unborn child. However, many drugs and medications taken during pregnancy cross the placenta, or are present in breast milk.

It is generally risky to take any drug while pregnant or breastfeeding without medical advice.

Using ketamine with other drugs

It may take longer to recover from anaesthesia with ketamine if a person has recently used some other drugs (see box page 76).

Drugs that may affect recovery from ketamine anaesthesia

Drugs that may increase recovery time from anaesthesia with ketamine include:

- » barbiturates such as amobarbital (Amytal), butabarbital (Butisol), mephobarbital (Mebaral), secobarbital (Seconal) and phenobarbital (Luminal, Solfoton)
- » opioid medications such as fentanyl (Actiq, Duragesic, Ionsys), hydrocodone (Lortab, Vicodin), hydromorphone (Dilaudid, Palladone), methadone (Dolophine, Methadose), morphine (Kadian, MS Contin, Oramorph), oxycodone (OxyContin, Percocet, Roxicodone) and propoxyphene (Darvocet, Darvon).

Dependence

Physical dependence can develop when ketamine is taken on a regular basis (see definition on page 2).

Withdrawal

Ketamine does not appear to produce significant withdrawal symptoms in chronic users. There are anecdotal reports of tension, twitchiness, poor attention span and restlessness in abstinent long-term users, but this may be due more to the sedative **norketamine** (a product of the breakdown of ketamine) lingering in the bloodstream.

Overdose

Unlike most anaesthetics, ketamine does not suppress breathing or heart rate, so overdose is unlikely.

Treatment

Few ketamine users currently seek treatment for their drug use, although as use of the drug increases, this is likely to change. Evidence from better-researched drugs suggests that services providing good social support, as well as psychological interventions to help maintain motivation and improve coping skills, are likely to be useful (see page 5).



12 LSD

acid, tabs, trips, blotters, microdots

LSD (**lysergic acid diethylamide**) was originally derived from the fungus ergot, which grows on rye and other grasses. It was first synthesised by a Swiss chemist, Albert Hoffman, in 1938. While studying the drug in 1943, Hoffman took 250 micrograms. Shortly afterwards he pedalled home on his bicycle and found himself 'transported to other worlds', thus becoming the first person known to go 'tripping'.

In the 1950s LSD was used to treat depression, while the Central Intelligence Agency (CIA) in the United States began using it in 'mind control' experiments. It gained popularity as a recreational drug in the 1960s when, due to its ability to produce changes in mood, perception, consciousness and thought, it became part of the psychedelic cultural movement.

LSD is usually prepared as a liquid, but is generally sold on small pieces of blotting paper known as tabs. They are taken orally, often held under the tongue until the paper dissolves. It is also sold as a liquid, or soaked into sugar cubes.

LSD and the law

It is illegal to use, possess, supply or manufacture LSD in New South Wales.

How LSD is used

LSD is usually taken orally, although a few users have reported snorting or injecting it.



LSD varieties
Image: Australian Drug Foundation

How common is LSD use?

The 2007 National Drug Strategy Household Survey found that 6.7% of Australians aged 14 and above had ever tried hallucinogens (including naturally occurring hallucinogens, such as magic mushrooms, as well as synthetic hallucinogens such as LSD), while 0.6% had used hallucinogens in the year preceding the survey.

More males than females, and more people from the 20–29 age group, used hallucinogens in the preceding year.³⁵

Effects

Short-term effects

The short-term effects of LSD may include:

- » vivid perceptual distortions (hallucinations)
- » a distorted sense of time and place
- » poor coordination
- » increased body temperature and sweating, and/or chills
- » a lack of control over thinking processes and concentration
- » in some cases, fear, anxiety and depression.

More experienced users may still experience the more unpleasant reactions.

The effects of LSD may be observed within five to ten minutes, with peak effects being reported after 30 to 90 minutes. Effects may decline after four to six hours, but they may last for up to 12 hours, depending on the amount taken and the user's tolerance, body weight and age.

Long-term effects

The most frequently discussed long-term effect of using LSD is **flashbacks**—a spontaneous recurrence of something that happened while the person was taking the drug. There are three types:

- » **perceptual** (for example, greater intensity of colour, faces changing shape, being crawled on by non-existent insects)
- » **somatic** (altered bodily sensations, such as feelings of pain without an apparent cause)
- » **emotional** (for example, experiencing loneliness or depression).

These are usually brief, but they can occur for days, weeks or even years after taking the drug.

Psychiatric disturbances such as prolonged psychosis, depression, personality disruption and post-hallucinogen perceptual disorder have been attributed to prolonged use of LSD. Other long-term effects include anxiety, and decreased memory.

There is no apparent link between LSD use and the development of schizophrenia or affective disorders, though use could precipitate pre-existing psychiatric illness.

LSD and driving

It is extremely dangerous to drive with the distorted sense perceptions, poor coordination and lack of judgement caused by taking LSD and other hallucinogens.

LSD and pregnancy

There is some evidence linking the use of hallucinogens in pregnancy to an increased risk of miscarriage and birth complications. There may also be

a higher incidence of birth defects among babies born to women using hallucinogens.

If a mother uses hallucinogens while breastfeeding, it is possible that the drug will be present in her milk and have adverse effects on the baby.

Using LSD with other drugs

Cross-tolerance can occur between LSD and other psychedelics—that is, users with a tolerance to LSD may find that they have a tolerance to drugs with similar effects such as mescaline. (See page 3 for a definition of tolerance).

Dependence

Tolerance of both the psychological and physical effects of LSD can develop, though it may be lost within several days. LSD is not thought to cause physical dependence (see definition on page 2). Regular users may develop psychological dependence, although this is not common.

Withdrawal

There are few physical effects when use ceases. Regular users may have to cope with feelings of anxiety, but these may be at a low level.

Overdose

It is not possible to overdose on LSD. It is not a particularly toxic drug; deaths that have been linked to LSD are usually classed as ‘accidents’, such as falls.

Treatment

People who use LSD do not generally seek treatment from health professionals and there are few treatment options that can be recommended, apart from those found to be generally effective for drug dependence (see page 4).



13

Magic mushrooms and other natural hallucinogens

***Psilocybin:** magic mushrooms, shrooms, mushies, gold tops, blue meanies*

***Mescaline:** mesc, buttons*

Many hallucinogens occur naturally, including **psilocybin** ('magic mushrooms'), **DMT** (dimethyltryptamine), **datura** and **mescaline** (from the peyote cactus).

Psilocybin is a hallucinogenic chemical found in some kinds of mushrooms. It belongs to the same chemical family as LSD, so its effects are quite similar. While the psilocybin mushroom is native to Mexico, other kinds of magic mushroom grow in other parts of the world and there are several species growing wild in Australia.

It is dangerous to pick and eat wild mushrooms because it is difficult to distinguish edible mushrooms from their poisonous lookalikes. Poisonous mushrooms can cause stomach pains, vomiting and diarrhoea, while some can cause permanent liver damage, respiratory failure, unconsciousness and even death. Symptoms can take up to 40 hours to develop.

DMT is a powerful hallucinogenic drug found in certain plants in the West Indies and South America. Its chemical structure is very similar to that of psilocybin. In Australia, most DMT bought on the street is synthetic. It can, however, be found in the bark of a number of commonly occurring trees as well as a number of other plants. In its pure form it is a crystal, though on the street it is usually found in powder form.

Natural hallucinogens and the law

It is illegal to use, possess, supply or manufacture hallucinogens in New South Wales.

How natural hallucinogens are used

Naturally occurring hallucinogens are used in a variety of ways, depending on their form. Mushrooms can be dried or boiled, then added to other foods. Other natural hallucinogens can be smoked, or boiled into tea preparations. DMT is usually smoked, though the powder form can also be swallowed.

How common is hallucinogen use?

The 2007 National Drug Strategy Household Survey found that 6.7% of Australians aged 14 and above had ever tried hallucinogens (including naturally occurring hallucinogens, such as magic mushrooms, as well as synthetic hallucinogens such as LSD), while 0.6% had used hallucinogens in the year preceding the survey.³⁶

More males than to females, and more people from the 20–29 age group, used hallucinogens in the preceding year.

Effects

Short-term effects

The short-term effects of naturally occurring hallucinogens include:

- » vivid perceptual distortions (hallucinations)
- » a distorted sense of time and place
- » poor coordination
- » increased body temperature and sweating, and/or chills
- » a lack of control over thinking processes and concentration.



'Magic mushrooms'
Image: Age fotostock

The effects produced by these substances, and the user's reaction to these effects, vary greatly between individuals.

Long-term effects

The most frequently discussed long-term effect of using hallucinogens is flashbacks—a spontaneous recurrence of something that happened while the person was taking the drug. These are usually brief, but can occur for days, weeks or even years after taking the drug.

Other long-term effects include impaired memory, and prolonged depression and anxiety.

Hallucinogens and driving

It is extremely dangerous, as well as illegal, to drive with the distorted sense perceptions, poor coordination and lack of judgement caused by taking hallucinogens.

Hallucinogens and pregnancy

There is evidence linking the use of hallucinogens in pregnancy to an increased risk of miscarriage and birth complications. There may also be a higher incidence of birth defects among babies born to women using hallucinogens.

If a mother uses hallucinogens while breastfeeding, it is possible that the drug will be present in her milk and have adverse effects on the baby.

Interaction with other drugs

Cross-tolerance can occur between psychedelics. This means that users with a tolerance to, for example, LSD, may have a tolerance to drugs with similar effects such as mescaline (see page 3 for a definition of tolerance).

Dependence

Naturally occurring hallucinogens are not thought to cause physical dependence (see definition on page 2). Regular users may develop psychological dependence, although this is not common.

Withdrawal

Regular users may experience a need or craving if they stop taking the drug.

Overdose

One of the dangers of using magic mushrooms is that of accidentally ingesting a highly toxic non-hallucinogenic variety. Some other naturally occurring hallucinogens, such as datura, may cause poisoning in high doses.

Treatment

People who use natural hallucinogens do not generally seek treatment for their drug use and there are few treatment options that can be recommended, apart from those found to be generally effective for drug dependence (see page 4).



14

Tobacco

smokes, ciggies, cigs, fags, rollies, durries

Tobacco is made from the dried leaves of the tobacco plant. The ingredient in tobacco that has an effect on the mind is **nicotine**, which is highly addictive.

Tobacco originated in the Americas and was introduced to Europe in the 15th century. It was first smoked in pipes, then snorted as snuff and smoked in cigars. By the early 20th century, smoking cigarettes was the most popular way of using tobacco.



Image: Age fotostock

An association between tobacco smoking and lung cancer was identified by medical researchers in the 1920s, and by the 1950s there was good evidence of a range of damaging effects. By this time, however, nicotine addiction was widespread, and tobacco companies opposed public health measures, which they perceived as threatening their commercial interests.

Since the 1970s, largely in response to pressure from medical and health organisations, laws have been introduced across Australia aimed at reducing the damage caused by tobacco through, for example, restrictions on advertising and other measures to minimise the impact of passive smoking.

Tobacco and the law

Tobacco use in Australia is legal, subject to many restrictions, including the following:

- » Smoking is prohibited in 'enclosed public spaces', which are very broadly defined to include, among other places: public transport, offices, shopping centres, hotels, restaurants and cinemas.

- » It is illegal to smoke in a car in which children under 16 are passengers.
- » It is illegal to sell or supply cigarettes and tobacco to people under 18.
- » Cigarette packets are required to carry graphic images of the harm caused by smoking tobacco.
- » Tobacco advertising is illegal on TV, on radio, in the print media and in retail outlets.
- » Two signs must be displayed prominently at retail outlets, one displaying the words 'SMOKING KILLS, Call the Quitline 131 848', and the other advising the illegality of selling tobacco products to people under 18.
- » Retailers must not display cigarettes, tobacco or smoking products so that they can be seen by the public from inside or outside the premises.

How tobacco is used

Tobacco can be smoked in cigarettes, pipes or cigars. It can be snorted in the form of a powder (snuff) and it can be obtained in blocks for chewing. Cigarettes account for 98% of all tobacco use.

Effects

Short-term effects

When tobacco is smoked, the nicotine dissolves instantly in the saliva, and is absorbed quickly into the bloodstream. In a few seconds it reaches the brain, and the smoker feels light-headed and dizzy. The short-term effects can include:

- » a feeling of stimulation and alertness
- » increased heart rate and blood pressure
- » acid in the stomach
- » nausea
- » a weakened sense of taste and smell
- » reduced appetite
- » reduced muscle tension, leading to a feeling of relaxation.

How common is tobacco use?

The 2007 National Drug Strategy Household Survey found that 16.6% of Australians aged 14 and over are daily smokers of tobacco. This is a decrease of around 30% since 1991, when 24.3% smoked on a daily basis. Overall females have always smoked less than males, and this remains true today. However, today's teenage girls are more likely to be daily smokers than teenage boys.³⁷

Long-term effects

- » Smoking is associated with an increased risk of diseases of the heart and blood vessels throughout the body, including the brain.
- » It is a primary cause of diseases of the airways such as emphysema, chronic bronchitis and chronic obstructive lung disease.
- » It worsens conditions such as hay fever, asthma and acute rhinitis (runny nose and inflammation in the nose).
- » It can reduce fertility in both men and women, particularly women.
- » It accelerates the ageing of the skin, delays wound healing, and contributes to osteoporosis.

Tobacco and cancer

Tobacco smoke is a mixture of almost 4000 different chemical compounds, including nicotine, tar, carbon monoxide, acetone, ammonia and hydrogen cyanide. Sixty-nine of these chemicals have been proven to be carcinogenic (cancer-causing). Smoking is a direct cause of lung cancer, oral cavity cancers (tongue, pharynx), oesophageal and stomach cancer, cancer of the larynx, kidney and bladder cancer, pancreatic cancer, leukaemia and cancer of the liver. The incidence of cancer is related to the amount and duration of smoking.

Tobacco and driving

There is little evidence that tobacco impairs driving ability. However, smoking while driving, like eating and using mobile phones, does contribute to road accidents by distracting the driver and occupying the driver's hands.

Tobacco and pregnancy

During pregnancy the chemicals in tobacco pass through the placenta to the baby in the uterus, while carbon monoxide replaces some of the oxygen in both the mother's and baby's bloodstreams. This can affect the baby's growth and development, increasing the risk of low birth weight, premature birth and spontaneous abortions.

After birth babies are vulnerable to the effects of passive smoking if people around them smoke. Babies of smokers are more likely to suffer from asthma and other respiratory infections, and have a greater risk of sudden infant death syndrome (SIDS) than babies of non-smokers.

Feeling better?

Nicotine may help some people concentrate. However, smoking also releases chemicals in the blood that increase stress. The smoker believes they are smoking to relieve stressful feelings, but in fact the smoking can increase agitation.

The feeling of relief is also associated with reducing the withdrawal symptoms which gradually increase between cigarettes.

Interaction of tobacco with other drugs

Alcohol consumption increases the risks of some of the cancers associated with smoking, especially oral, pharyngeal and laryngeal cancer. Heavy alcohol consumption further increases these risks.

There is no evidence that other drugs increase the damaging effects of tobacco.

Dependence

Nicotine is addictive. Tolerance develops rapidly, with two in three smokers demonstrating nicotine dependence; that is, they experience withdrawal symptoms when they try to stop (see definition on page 2).

Tobacco and breastfeeding

The harmful products of tobacco smoking are absorbed in breast milk. Apart from causing direct harm to the baby, they can reduce the supply of breast milk, can affect the 'let-down' process and make feeding more difficult.

It is recommended that a mother who finds that she cannot quit smoking should still breastfeed, but should not smoke before feeds, and should always go outdoors to smoke.

Withdrawal

Symptoms of withdrawal from nicotine include irritability, anxiety, difficulty concentrating, restlessness, sleep problems, cravings, tingling sensation and dizziness, coughing (because the lungs are recovering), and a possible increase in appetite.

Not everyone has all these symptoms.

Symptoms are usually strongest for the first one to two days, and decline in intensity over the next two weeks. Craving may recur, especially under stress, for months, or even years after quitting.

Overdose

Nicotine is a poison (eating quite a small amount of pure nicotine could kill an adult), but it is not possible to overdose by smoking or chewing tobacco, or using snuff.

Treatment

Research has shown that nicotine replacement therapies (such as transdermal patches, gum, lozenges, inhalers, nasal sprays and sublingual tablets) may be useful for people trying to give up smoking.

Medications such as Zyban and Champix can help some people cope with physical withdrawal symptoms. However, such medications are only of use during the period of withdrawal—up to two weeks—and in most

cases psychological dependence must also be addressed. Psychological intervention (see page 5), support groups or even good self-help books can be helpful. For more information on quitting smoking, contact Quit on 13 78 48, or see your GP for further advice and support.

The benefits of quitting

In general, after a person stops smoking:

- » there is an improvement in sense of taste and smell after about five days
- » blood pressure returns to normal and the immune system shows signs of recovery within a month
- » risk of death from heart disease is halved within 12 months
- » after ten years the risk of lung cancer due to smoking is halved, and continues to decrease
- » after 15 years the risk of heart attack and stroke returns to that of a person who has never smoked.

Risks associated with other lung diseases such as emphysema and chronic bronchitis are also reduced once smoking has stopped.



Tobacco

Image: Age fotostock



Drug seizure

Image: Fairfax Media Publications



15

Drugs & the law

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History of drug laws

Patterns of drug use and social attitudes to drug use have changed dramatically over time.

The notion of making drug use illegal did not really emerge in Western societies until the late nineteenth century. Before that, in Australia, Britain, Europe, and the United States, whether people used drugs was considered a personal decision—subject to social disapproval, but not illegal. Alcohol was of course the most widely used psychoactive substance.

Drugs in Australia

The first Australian drug law was an 1857 Act imposing an import duty on opium. In the following years, a number of other laws were passed imposing often prohibitive tariffs on opium. The primary purpose of the laws was clearly to discourage the entry of Chinese people to Australia, rather than to restrict the importation of opium itself.

Australians in the nineteenth century were among the world's biggest consumers of opiates, thanks to the very wide popularity of patent medicines, most of which contained a high proportion of alcohol or morphine or both. Laudanum, a mixture of opium and alcohol, was taken regularly by upper class matrons and administered to children to calm them.

The first laws restricting opium were carefully worded to apply to opium in smokable form only—not opium as it was taken by the European population.

Cannabis plants were sent to Australia by Sir Joseph Banks on the First Fleet, in the hope that the new colony might grow enough hemp to supply the British Navy with rope. Cannabis was not consumed on a large scale (although it was readily available for sale as cigarettes called 'Cigares de Joy' until the 1920s). Cannabis importation and use was prohibited by federal legislation in 1926 (implementing the 1925 Geneva Convention on Opium and Other Drugs), with the states adopting similar prohibition in the following years.

Heroin was legally available on prescription in Australia until 1953. It was so widely used as a painkiller and in cough mixtures that Australia was the world's largest per capita user of heroin. The 1953 prohibition of heroin was the result of international pressure on Australia to conform to the prohibition of heroin adopted by other countries, with some opposition from the Australian Medical Association.

Ironically, heroin, cannabis, and other drugs were prohibited in Australia well before their use became a major social issue.

Before the 1960s, drug use was not completely unknown, but dependent drug use was typically the result of the use of opiates after first using them for medical reasons. There were drug dependent doctors (and their wives), and a small bohemian subculture that used drugs. Many Australian arrests for drug offences involved visiting jazz musicians.

Among the significant social changes of the 1960s was the emergence of the concept of 'recreational' drug use—the consumption of cannabis, heroin, LSD and other psychoactive drugs for pleasure, or in pursuit of spiritual enlightenment. For the first time, drug use became widespread—if not quite mainstream—rather than an activity pursued by a few painters or poets. The official response was increased law enforcement, and legislative change to extend the range of offences and increased penalties for drug offences.

The Vietnam War contributed to the significant increase in drug consumption in Australia in the late 1960s, with American soldiers on 'rest and recreation' leave in Australia creating a market for heroin, marijuana and other illicit drugs, and providing a glamorous example for the locals.

The 'old' Australian drug laws were mostly under the various state Poisons Acts, reflecting an underlying approach of regulation and control of medicinal substances, with potentially addictive drugs legally available only on a doctor's prescription. The 'new' drug laws introduced a distinction between use and possession offences, and supply offences. Penalties for possession and use increased, but very substantial penalties were



Random breath test patrol
Image: Fairfax Media Publications



Image: Age fotostock

introduced for drug supply, and especially supply of large quantities ('drug trafficking'). By 1970, all the states had enacted laws that made drug supply a separate offence to drug use or possession offences.

In 1985, the federal and state governments adopted a National Drug Strategy which included a pragmatic mixture of prohibition and a stated objective of harm reduction. Harm reduction has been an official part of Australian drugs policy ever since, although most resources by far are devoted to policing and border patrol attempts at interdiction ('supply reduction'). Fewer resources are made available for health treatment and drug rehabilitation programs, or for preventative public health programs such as needle exchange.

The needle exchange program has been successful. Australia maintains an extremely low rate of HIV infection among injecting drug users. The success of the needle exchange programs encouraged governments to at least consider adopting other harm minimisation initiatives.

The merits of a trial of a heroin prescription program, based on the Swiss model, were debated in the 1990s. The ACT government took steps to begin a trial program, but the federal government refused to allow the importation of heroin. Unable to source legitimate and controlled quality heroin, the ACT government abandoned the proposed trial.

Australia has been tentative about allowing legal injecting rooms, with NSW the only state to permit an injecting room, and then only one. The Medically Supervised Injecting Centre (MSIC) operated from 2001 to 2010 on a 'trial' basis. In October 2010, legislation to make the Kings Cross MSIC permanent was passed by both Houses of the NSW Parliament. The Police Commissioner and the Director-General of NSW Health will continue to oversee the centre and it will undergo regular statutory evaluations every five years.

In all states, the impact of prohibitionist laws on drug users is somewhat modified by a number of diversion programs, diverting some eligible users from the criminal justice system to cautions or treatment.

Harm Reduction

Harm reduction focuses on minimising the negative impacts associated with drug use, individually and socially. While not advocating drug use, supporters of harm reduction argue that we should accept that some drug use will occur, and focus on addressing the harms caused.

Drug laws in NSW

What are illegal drugs?

In NSW, it is an offence to possess, use, produce or supply a drug which has been declared prohibited. Most drug charges in NSW are laid under the *Drug Misuse and Trafficking Act 1985* (NSW). The *Commonwealth Criminal Code* covers offences involving importing and exporting drugs.

The Drug Misuse and Trafficking Act 1985 (NSW)

The NSW *Drug Misuse and Trafficking Act 1985* ³⁸ classifies a wide range of drugs as ‘border controlled drugs’ (and ‘prohibited plants’ in the case of cannabis, opium and coca). The Act creates offences for:

- » use of prohibited drugs
- » possession of prohibited drugs
- » supply and trafficking of prohibited drugs (with the seriousness of the offence depending on the quantities involved)
- » cultivation and possession of prohibited plants
- » manufacture of prohibited drugs
- » aiding and abetting and taking part in offences involving prohibited drugs or plants
- » possession of drug-use implements.

The drugs prohibited by the Act are listed in a schedule to the Act. They include the common street drugs—cannabis (marijuana), heroin, ecstasy, amphetamines, LSD, cocaine, methadone—and many others.

Commonwealth Criminal Code

The *Commonwealth Criminal Code* ³⁹ is a federal law that aims, among other things, to prevent the import and export of prohibited drugs. The range of drugs (again listed in a schedule) is similar to that in the *Drug Misuse and Trafficking Act 1985* (NSW).

Commonwealth Criminal Code offences include dealing with imported drugs after they have been brought into the country.



Drug seizure

Image: Age fotostock

International treaties and conventions

Australia is a signatory to a number of international treaties and conventions about drugs and drug policy. These treaties are all prohibitionist in their basic intent. Countries that sign these treaties must agree to pass laws against using and trading of recreational drugs.

International treaties and conventions are not law in Australia. The only law in NSW is legislation passed by state or federal parliament and precedent decisions made by the courts. The legal status of the treaties is to guide the federal government. In some cases, treaties give the federal government constitutional power to pass laws it might not otherwise have had. New South Wales and other Australian states are not signatories to international treaties so they are not strictly legally bound by their terms, although there is a tradition that states and provinces should act consistently with treaties entered by their national governments.



Drug search

Image: U.S. Drug Enforcement Administration

The main international treaties about drugs that Australia has signed are:

- » the Single Convention on Narcotic Drugs 1961
- » the Convention on Psychotropic Substances 1971
- » the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988.

These treaties require the nations that sign them to pass laws imposing criminal penalties on drug use, possession and supply. However, the treaties also allow for flexibility. For example, they allow signatory countries to permit the use of prohibited drugs for medical purposes.

Importantly, the treaties also provide an option to divert drug offenders to rehabilitation and treatment programs, instead of imposing criminal punishments.

Possession, use and supply

Some of the most common drug offences are for possession, use and supply of prohibited drugs. Each drug offence has specific legal 'elements' which the prosecution must prove beyond reasonable doubt. In this section, we examine the necessary legal elements for these offences. These elements are established by the terms of the legislation, as interpreted by precedent court decisions.

Possession

Possession of a prohibited drug is an offence under section 10 of the *NSW Drug Misuse and Trafficking Act*. To prove possession, the prosecution must show beyond reasonable doubt that:

- » an illegal drug was in a person's 'custody' or 'control', and
- » the person knew that they had custody or control of a prohibited drug.

Proving custody or control

The police must prove that the person actually had control over drugs found, for example, in their car or house. The fact that a person owns a car, or owns or rents a house, does not necessarily mean that they own things in it. If a person knows that there are drugs in their house, but someone else has control of them (that is, the person does not own the drugs or have any right to use them), they are not guilty of possession.

What is custody or control?

Custody means immediate physical possession, such as a person having something in their pockets.

Control refers to the right to do something with the drug—for example, to keep, consume or share it.

Momentary custody and control

A person can be found guilty even if their custody and control was only momentary: for example, by taking a joint passed to them.

Proving knowledge

The prosecution must prove that the person knew they had something in their physical custody and control that was, or was likely to be, a prohibited drug.

The legal test for the prosecution is not ‘what a reasonable person might or should think in the circumstances’. The actual knowledge of the accused person must be proved. Knowledge can be inferred from the circumstances in which the drugs were discovered.

If someone is apprehended with drugs on them, a court would probably reasonably infer that they had knowledge and control of those drugs. It is difficult for someone in this situation to escape the inference that they knew what was in their bag or sock or pockets. Similarly, where drugs are stored in a part of a house that is private (say, in a person’s bedroom) it is open to be inferred that they had possession of those drugs.

Shared houses

When drugs are found in a place that is accessible to a number of people (such as the living room of a shared house), it may not be inferred that any single person has possession of the drugs. The drugs could belong to anybody who had access to the room.

If no one makes a statement to the police that the drugs are theirs (or someone else’s), it is likely that no-one will be convicted.

The prosecution must rule out all other reasonable explanations. If there is the possibility of several people having access to the drugs, there is

room for reasonable doubt about whether the drugs are possessed by the accused. They could be possessed by someone else.

It is possible that all the people living in a shared house could be charged and convicted of possession if the police can prove that they all had knowledge and control over (or access to) the drugs. But that would require evidence that all people had access—for example, statements from *all* the residents admitting they had knowledge and access.

Charges against several persons

If a number of people are charged with possession in this situation, the prosecution must prove in each case that the person charged had possession of the drugs.

This can be difficult. Courts are not allowed to presume that all the people must have shared possession—each individual accused is presumed innocent. Without admissions ('Yeah, I knew the dope was in the cupboard. . .'), it may be difficult to prove that any one of the accused is guilty of possession.

Medicinal cannabis

It is not a defence to a charge of possession of cannabis (or self-administration or cultivation of cannabis) that the person used the cannabis for a legitimate medical reason. However, such motivation can be a relevant issue to be taken into account in sentencing.

Use

Using an illegal drug (also known as 'self-administration') is an offence under section 12 of the *NSW Drug Misuse and Trafficking Act*. The police must prove that the substance consumed was a prohibited drug. Obviously they cannot analyse the substance if it has been completely consumed, and blood tests can only be taken by a doctor after arrest. So for most convictions they must rely on admissions made by the accused.

Intoxication as a defence to criminal charges

Self-induced intoxication with illegal drugs does not generally provide defence to criminal charges.



Image: iStockphoto

Prescription drugs

It is legal to possess and use some drugs, like methadone and the benzodiazepines (such as Serapax and Valium), if they have been prescribed by a doctor. It is only an offence to possess or use these drugs without a prescription.

Injecting methadone

It is an offence to inject methadone, even by someone on a methadone program. Methadone is legally prescribed subject to conditions on quantity and the 'purpose' of the prescription, which must be according to 'recognised therapeutic standards' (NSW Poisons and Therapeutic Goods Regulation 2002).

The 'purpose' specified in methadone prescriptions is oral dose. Administration by any other method means the methadone is not lawfully prescribed and is illegal.

Administering drugs to others

It is also an offence to administer a drug to someone else, for example by injecting them, or to allow someone to administer drugs. It is an offence even if the person consents to the drug being administered to them.

Drink spiking

The offence of administering a prohibited drug includes drink spiking, where a prohibited drug is added to someone's alcoholic drink, and the person is not aware and does not consent to the administration of the drug.

If someone dies

A person who injects someone else with a drug that causes their death may be charged with manslaughter. Manslaughter means causing an unlawful death where the intention was not to kill or inflict a serious injury, but to inflict a minor injury or commit some other criminal offence.

Getting medical help

If an overdose or other emergency situation involving drug use occurs, you should call an ambulance or seek other suitable medical help. It is obviously the best medical option for the person who has overdosed.

The ambulance service does not notify the police when it attends a drug overdose. Hospitals and doctors also do not notify the police if you go to them requesting medical attention.

Police sometimes do attend overdose scenes. But police guidelines are designed to encourage people to seek medical help when necessary. So police are directed not to arrest an overdose victim or their friends, or any other people who are present at an overdose and may have also consumed drugs or be in possession of drugs.

Injecting rooms

In October 2010 the NSW Government passed legislation to make the Medically Supervised Injecting Centre in Kings Cross permanent. The Centre had been operating since 2001 on a trial basis.

It is lawful for a person to use or possess a small quantity of a prohibited drug while in the injecting centre. Police guidelines also encourage the

exercise of discretion to not arrest or charge a person who is on their way to or from, or in the vicinity of, the injecting centre with possession offences. Supply offences in or near the injecting centre are policed.

It is an offence for anyone except the operators of the licensed injecting centre to 'advertise or hold out in any way' that their premises are available for the administration of a prohibited drug.

Supply

Supply is very broadly defined to include not only selling or giving away drugs but also simply agreeing to supply them.

Supply also includes 'deemed supply'—possessing certain quantities of drugs which are deemed to be for the purpose of supply.

A person can be charged with supply if they tell police they intended to sell even a small quantity of drugs found in their possession, or if they deliver drugs to a friend.

They are also guilty of supply if they simply offer to supply a drug, even if they have no hope, or no intention, of fulfilling the offer.

What if it isn't really a drug?

If a person offers a substance to someone and says that it is a drug to persuade that person to buy or take it, they are guilty of supplying the drug whether the substance is actually the drug or not. For example, a person who offers to supply someone with heroin when all they have is icing sugar is considered guilty of supplying heroin.

This is the case whether they have made a genuine mistake or are deliberately attempting to cheat the buyer.

For possession and use offences the court must be satisfied that the substance is in fact a prohibited drug.

Deemed supply

A person will be presumed to be supplying a drug if they are simply in possession of a particular quantity of the drug, known as the traffickable quantity. This amount varies from one drug to another, and in many cases is not especially large.

If the police can prove that a person is in possession of a traffickable quantity of a drug, the person then has the onus of proving that the possession was not for the purpose of supply.

A traffickable quantity of a drug is an amount deemed in law to be in a person's possession for the purpose of supply.



Ecstasy (MDMA) seizure

Image: U.S. Drug Enforcement Administration

Purity does not matter—only weight. Under NSW law, one gram of a powder that is 10% heroin and 90% glucose is treated as one gram of pure heroin.

Anybody found in possession of a traffickable quantity is presumed to be a supplier unless they can prove otherwise—for example, that the drug was intended for personal use, or disposal.

Ongoing dealing

Ongoing dealing involves the supply of a prohibited drug (except cannabis) on three separate occasions within a 30 day period. The acts of supply must be for some financial or other material reward. They do not all have to involve the same drug.

A charge of ongoing dealing could be laid where an undercover police officer buys drugs from the same street dealer on three different days. The police are not obliged to arrest the dealer immediately after the first sale.

Large scale supply

Higher penalties apply for charges involving the supply of larger amounts of drugs.

The Act divides trafficking offences into:

- » indictable quantities
- » commercial quantities
- » large commercial quantities.

As with deemed supply, proof of possession of the relevant quantity is sufficient to establish that a person is guilty of that particular trafficking offence, unless the person can prove that the possession was for a reason other than supply (which is obviously more difficult the larger the quantity).

Other offences

Drug use equipment

It is an offence to possess equipment with the intention of using it to consume drugs. The use must be future use. Evidence that the equipment has been used in the past is not relevant or sufficient to prove the charge.

The prosecution must show that the equipment was illegally possessed. The law is the same as for possession—there must be knowledge and custody or control.

Injecting equipment

It is not an offence to possess a needle or syringe, whether it has been used or not.

It is (technically) an offence to possess other injecting equipment, such as tourniquets, spoons, and swabs. In practice, possession of this equipment is not prosecuted.

Sale of bongs and pipes

It is an offence to sell, supply or display for sale a bong or ice pipe, or the component parts of a bong or pipe, whether or not the bong or pipe was intended to be used to administer a prohibited drug.

Offences involving prohibited plants

The cultivation or possession of prohibited plants, such as cannabis, is an offence.

It is an offence to:

- » cultivate
- » knowingly take part in the cultivation of
- » possess
- » supply

a prohibited plant.

What is included?

Cultivation is defined to include sowing seed, planting, tending, nurturing or harvesting.

Watering a plant, shading it from the sun, picking the heads off a friend's plant, even watering ungerminated seeds, all come within the definition of cultivation.

Possession of plants is also an offence under the same section and with the same maximum penalty as for cultivation. A charge of possession

of prohibited plants would be laid where there was no evidence of any act of cultivation (such as planting or watering), but there was evidence of possession (again, requiring proof of knowledge and custody or control) of the plants.

Quantities

The penalty categories for cultivating cannabis depend on the number of plants, not their gender or size. Cultivating a hundred seedlings that can fit into a baking tray is treated the same as cultivating a hundred mature female plants. Having 250 seedlings is regarded as more serious than having five big plants, even though the weight of the five big plants may be many times greater.

Higher penalties apply to offences involving the cultivation, supply and possession of a 'commercial quantity' of prohibited plants.

Defences to cultivation

It is a defence to a charge of cultivation of a prohibited plant if the accused can establish that they did not know the plant was a prohibited plant. The prosecution may rebut the accused's evidence by bringing, with leave of the court, evidence of any previous convictions.

Hydroponic cultivation

It is an offence to participate in the 'cultivation by enhanced indoor means' of five or more plants for a commercial purpose. 'Commercial purpose' means intending to sell or believing that another person intended to sell. [Note that the offence of (outdoor) cultivation of cannabis does not involve any requirement to prove a commercial purpose.]

The offence requires the cultivation to be:

- » inside a building or structure and
- » involve growing the plant in nutrient enriched water or applying artificial light or heat or suspending the roots and spraying them with nutrient solution and
- » involve five or more plants and
- » be done with the intention to sell (or the belief that another person intends to sell) the cannabis produced.

Manufacturing drugs

It is an offence to manufacture, or to take part in the manufacture of, a prohibited drug.

The maximum penalty for manufacture of a prohibited drug depends on the quantity involved, with the same penalties applying as for supply offences involving comparable amounts.



Heroin seizure

Image: U.S. Drug Enforcement Administration

Possession of precursors

It is an offence to possess a 'precursor' intended to be used in the manufacture of a prohibited drug. Substances defined as precursors are listed in Schedules 1 and 2 *Drug Misuse and Trafficking Regulation 2006* (NSW). The Regulation also provides that, for legitimate uses, records must be kept for any storage or supply of precursors, including an 'end user certificate' which includes the name and address and proof of identity of the end user.

Knowingly take part in cultivation, manufacture or supply

It is an offence to 'knowingly take part in' the supply, cultivation, or manufacture of a prohibited drug or plant.

'Taking part in' manufacture, cultivation, or supply is defined to mean:

- » the person takes, or participates in, any step, or causes any step to be taken in the process of manufacture, cultivation or supply; or
- » the person provides or arranges finance for any step in that process; or
- » the person provides the premises in which any step in that process is taken, or allows any step in the process to be taken in premises owned, leased, occupied or managed by the person.

A person may be considered to be taking part in supply, for example, if they arrange or provide finance or provide premises, or allow their premises to be used for selling or distributing or growing drugs. It would also include making a telephone call to arrange a meeting or allowing their house to be used for a meeting at which supplying drugs is discussed.

The participation must be done 'knowingly'. Proof that a person suspected that somebody else might be involved in drug offences is not proof of knowledge, but knowledge may be inferred if someone shuts their eyes to suspicious circumstances.

Similarly, the word 'permits' means the owner or controller of the premises knew or had grounds for reasonable suspicion that the premises would be used by someone for that purpose, and was unwilling to take reasonable measures to prevent it.

Drug premises

Drug premises are premises used for the supply or manufacture of prohibited drugs or the commercial indoor cultivation of cannabis.

It is an offence to be found on or entering or leaving drug premises. It is also an offence for an owner or other occupier to allow property to be used as drug premises, or for a person to organise or conduct drug premises, or to assist in the conduct of drug premises (for example, as a lookout or door attendant).

Any place where there are five or more indoor cannabis plants being grown for profit is capable of being a drug premises, exposing occupants and visitors to prosecution for offences such as entering or being on drug premises.

Importing and exporting

It is an offence to import, or try to import, prohibited drugs.

The prosecution must prove that the accused intended to import the substance. In other words, a person will be acquitted if they did not realise that they were carrying drugs.

It is also an offence under the *Commonwealth Criminal Code* to assist or be knowingly concerned in any illegal importation of drugs. The prosecution must prove that the accused was fully aware of what was going on and performed some act such as providing money. Mere knowledge or inaction does not establish the offence.

Drugs and driving in NSW

It is an offence (under the *NSW Road Transport (Safety and Traffic Management) Act 1999*) to drive 'under the influence' of a drug or alcohol. A full list of drugs can be found in Schedule 1 of the *NSW Drug Misuse and Trafficking Act 1985*. Proof of this offence requires proof beyond reasonable doubt that the driver was intoxicated to some degree by the drug or alcohol.

Since the introduction of breathalysers and random breath testing for alcohol, drink driving offences are now much more commonly charged

as driving with the relevant 'prescribed concentration of alcohol'. This in effect bypasses any need to prove intoxication—the presence of alcohol in a person's system is sufficient evidence for the offence to be proved.

A person convicted of driving under the influence of a drug and causing death is liable for a maximum penalty of 10 years jail (or 14 years if there are circumstances of aggravation such as speeding).

Drug testing

If the police reasonably suspect that a person is driving under the influence of a drug, they have the power to take them to a hospital for a blood or urine test for the presence of drugs, under the supervision of a doctor. The sample is divided into two. One half is sent to government laboratories and the other half is given to the person for independent analysis.

It is an offence to refuse to submit to a blood test or a urine test in these circumstances. It is likewise an offence to wilfully alter the amount of drug in your blood or urine before having the test, unless it is more than two hours since you were driving.

Random drug testing

The NSW Government has introduced legislation to allow random roadside testing of drivers, to test for the presence of cannabis, amphetamine or ecstasy. The roadside tests involve a saliva test using portable drug screening machines.

The testing method is by saliva swab (an 'oral fluid test') to test for the presence of THC (the psychoactive ingredient of cannabis), methamphetamine and ecstasy. If the saliva testing device indicates positive, then a further saliva sample may be taken for analysis, with the test result being provided as evidence in court.

It is an offence to drive with THC, methamphetamine or ecstasy present in the person's oral fluid, blood or urine (although only a driver's saliva will be tested in most cases).

It is also an offence to drive with morphine or cocaine, but these substances will not be tested by saliva swab.

As for the similar law about random alcohol testing, it is an offence to wilfully refuse to provide a saliva sample, and to consume a drug after driving and before undergoing a saliva test.

Fatal accidents

Police can obtain blood or urine samples from drivers involved in fatal road accidents.

Drugs in sport

Sporting associations have a general right to make rules for the conduct of organised sporting competitions. Those rules are binding, on the basis of a contract, on players who want to participate in those organised competitions.

At elite levels, the rules always include the right of sporting bodies to require players to have a drug test for performance enhancing drugs like anabolic steroids, in and out of competition. Some sports also test for recreational drugs.

The general principle is that if an athlete refuses or fails a drug test, the sporting bodies are entitled, subject to their own constitutions and rules of procedural fairness, to suspend or ban the player.

Police powers

Undercover police

Police investigations into drug offences commonly involve the use of undercover officers who either offer a degree of encouragement to people to commit an offence, or participate in criminal activity, or both. There is no substantive defence of entrapment in Australian law.

The fact that drugs are supplied to an undercover police officer who encourages the supplier to break the law is not a mitigating circumstance in sentencing.

Police directions in public places

Police can legally give a 'reasonable direction' to a person in a public place who they believe on reasonable grounds is supplying, or soliciting supply of, or purchasing prohibited drugs. The direction must be 'reasonable in the circumstances for the purpose of stopping' the supply or purchase. It is an offence to fail to comply with the direction without reasonable excuse.

Searches

Police have some powers to search people and property, and seize articles such as drugs for evidence, but their powers are not unlimited.

There are different rules for personal searches, and searches of houses or land.

Personal searches

The police can search a person without arresting them (under the *NSW Law Enforcement Powers and Responsibilities Act 2002*, section 21). This gives police the power to 'stop, search and detain' anyone who they 'reasonably suspect' might be in possession of drugs. Police can search a vehicle if they have a similar reasonable suspicion.

Search after arrest

The police have the right to search a person after an arrest and they generally do.

A police officer above the rank of sergeant can request that a doctor examine a person in custody (if such an examination is relevant to the charge) without the person's consent.

Women should only be searched by a woman police officer. If no female constable is available, however, the police can request 'any female' to conduct the search under their direction.

Sniffer dogs

Police can use sniffer dogs without a warrant to detect illicit drugs (under the *NSW Law Enforcement Powers and Responsibilities Act 2002*) but only



*Sniffer dog search
Image: Age fotostock*

for ‘general drug detection’, defined to mean using a dog to detect the potential presence of drugs by smell, before the police conduct any actual search of the person or their belongings.

Sniffer dogs can be used in relation to a person who is at, entering or leaving:

- » premises licensed for the consumption of liquor sold there (not including a restaurant or dining room)
- » a public place being used for ‘a sporting event, concert or other artistic performance, dance party, parade or other entertainment’
- » a train, bus or light rail vehicle, on a prescribed route, or a station, platform or stop.

In other circumstances—for example, in a public street—police can only use drug detection dogs to search people or vehicles with a warrant.

Personal searches by customs officers

People coming into Australia are obliged to answer questions from a customs officer about border controlled drugs. Luggage can be inspected even where there is no reason to suspect that it might contain drugs.

Types of search

There are two types of personal searches available under the *Customs Act 1901* (Commonwealth) in relation to a person suspected of carrying border controlled drugs: frisk searches and external searches.

A frisk search is a quick feel of a person's outer garments, including any clothing voluntarily removed. An external search involves a search of a person's body (but not body cavities) and any of their clothing.

If a person refuses a frisk or an external search, the customs or police officer may apply to a specially authorised customs officer or a magistrate for an order that an external search be made.

Detention and search

If a customs or police officer suspects on reasonable grounds that a person is carrying prohibited imports, they may be detained and searched. The search must be conducted as soon as practicable by an officer of the same sex, and appropriate arrangements made for privacy.

If internal concealment is suspected

People reasonably suspected of internally concealing a suspicious substance may be detained by a customs officer or police officer. The chief executive officer of Customs or a police officer must then seek a detention order (up to 48 hours, but renewable) from a judge or magistrate.

If the person detained does not consent to an internal search, the customs or police officer must apply to a judge for an order for a medical practitioner to carry out the search.

Searches of property

To enter a person's home or any other private property without an invitation, the police must have a search warrant (except in emergency situations such as chasing an escaping suspect, or where there is apparently an assault occurring on the premises). To obtain a search warrant, the police must swear on oath to an authorised officer that they have reasonable suspicion of a crime being committed on those premises, and the basis of that suspicion.



Police seizure of marijuana plants

Image: Fairfax Media Publications

When police are at the premises

When police go to premises with a search warrant they must produce an occupier's notice, otherwise they do not have the right to enter the premises.

It is an offence to obstruct or delay police entry, or give an alarm.

Police powers with a warrant

The police can use as much force as is reasonably necessary to conduct the search, which can mean pulling out drawers (and ceilings).

Search warrants also give police the right to search a person found in or on the premises if they have a reasonable suspicion that the person has the thing mentioned in the warrant.

In the case where police have a warrant to search a property reasonably suspected of being drug premises, police can cross property owned by others, break open doors and windows, and do other 'necessary' acts to gain entry.

Evidence from illegal searches

Evidence obtained through illegal police searches (or otherwise illegally or improperly obtained) is inadmissible, but can be used in evidence if the judge or magistrate uses their discretion to allow it in.

Detection by helicopter

Where a police helicopter detects cannabis plants from the air, police still must obtain a search warrant to enter the property. Without a warrant, any evidence would be unlawfully obtained and so inadmissible (unless the judge or magistrate used their discretion).

Seeking the proceeds of crime

Search warrants can also be issued under the legislation dealing with the confiscation of proceeds of crime. They can, for example, cover documents that can assist in tracking down property that is drug-derived or which belongs to those who are reasonably suspected of drug-related activities.

Youth drug and alcohol issues

Drugs in state schools

State school principals have wide legal powers to make rules about the conduct of the students at their school and to suspend students who break the rules in a serious way. Most schools have rules against possessing or using drugs at school.

If a student is found possessing or using drugs, they will probably be suspended for at least several days. If a student is caught dealing drugs at school they will probably be expelled, or at least suspended for a lengthy period of time.

The school may also report the student to the police, in which case they may be dealt with by a warning or caution; or charged and brought before the court (the Children's Court if they under 18 years of age).

Teachers' powers

Teachers do not have the same powers as the police have. Teachers do not have the right to:

- » search a student, their clothing or their bag (unless the student agrees to being searched)
- » hold a student or lock them in a room.

However, teachers can:

- » search school property, like a desk or a locker (if the student has not paid to use it)
- » confiscate any drugs they find.

The school may call the police, who do have the right to search the student.

Suspension and expulsion

State school principals have the power to suspend students for a limited period of time, but principals don't have the power to expel. A decision to expel a student can only be made by the Department of Education and Training (NSW). The principal must write to the student and their parents or carers if they are considering recommending expulsion to give the student a chance to dispute the reasons or make any other comment. If the principal then decides to recommend expulsion, the student must receive a copy of the principal's submission to the department. The student has 14 days to make any comment.

If a student is suspended or expelled because of drugs and they are not guilty or they think the penalty is too severe, they can appeal to the School Education Director or the Regional Director and ask that the decision be reconsidered.

Drugs in private schools

Private schools each have different rules. Private school principals usually have more independent authority.

Generally private schools and state schools could be expected to have a similar approach in cases of possession or supply at school. Expulsion or suspension are likely, depending on the circumstances.

Alcohol and young people

There is no general law that absolutely prohibits young people drinking alcohol. It is illegal in some circumstances, but not in others.

It is illegal for a person under 18 to possess or drink alcohol in a public place, if they are not under the supervision of a responsible adult. The young person can be fined and the alcohol confiscated.

It is also illegal for a person under 18 years to drink alcohol on licensed premises, such as pubs, clubs and licensed restaurants.

But it is not illegal for a person under 18 years to consume alcohol in a private place—for example, at home or at a private barbecue or party. A person under 18 can also legally drink in a public place if they are with a responsible adult (and provided they are not in a declared alcohol free zone).

Someone under 18 years can legally drink alcohol in an unlicensed (BYO) restaurant, but only if they are in the company of a parent or guardian who has approved their drinking.

It is an offence for anyone except the parent or guardian of the young person to sell or supply alcohol to a person under 18 years old, or to obtain alcohol on behalf of someone under 18. Similarly, it is an offence for the licensee of licensed premises to allow alcohol to be supplied to a person under 18.

It is an offence for a young person to obtain or attempt to obtain alcohol from licensed premises, including a bottle shop. It is also an offence for a young person to use false evidence of age to obtain alcohol.

The exception allowing a parent or guardian to supply alcohol to a young person does not apply to licensed premises. In other words, parents and guardians can legally supply their under 18 year-old children with alcohol, but not in pubs, clubs and licensed restaurants.

Tobacco and young people

It is not an offence for a person under 18 to possess or use tobacco cigarettes. Police however have the power to confiscate tobacco from a person under 18 in a public place.

However, it is an offence (under the *NSW Public Health (Tobacco) Act 2008*) to sell tobacco or 'non-tobacco smoking products' (that is, herbal cigarettes) to a person under 18 or to purchase tobacco products (or herbal cigarettes) for a person under 18.



Image: Age fotostock



Image: State Library of NSW

Legal information and advice

Legal information

The Legal Information Access Centre (LIAC) in the State Library of NSW can help you with legal information including cases, legislation and commentary. The service is free and confidential.

www.legalanswers.sl.nsw.gov.au or phone 02 9273 1558

Getting legal advice

You may be able to obtain free help (or help at a reduced cost) from:

LawAccess NSW

LawAccess NSW is a free government telephone service offering legal information, referral to appropriate free legal services in your area or private solicitors, and in some cases, legal advice.

www.lawaccess.nsw.gov.au or phone 1300 888 529

Legal Aid NSW

Legal Aid NSW provides free legal representation in drug cases if you qualify under the means test. The means test is complicated. Whether you qualify depends on your income, how many dependants you have and other factors like how much rent you pay.

Legal Aid NSW will also give you free advice, even if you don't qualify for legal aid.

www.legalaid.nsw.gov.au or phone 02 9219 5126

Aboriginal Legal Services

If you are an Aboriginal or Torres Strait Islander person, you can get free legal representation for drug cases and other criminal matters from the Aboriginal Legal Service in your area.

www.alsnswact.org.au or phone 02 8303 6699

Community Legal Centres

If you don't qualify for legal aid and you can't afford to pay a lawyer, you can get free legal advice from a community legal centre. They will advise you but usually will not represent you in court.

www.nswclc.org.au or phone 02 9212 7333



Image: Age fotostock



Drug and alcohol information, support and treatment centres

Phone support and information

Alcohol and Drug Information Service (ADIS)

02 9361 8000

1800 422 599 (outside Sydney)

A confidential, anonymous information, advice and referral service.

For information about drugs, parent advice and detox.

24 hours, 7 days a week

Family Drug Support (FDS)

02 9818 6166

1300 368 186

Telephone support for families in crisis due to drug and alcohol issues. FDS is staffed by volunteers who have experience of drug dependent family members.

www.fds.org.au

24 hours, 7 days a week

Counselling Online

www.counsellingonline.org.au

Free online alcohol and drug counselling. Provides support for alcohol and other drug users, and others affected by alcohol and drug use in the community, including family members, relatives and friends.

24 hours, 7 days a week

Includes a telephone helpline at **DirectLine** 1800 888 236

National Cannabis Prevention and Information Centre (NCPIC)

1800 30 40 50

Confidential information and support line for cannabis users and friends and family who are concerned about cannabis use of others. Referrals to the most appropriate support services and resources for your situation in your area. The Helpline is available from 11am-8pm Monday to Friday (including public holidays).

<http://ncpic.org.au/>

HealthDirect Australia

1800 022 222

Health advice line staffed by Registered Nurses to provide expert health advice. It is currently available to residents of the Australian Capital Territory, Northern Territory, New South Wales, South Australia and Western Australia.

www.healthdirect.org.au

24 hours, 7 days a week

Quitline

13 QUIT (13 7848)

A confidential telephone based service designed to help smokers quit smoking, funded by the Cancer Institute NSW. The staff can also provide assistance to the family and friends of smokers and others requesting information about smoking.

24 hours, 7 days a week

Needle Clean Up Hotline

1800 633 353

Coordinates the clean up of dumped needles and syringes across NSW.

24 hours, 7 days a week

Parent Line

1300 1300 52

A telephone counselling, information and referral service for parents and carers of children ages 0 to 18 in New South Wales.

www.parentline.org.au

24 hours, 7 days a week

Kids Help Line

1800 55 1800

Provides a telephone and email counselling service.

counsellor@kidshelp.com.au

www.kidshelp.com.au

24 hours, 7 days a week

Lifeline

13 11 14

Counselling and information, suicide prevention, crisis support and mental health services.

24 hours, 7 days a week

Methadone Advice & Conciliation Service (MACS)

1800 642 428

The MACS telephone helpline provides opiate pharmacotherapy information (including methadone and buprenorphine), referrals, advice and a forum for pharmacotherapy concerns.

Available from Monday to Friday 9.30am to 5.00pm

Drug and Alcohol Specialist Advisory Service (DASAS)

9361 8006 (Sydney)

tollfree 1800 023 687 (outside Sydney)

The DASAS helpline assists health professionals seeking advice about the diagnosis and treatment of a patient with alcohol or drug issues. The DASAS is a free service available in NSW.

24 hours, 7 days a week.

Emergency 000

In an emergency call 000 or go to a hospital emergency department, where they may refer you to a drug and alcohol service.

24 hours, 7 days a week

Treatment and support centres

Cannabis Clinics

NSW Health has established clinics for cannabis users. The clinics offer outpatient services for people 16 years or over seeking to stop or reduce their cannabis use. Cannabis users with mental health issues and parents and carers of cannabis users are also offered support.

Sutherland Cannabis Clinic – 02 8536 0300

http://www.sesiahs.health.nsw.gov.au/Cannabis_Clinic

Located in the Sutherland CBD.

Central Coast Cannabis Clinic – 02 4394 7999

Based at Wyong Hospital with outreach to Gosford, Erina, Long Jetty and Woy Woy.

Central West Cannabis Clinic – 1300 663 433

Based at Orange with outreach to Bathurst, Condobolin, Cowra, Forbes and Parkes.

Hunter Cannabis Clinic Newcastle West – 02 4923 6760

Based in Newcastle with outreach to Maitland headspace for young people and Taree and surrounds for Aboriginal Communities.

Email: ncc@hnehealth.nsw.gov.au

North Coast Cannabis Clinic – 1300 664 098

Based at Tweed Heads, Lismore, Coffs Harbour, Kempsey and Port Macquarie, as well as a range of smaller towns and community health centres across the North Coast.

Tweed Heads – 07 5506 6820

Lismore – 02 6620 7627

Coffs Harbour – 02 6656 5337

Port Macquarie – 02 6588 2657

Western Sydney Cannabis Clinic, Parramatta – 02 9840 3355

Stimulant treatment program

Two NSW Health clinics provide treatment for stimulant users, one at St Vincent's Hospital, Darlinghurst and another in Newcastle. The clinics offer outpatient services to people 16 years and older seeking to stop or reduce their use of amphetamines, methamphetamines, cocaine or ecstasy.

Sydney 02 9361 8088

Outside Sydney 1800 101 188

NSW Health Drug and Alcohol Services

To access a local public drug and alcohol service in NSW, contact your local area health service via these intake numbers.

| Area Health Service | Central Intake Number |
|------------------------------------|--|
| Greater Southern | West of Greater Southern: 1800 800 944 / 02 9425 3923 East of Greater Southern: 1800 809 423 / 1800 677 114 / 02 9425 3988 |
| Greater Western | Greater Western: 1800 665 066 Broken Hill: 08 8080 1556 Greater Western: Lines currently being diverted to the Mid Western Area (below): 1800 092 881 Dubbo: 02 6841 2360 Mid Western Area includes Bathurst, Orange, Cowra and Forbes Park. It does not include Lithgow and Dubbo: 1300 887 000 |
| Hunter/New England | Southern Hunter: 02 4923 2060 Northern Hunter/New England/Tamworth: 1300 660 059 North Coast Area Health Service: 1300 662 263 Coffs Harbour: 02 6656 7936 North Coast: 02 6588 2882 Riverlands: 02 6620 7612 |
| Northern Sydney/ Central Coast | Northern Sydney: 1300 889 788 Central Coast: 4394 4880 |
| South Eastern Sydney/ Illawarra | St George: 02 9113 2944 Illawarra: 1300 652 226 / 4223 8420 Shoalhaven: 02 4421 7897 / 02 4422 9662 / 1300 652 226 |
| Sydney South West | Royal Prince Alfred: 02 9515 6311 |
| Sydney West | Wentworth: 02 4734 1333 Western Sydney: 02 9840 3355 |

headspace

Provides mental and health wellbeing support, information and services to young people (aged 12 to 25) and their families across Australia. Includes support for alcohol and drug issues.

Central Coast headspace Gosford 02 4304 7870

Central Sydney headspace 02 9114 4100
Redfern/Waterloo, Camperdown and Marrickville

headspace Campbelltown 02 4627 9089
Campbelltown and Tahmoor

Mt Druitt headspace 02 9675 2602 / 02 8887 5600

Central West headspace Bathurst 02 6338 1100
Cowra 02 6342 6186

Hunter headspace Maitland 02 4931 1000

Riverina headspace 02 6923 3170

Mid North Coast headspace Coffs Harbour 02 6652 1878

Illawarra headspace Wollongong 02 4225 1184



Image: Sarah Herman, State Library of NSW

Online information

drug info @ your library

www.druginfo.sl.nsw.gov.au

Provides accurate, up-to-date, easy-to-read drug and alcohol information through a dedicated website and a collection of books and free pamphlets in NSW public libraries.

Your Room

www.yourroom.com.au

An interactive drug and alcohol website with current information on drugs and alcohol, online resources, phone helplines, treatment options, community action and the spinner quiz.

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From www.aihw.gov.au type in "national drug strategy"

2007 National Drug Strategy Household Survey: Detailed Findings,
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Supplement, 2008. From www.aihw.gov.au type in "national drug strategy"

Australian Institute of Criminology – illicit drugs www.aic.gov.au/en/statistics/drug.aspx

Australian National Council on Drugs www.ancd.org.au/publications

Bureau of Crime Statistics and Research www.bocsar.nsw.gov.au
Look in the A-Z Subject List under the headings Alcohol, Drug courts, Drug law enforcement and Drugs and crime.

Illicit Drug Data Reports, Australian Crime Commission website at
www.crimecommission.gov.au/publications/iddr/index.htm

National Drug and Alcohol Research Centre
www.med.unsw.edu.au/NDARCWeb.nsf/page/Publications

NSW Office of Drug and Alcohol Policy www.druginfo.nsw.gov.au



Image: Sarah Herman, State Library of NSW

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18. Cannabis Answers to Your Questions, page 21. From www.ncnd.org.au Go to Publications and reports, click on Research papers, scroll down to the publication
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39. The Commonwealth Criminal Code is a schedule to the Criminal Code Act 1995 (Commonwealth) Chapter 9 relates to drugs and drug related offences. From www.comlaw.gov.au type in "criminal code 1995"





www.druginfo.sl.nsw.gov.au