



**PARLIAMENT OF VICTORIA
LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE**

**INQUIRY INTO THE SUPPLY
AND USE OF METHAMPHETAMINES,
PARTICULARLY ICE, IN VICTORIA**

Final Report

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Functions of the Law Reform, Drugs and Crime Prevention Committee

The Victorian Law Reform, Drugs and Crime Prevention Committee is constituted under the *Parliamentary Committees Act 2003* (Vic) as amended.

Section 7

The functions of the Law Reform, Drugs and Crime Prevention Committee is to inquire into, consider and report to the Parliament on any proposal, matter or thing concerned with –

- (a) legal, constitutional or parliamentary reform;
- (b) the administration of justice;
- (c) law reform;
- (d) the use of drugs, including the manufacture, supply or distribution of drugs;
- (e) the level or causes of crime or violent behaviour.

Terms of Reference

That, under s 33 of the *Parliamentary Committees Act 2003*, an Inquiry into the supply and use of methamphetamine, particularly 'ice', in Victoria be referred to the Law Reform, Drugs and Crime Prevention Committee for consideration and report no later than 31 August 2014 and, in particular, the Committee is required to:

1. examine the channels of supply of methamphetamines including direct importation and local manufacture of final product and raw constituent chemical precursors and ingredients;
2. examine the supply and distribution of methamphetamines and links to organised crime organisations including outlaw motorcycle gangs;
3. examine the nature, prevalence and culture of methamphetamines use in Victoria, particularly amongst young people, indigenous people and those who live in rural areas;
4. examine the links between methamphetamines use and crime, in particular crimes against the person;
5. examine the short and long-term consequences of methamphetamines use;
6. examine the relationship of methamphetamines use to other forms of illicit and licit substances;
7. review the adequacy of past and existing state and federal strategies for dealing with methamphetamine use;
8. consider best practice strategies to address methamphetamines use and associated crime, including regulatory, law enforcement, education and treatment responses (particularly for groups outlined above).

Chair's Foreword

The Inquiry into the Use and Supply of Methamphetamine in Victoria has been a long and complex task. The Committee has undertaken a wide-ranging investigation that has involved extensive consultation with the community. The Committee received 78 written submissions, held over 113 public hearings and heard from 220 witnesses, including police and emergency services personnel, hospital and health workers, drug treatment providers, researchers and the families and friends of methamphetamine users. In addition, the Committee has undertaken extensive research drawing from statistical evidence and academic and policy literature dealing with prevalence, harms and the relationship between drug use, violence and criminal behaviour. This process has resulted in a comprehensive Report that has examined, amongst other issues, the prevalence and supply of methamphetamine, the harm it causes, and its impact on the wider community.

One of the main findings to come out of the Inquiry has been that whilst methamphetamine use as a generic category may have stabilised over the last decade, there has been a significant rise in the use of crystal methamphetamine the more potent and dangerous form of the drug, particularly by young people between 20 and 29.

The Committee spent much time visiting rural and regional areas of the State, to take evidence as to how the use of methamphetamine, particularly crystal methamphetamine, was impacting on these communities. It was clear that people from across the state felt that methamphetamine was having a damaging effect on sections of their community and that extra support was required in the areas of health, law enforcement, education and particularly family support. In short, the Committee believes there needs to be a response to a drug problem that is having a significant impact on the social fabric of local communities. The evidenced based recommendations and the findings of the Report provide the Government with direction for a coordinated and comprehensive strategy to address this problem; one that is grounded in prevention and harm reduction approaches.

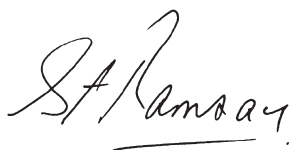
This two-volume, 32-chapter Report, which I believe is the most detailed, comprehensive, and current report of its kind on methamphetamine use in Australia, is the result of the hard work and dedication of the Committee's members and the staff who have contributed to the drafting of the Report.

In particular, the Committee would like to thank the staff of the Committee Secretariat; Executive Officer Sandy Cook, Senior Research Officer Pete Johnston, Committee Administration Officers, Kim Martinow and Justin Elder. The commitment to finish this Report on the tabling date required long hours and a heavy workload and the Committee would like to acknowledge their guidance and professionalism to the task.

The Committee would also like to thank the consultants working on the Report, particularly the Australian Institute of Criminology and their staff led by Dr Russell Smith for their work on the prevalence and supply of methamphetamine and Dr Nicole Lee and her staff for their work on treatment issues. The Committee also thanks John Aliferis from the Victorian Parliamentary Road Safety Committee for his support and advice particularly with regard to statistical and drug-driving issues. The Committee is also grateful for the invaluable contribution to the Inquiry made by members of the community particularly those who made submissions or gave evidence at public hearings.

This Inquiry and the tabling of the Report has been the culmination of 10 months hard work and a combination of good will and good faith by a bipartisan Committee. As such I would like to thank Deputy Chair Johan Scheffer, and Committee members David Southwick, Ben Carroll and Tim McCurdy for their support and hard work.

Finally, this Report and the recommendations made by the Committee were influenced by the many personal stories of those affected by this drug and the destructive consequences that crystal methamphetamine has had on their lives. The Committee hopes that the Report goes some way to address this serious social problem.

A handwritten signature in black ink, appearing to read 'S Ramsay', with a horizontal line underneath the name.

Simon Ramsay MLC

Chair

Acknowledgements

The Committee wishes to thank the research team from the Australian Institute of Criminology for undertaking the research for and drafting the chapters relating to the prevalence and supply side aspects of the Inquiry. The members of the team were:

Dr Russell G Smith, Principal Criminologist; Dr Jason Payne, formerly Research Manager; Mr Matthew Willis, Research Manager; Dr Susan Goldsmid, Principal Research Analyst; Mr Santanu Burman, Research Officer; and the staff of the Communications and Information Services Section.

The Committee is also most grateful to Associate Professor Nicole Lee and Linda Jenner from LeeJenn Health Consultants for researching and drafting the chapters relating to treatment and national and state strategies.

The Committee also would like to acknowledge the valuable contribution of Frances Essaber and Mignon Turpin for editing the report, Matt Clare at Mono Design for the cover design, Luke Harris from Working Type Studio for laying out the Report and Phil Balzer from Tenderprint Australia for printing it.

Executive Summary and Recommendations

Introduction

The Law Reform, Drugs and Crime Prevention Committee was given Terms of Reference to investigate and report to Parliament on the supply and use of methamphetamine, particularly ice, in Victoria. Methamphetamine is part of the family of drugs broadly referred to as amphetamine-type stimulants (ATS). Methamphetamine, unlike cocaine, cannabis or other plant based drugs is a purely synthetic substance. Crystal methamphetamine colloquially known as 'ice' is the most potent of the amphetamine class of drugs and therefore has a stronger effect on the central nervous system. It is generally stronger, more addictive and has more harmful side effects than the powder form of the drug known as 'speed'. The 'high' experienced from ice is much more intense, and with intense reactions come powerful responses including comedown, the potential for dependence (addiction) and chronic physical and mental health problems. Despite the colloquial use of 'ice' to denote the drug crystal methamphetamine, the Committee has decided to use the term crystal methamphetamine unless the context otherwise demands it. This is to avoid 'glamourising' or sensationalising the drug and its impact on society.

This Inquiry has proved to be complex. The Terms of Reference were extremely broad and required the Committee to undertake a wide-ranging investigation into the supply and use of this drug. The Committee's deliberations involved extensive consultation with the community, and experts in law enforcement, drug treatment and statistics.¹ In all the Committee received 78 submissions and took evidence from 220 witnesses.¹ In addition to hearings in Melbourne, the Committee also travelled widely throughout the state ascertaining the views of rural and regional Victorians. The Committee's research, deliberations and investigations have been based on the evidence from the academic literature, submissions and information provided in public hearings.

The Committee acknowledges that during the course of the Inquiry there were differing, and sometimes conflicting, viewpoints presented by various stakeholders. Notwithstanding this, the Committee has sought to be objective in presenting and balancing the opposing arguments and contradictory evidence.

This Executive Summary commences with an account of the key findings arising from the Inquiry. It is followed by a list of the principles informing the Committee's recommendations. The Summary concludes with a commentary on the content of the Report that underpins and justifies the recommendations.

Key Findings on the Use and Supply of Methamphetamine

This section outlines the main findings of the Report based on the evidence given to the Inquiry. An expanded account of these findings is located in the concluding chapter of this Report.

¹ See Chapter 1 for a full account of the work of the Committee.

Concerns about the supply and use of methamphetamine in Victoria

Methamphetamine use is not a new phenomenon in Victoria. Nonetheless, throughout this Inquiry grave concerns have been expressed by members of the community, including witnesses to the Inquiry, about the current extent of methamphetamine use and its impact. Particular concerns have been expressed that methamphetamine is having a serious impact on families and the extended community, including in rural and regional areas of Victoria and in Aboriginal communities.

The extent of use

Recent statistics provided by the Australian Institute of Health and Welfare (AIHW) (2014) show that the prevalence of methamphetamine use in Australia and Victoria has remained relatively stable since 2001.² What has changed, however, is that there has been a significant shift in use from the powdered form of methamphetamine to crystal methamphetamine, the more potent crystallised form of the drug. It should also be noted that whilst the use of methamphetamine has not increased in the general population nationally or in Victoria, those who use the drug regularly (daily or weekly) are using on a more frequent basis. This is particularly true of crystal methamphetamine users. There would appear to be a discrepancy, however, between the prevalence data and the supply/seizure data³ which shows an increasing amount of amphetamine type stimulants crossing Australia's borders.

The purity of crystal methamphetamine has also increased over the past two years which exacerbates the drug's harmful effects. It is this shift in use which could account for the increase in the extent of harms reported by the community and recorded in a number of Australian and Victorian health datasets.

Media accounts, therefore, that report in terms of an ice crisis, epidemic or pandemic are not borne out in the data up until 2013, although it is possible that a one-year time lag between collating the data and what is happening in 'real time' may not accurately reflect actual prevalence now.

It is important to acknowledge that the most recent survey research shows that the use of methamphetamine, both in Victoria and nationally, is considerably lower than the harmful use of alcohol and much lower than tobacco and cannabis. It is also lower than the use of ecstasy and misuse of pharmaceutical drugs.⁴ This is not to underestimate the seriousness of the harms associated with crystal methamphetamine. As stated throughout this Report it is a harmful drug.

Harms associated with methamphetamine use

Methamphetamine use on its own rarely results in overdose or death. The sometimes chaotic lifestyle (a lack of sleep, poor nutrition) can contribute, however, to poor health outcomes for some users.

The use of methamphetamine, particularly over an extended period, can cause a broad range of physical, psychological and social harms. Compared with amphetamine, methamphetamine produces a more intense experience through its interactions with the nervous system. In the short term, methamphetamine can cause dehydration, sweating, headaches, sleep disorders, anxiety and paranoia. Used over the longer term, physiological impacts include weight loss, dermatological problems, neurotoxicity, reduced immunity, elevated blood pressure, damage to teeth and gums, cardiovascular problems and kidney failure. Long-term use can lead to psychological, cognitive and neurological impacts including, depression, impaired memory

2 See discussion in Chapter 5.

3 See discussion in Chapter 5.

4 See the website of the Australian Institute of Health and Welfare at <http://www.aihw.gov.au/> and the discussion in Chapter 5 of this Report.

and concentration and aggressive or violent behaviour. It may also impact negatively on people with a predisposition to schizophrenia. The research literature also indicates the existence of both a discrete methamphetamine psychosis and an independent methamphetamine dependence syndrome in certain users. The use of methamphetamine alongside other drugs can increase methamphetamine toxicity while also compounding the harmful effects of the other substances, leading to heightened risks of respiratory failure, blood-borne diseases, alcohol poisoning and accidents.

Methamphetamine use can also have significant social impacts including involvement in criminal activity; loss of employment, income and productivity; loss of accommodation; increased reliance on health treatment and welfare support; impaired family and other interpersonal relationships. Indeed, the social impact of the drug on family and friends and community can be profound. Family trauma and violence and child endangerment can all result. Environmental hazards due to clandestine manufacture can also impact seriously in the community.

There may also be issues pertaining to the use of methamphetamine and driving. The research on drug driving, specifically methamphetamine, and its contribution to road trauma in Victoria is however somewhat inconclusive. The available fatality data, but not injury data more generally, suggests that this is not a major problem compared to alcohol.

Patterns and profiles of use

Drug use is influenced by many factors in addition to the pharmacological properties of the drug. The patterns of methamphetamine use comprise the rituals, 'culture' and 'natural history' of the drug, including such matters as how the drug is administered and the trajectory of drug use over time.

Methamphetamine is used by a wide cross-section of the community (young people, professionals, women, Aboriginals, CALD communities, prisoners, people in out-of-home care), in many different contexts (functional, recreational, dependent use) and for many different reasons. Although people of many age groups use ice, those aged 20–29 are the most frequent users and most in this age group are male.

There is also a significant cohort of methamphetamine users who could be described as experimental, occasional or recreational users. Of these occasional users of the drug, many will not progress to dependence on the drug. Indeed, the most recent National Drug Strategy Household Survey (NDSHS) 2013 shows that around 15.5 percent who have used methamphetamine in the last 12 months reported using weekly or more, an indicator of possible dependence (AIHW 2014). However, of some concern is the trend towards smoking crystal methamphetamine as it has the potential to introduce younger users into a risky pattern of drug use that ultimately may lead to a transition to injecting drug use.

Research into drug use patterns indicates that many users engage in the use of both licit and illicit drugs, rather than only using one drug type. Certainly the evidence suggests that methamphetamine users are predominantly poly-drug users who not only use other drugs at different times, but use other drugs concurrently with methamphetamine to achieve specific behavioural outcomes. A number of recent research studies have also indicated that many people, both recreational and dependent users, take methamphetamine as part of a suite of drugs they use. Alcohol, tobacco and cannabis use are very common drugs used in conjunction with methamphetamine. Substances that produce sedative effects, such as opioids and tranquilisers, are also often used to self-medicate against the adverse effects of methamphetamine and/or during the withdrawal phase.

Factors contributing to methamphetamine use

There are many reasons why people may use methamphetamine. There is also no single 'cause' or contributory factor that leads to people using this drug, just as there is no standard profile of a methamphetamine user.

Nonetheless, in the Report the Committee does present some explanations as to why some people may use methamphetamine and some more problematically than others. For some young people, for example, a lack of leisure activities (leisure boredom) can be one of the main reasons for drug use. Another reason a person may use methamphetamine is to 'self-medicate' physical or psychological illnesses that have gone untreated. While there may be some common reasons for some people using methamphetamine there is no single template or explanatory theory that can be applied to all. The reasons may vary depending upon the person's sex, age, economic circumstances, racial background or a number of other variables.

Access and availability

Methamphetamine including crystal methamphetamine is readily available and easy to access. There are only limited indications, however, that methamphetamine is being accessed through organised crime syndicates including outlaw motor cycle gangs (OMCGs). However, a complete understanding of the involvement of OMCGs in methamphetamine production and distribution has not been possible because the Committee has not been able to access sensitive operational information and intelligence held by Victoria Police and other law enforcement agencies.

Production and supply of methamphetamine

The global market for methamphetamine has increased since 2010 with global seizures of amphetamine-type stimulants having increased between 2010 and 2011 by 66 percent. Methamphetamine has replaced heroin as the most problematic drug in Asia but availability and use of the drug is relatively low in Europe compared to Australia.

According to the Australian Crime Commission (ACC) and Australian Customs Border Protection Service (ACBPS) data, there has been a general increase in seizures of ATS including methamphetamine and crystal methamphetamine, as well as precursor chemicals at national borders since 2010. At Victorian borders, there has also been an increase in seizures of methamphetamine and crystal methamphetamine, and particularly precursor chemicals.

Data from the ACC, ACBPS and Victoria Police also show an increase in the detection of clandestine laboratories since 2010. The extent of imported chemicals used to produce drugs in clandestine laboratories, as opposed to locally-sourced chemicals from pharmacies or industry warehouses, is not known. The proportion of methamphetamine and crystal methamphetamine sold in Australian and Victorian markets that come from overseas, as opposed to having been made locally, is also not known.

Local Manufacture

Methamphetamine including crystal methamphetamine are not only imported into Australia, but are manufactured locally in clandestine drug laboratories using chemicals obtained in Australia or imported from overseas.

During 2011-12 and 2012-13, in Australia 68.2 percent of clandestine laboratories were located in residential areas followed by those in vehicles (9%), commercial or industrial areas (8.9%), public places (3.8%), rural areas (2.2%) and other places (7.9%) (ACC 2014a). Between 2011-12 and 2012-13 in Australia, the majority of detected clandestine laboratories were individual, addict-based (58.8%) whereas others were small-scale labs (23.5%), medium sized labs (9.7%) and industrial-scale labs (8%). (ACC 2014a). According to a submission from Victoria Police in 2013, of 108 laboratories located in Victoria, 75 were

in residential premises. More precise statistics on the location of clandestine laboratories in Victoria, such as the number in urban as opposed to regional or rural locations, are unavailable. Victoria generally ranks third amongst states and territories in terms of the number of detected laboratories, following Queensland and Western Australia. A high proportion of clandestine laboratories are located in residential premises which pose hazards to police, forensic chemists, hazardous materials contractors and children and others who live in or close to such environments.

Importation

There was a large number of crystal and other methamphetamine seizures at national borders in 2013, which may indicate either increased levels of production overseas or more effective law enforcement detection capabilities. There was also a substantial increase in seizures of ATS precursor chemicals at national borders between 2010 and 2013. The number of domestic arrests and quantity of seizures related to methamphetamine indicate a potential increase in the demand for the drug in Australia in recent years.

Online drug markets are becoming an increasing concern for law enforcement agencies in recent years as users have access to information on the effects of substances, the market for such drugs internationally and ways of avoiding detection by law enforcement agencies when importing drugs. Online drug markets facilitate the importation of drugs including methamphetamine into Australia in small quantities through postal services directly to residential and other premises.

Involvement of Organised Crime

Although many people think of organised crime groups as large-scale criminal organisations such as the Mafia or Yakuza, the United Nations has a more specific definition of 'a structured group of three or more persons, existing for a period of time, acting in concert with the aim of committing serious criminal offences in order to obtain, directly or indirectly, a financial or material benefit' (UN 2004, p.5). According to this definition, an organised criminal activity requires three or more persons to come together for the execution of a common purpose. The production and sale of methamphetamine is a lucrative source of income for organised crime groups as there is a high demand for the drug in Australia. Prices for the drug in Australia are also much higher than in other countries, making the market more profitable here than elsewhere. The methamphetamine trade also provides numerous incentives for criminal activity as the production of the drug does not require any extensive up-front costs and the drug is relatively easy to produce resulting in greater profitability.

In Australia, there are diverse types of organised crime groups ranging from those who commit small-scale street crime, organised cybercrime to more serious large-scale criminal activities such as corporate fraud and illicit drug production and supply.

Groups involved in the illicit drug trade include traditional organised crime groups such as the Mafia or Asian Triads, as well as Middle-Eastern, East-European, West-African and Southeast-Asian organised crime groups.

Members of OMCGs and small networks of individuals are suspected of being involved in the production, sale and distribution of drugs including methamphetamine. However, the direct involvement of OMCGs in the methamphetamine market is difficult to establish as they are known to operate within complex social structures involving networks within and beyond their own clubs. Nonetheless, the Law Enforcement Assistance Program (LEAP) database managed by Victoria Police has recorded a total of 111 amphetamine-type stimulant-attributable offences alleged against OMCG members between 2010 and 2013.⁵

5 Again such data is not able to be disaggregated to account for crystal methamphetamine (ice) specifically.

The needs of family members and friends must be addressed

The Committee has received much evidence that many family members of crystal methamphetamine users, particularly where such use is heavy or dependent, are at loss to know how to handle the situation. The impact on families of problematic methamphetamine use by a family member can be profound, particularly in cases where the adverse effects of methamphetamine use are severe and the family member is reluctant to seek treatment.

The Inquiry heard evidence of family breakdown, financial strain and loss of assets, families providing round-the-clock support to loved ones who are agitated and awake during periods of intoxication, and fear of aggression and violence.⁶

The negative consequences on children of people who use methamphetamine were also raised by some witnesses and cases involving Children's Court and Child Protection services were described to the Inquiry.⁷ Grandparents are also sometimes forced into a full-time caring role when their children are unable to provide care for their own offspring.

Whilst addressing the condition of the crystal methamphetamine user is clearly important, the needs of family members must not be forgotten. They require information on the drug and its effects, in addition to a range of supports to assist them in coming to terms with their loved one's drug use. Not the least of which is the ability to discuss their problems with people who have been going through similar issues.

In short, family sensitive and responsive practice should be seen as central to AOD treatment, particularly where the use of methamphetamine is involved. Services must be adequately resourced to provide effective support to families, and their capacity to do so should be monitored.

Treatment issues

There are a number of problems associated with providing treatment for those who need it, such as dependent or chronic users of methamphetamine. Methamphetamine has a particularly complex action in the brain, requiring longer and more complex treatment interventions compared to most other illicit drugs.

The limited range of psychological and pharmacological therapy restricts the options available to users. In addition, waiting lists for treatment and withdrawal are long and there are few services that have specific programs for methamphetamine users, a problem that is amplified in rural and regional Victoria.

Moreover, many alcohol and other drug (AOD) treatment providers are unaware of the available options, including the many resources in existence to support work with methamphetamine users. Also, such resources require review, updating and dissemination.

Statement of Principles underlying the Recommendations

The Committee's recommendations have been guided by a series of principles. These Principles have been drawn from the research literature on methamphetamine use; evidence based best practice on 'what works'; national and state drug policies and frameworks; and the evidence given to the Law Reform, Drugs and Crime Prevention Committee, including written submissions and oral testimony at public hearings.

6 See Ms Mary Bassi, Manager, Primary Health, Sunraysia Community Health Services, Public Hearing, Mildura, 5 December 2013; Ms Bev McIlroy, Manager, Glenelg Southern Grampians Drug Treatment Service (QUAMBY), Public Hearing, Warrnambool, 3 March 2014; Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013; Dr Niall Quiry, Senior Medical Officer, Victorian Aboriginal Health Service, Public Hearing, Melbourne, 3 February 2014.

7 See Mr David Giles, General Manager, Family and Community Services, Anglicare Victoria, Public Hearing, Melbourne, 3 February 2014; Ms Jan Rowe, Chief Executive Officer, Mirabel Foundation, Public Hearing, Melbourne, 17 February 2014.

LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

INQUIRY INTO THE SUPPLY AND USE OF METHAMPHETAMINE IN VICTORIA

Addendum:

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Statement of Principles underlying the Recommendations

The Committee's recommendations have been guided by a series of principles. These Principles have been drawn from the research literature on methamphetamine use; evidence based best practice on 'what works'; national and state drug policies and frameworks; and the evidence given to the Law Reform, Drugs and Crime Prevention Committee, including written submissions and oral testimony given at public hearings.

1. An effective response to methamphetamine use and supply requires a multi-faceted approach.
2. An effective response to methamphetamine use and supply must also engage Commonwealth, state and local government, and should enlist the private and non-government (community) sectors and the general community.
3. An effective response to methamphetamine use must give equal (balanced) emphasis to supply, demand and harm reduction, consistent with the National Drug Strategy.
4. Methamphetamine abuse should be primarily regarded as a health issue.
5. Laws and legislation pertaining to drug-related crime should reflect the seriousness of the harms associated with methamphetamine.
6. An effective law enforcement response to methamphetamine must involve the collaborative engagement of all branches of the law enforcement apparatus including local, state and federal authorities.
7. Demand reduction for both illicit and licit drugs requires the development and dissemination of best practice strategies and information to diverse audiences.
8. An effective response to methamphetamine use and supply must address its underlying causes, such as the economic, social and personal problems encountered by people with drug dependence.
9. An effective response to methamphetamine use must be culturally sensitive, gender specific and tailored to take into account a range of individual needs.
10. An effective response to methamphetamine use in Aboriginal communities must be culturally sensitive and specific to particular community needs and be developed in partnership with affected communities.
11. An effective response to methamphetamine use in rural and regional communities requires tailored interventions that take into account the specific, evidenced based needs of the community.
12. An effective response to methamphetamine use must be based on recognition of the prevalence of poly-drug use.
13. An effective response to methamphetamine use must be based on an understanding that methamphetamine users consist of those who are dependent and 'non-dependent'.
14. An effective response to methamphetamine use must be informed by the views, opinions and input of drug users and take account of the cultures in which they live.
15. An effective response to methamphetamine use and supply must be informed by robust, quantitative, qualitative and evaluative research.

Recommendations

A methamphetamine strategy for Victoria

The issue of methamphetamine use and its associated harms is extraordinarily complex. It is quite clear that a 'one size fits all' approach will be inadequate to address this issue. Therefore multifaceted strategies will be required. This is particularly the case given that methamphetamine use and other forms of drug abuse may impact in different ways upon discrete groups in the community, including the families of people who use methamphetamine.

The need for a coordinated response to methamphetamine use through multifaceted strategies is examined in this Report. A coordinated response is only possible if clear directions and parameters are set. The Committee therefore proposes the development of a new strategy that includes two components: a structure and an action plan that specifically addresses methamphetamine. This is best achieved through the establishment of a state framework that sets out the goals, aims and objectives for addressing methamphetamine in this state and the optimal ways to achieve them. This Report recommends that the best way of implementing this framework is through the establishment of a specific Ministerial Council on Methamphetamine led 'from the top'. This approach is influenced by the New Zealand model to address methamphetamine supply and use (*Tackling Methamphetamine: an Action Plan*).⁸

The Ministerial Council on Methamphetamine

The Ministerial Council on Methamphetamine (MCM) should be responsible for a wide range of tasks and duties that are indicated in the recommendations set out below. Whilst the MCM should at this time concentrate on the current problem of methamphetamine use, the structure should be flexible enough to be able to address other problematic drug use should the situation arise.

The Committee believes that the MCM should be led by the Premier of Victoria and comprise of representatives from a wide range of Ministries. This will allow for the coordination and resourcing of methamphetamine-related issues over a wide range of sometimes competing portfolios at state, regional and local government level. A centrally located Ministerial Council led by the Premier will send a message that issues pertaining to methamphetamine are given the highest priority by the state.

Recommendation 1

A coordinated all-of-government approach is required to address methamphetamine-related harm in the community. **The Committee therefore recommends** that the Victorian Government establish a state committee, known as the Ministerial Council on Methamphetamine (MCM).

(Chapter 31)

Recommendation 2

The Committee recommends that the MCM be chaired by the Premier and comprised of the following lead Ministers and their senior executive staff:

- *Minister for Health*
- *Minister for Human Services*
- *Attorney-General*
- *Minister for Justice*

⁸ The New Zealand model is discussed in Chapter 31 of this Report.

- *Minister for Police and Emergency Services*
- *Minister for Crime Prevention*
- *Minister of Education and Early Childhood Development*
- *Minister for Youth Affairs*
- *Minister for Aboriginal Affairs*
- *Minister for Local Government.*

(Chapter 31)

A State Methamphetamine Action Plan

Australia’s national drug policy, the National Drug Strategy (NDS) 2010–2015, provides a vision and direction for governments and non-government organisations in developing strategies and allocating resources for the prevention and reduction of alcohol, tobacco and other drug-related harms in Australian society. However, while national frameworks provide an overall direction for a national drug policy, the shape and detail of programs and policies pertaining to drug use are usually devised and implemented at state and local level. State-level initiatives have been developed that specifically incorporate the three pillars of harm minimisation into their policies and programs. Much of the detailed work addressing local alcohol and drug issues is increasingly being undertaken by local government, particularly through the use of the now relatively common local drug action plans or similar developments. Local government agencies and local community groups are becoming more significant players and stakeholders in the development of drug policy and the implementation and delivery of drug education and harm reduction programs and initiatives. The importance of local level approaches to alcohol and drug is recognised in the latest iteration of the Victorian Drug and Alcohol Strategy (Reducing the alcohol and drug toll: Victoria’s Plan 2013–2020).

Whilst in recent years there has been a move away from specific drug strategies to relying on a single overarching alcohol and other drug strategy, the Committee believes that when it comes to methamphetamine, in particular crystal methamphetamine, a generalist alcohol and drug strategy may not be able to address the complex and wide-ranging issues associated with this drug. Such an approach reflects the evidence the Committee received with regard to a lack of coordination and ad hoc responses to addressing methamphetamine use, in particular the development of policy and programs in ‘silos’ across and between government departments. There is currently no single document that assists health, justice or other sectors to implement policy with respect to methamphetamine (or other drugs).

Recommendation 3

The Committee recommends that the MCM develop and implement a State Methamphetamine Action Plan.

(Chapter 31)

The Alcohol and Drugs Executive Group

Under the proposed MCM structure, it is envisaged that the existing State Alcohol and Drugs Executive Group will continue to play an important role. This body clearly has valuable experience and expertise in addressing drug-related issues and could therefore act as a second tier group to administer the directions established by the MCM and oversee the implementation of the Action Plan. In particular, the Alcohol and Drugs Executive Group working under the direction of the MCM should take responsibility for the matters listed in Recommendation 4.

Recommendation 4

The Committee recommends that the Alcohol and Drugs Executive Group working under the direction of the MCM should take responsibility for:

- *The development and publication of a community engagement strategy to indicate how the public, community organisations and specialist stakeholders can have ongoing input into policy and programs with regard to methamphetamine;*
- *Ensuring cross-departmental strategies and intervention programs be established between all relevant state government departments to ensure coordinated responses in addressing methamphetamine use;*
- *Liaising with federal and state agencies, professionals in the field, community agencies and media;*
- *Liaising with regional Health Department offices to facilitate, advise and support the development of local level community partnerships and local level methamphetamine action plans;*
- *Disseminating information with regard to methamphetamine;*
- *Developing and coordinating training programs on methamphetamine;*
- *Developing and coordinating a research agenda and commission research on methamphetamine;*
- *Assessing and supporting programs, research and evaluation relating to methamphetamine;*
- *Developing guidelines, in liaison with media representatives, on the reporting of methamphetamine issues;*
- *Identifying available resources and gaps in service delivery in order to plan a response to methamphetamine abuse at both state and local levels;*
- *Identifying key personnel and agencies in the community who have expertise in dealing with methamphetamine in order to establish a comprehensive referral and resource network;*
- *Commissioning a mapping exercise to establish the current levels of services available to support people with methamphetamine abuse-related problems and their parents and families, and to inform community workers and other professionals of such services available;*
- *Identifying best practice initiatives and assessing their applicability to local communities.*

(Chapter 31)

Community Action Partnerships: Engaging communities to address methamphetamine use

Methamphetamine use can clearly have repercussions that spread beyond the individual involved. It is important therefore that harms experienced by third parties and society collectively are taken into consideration during the development of strategies to address methamphetamine. In short, an all-of-community multi-layered response by government, the community and private sectors, including user groups, families and family support groups, individuals and organisations is needed to combat this problem.

It is the Committee's view that this can best be done through the establishment of Methamphetamine Community Partnerships. Such partnerships should comprise of government and non-government representatives with relevant expertise in the area of drug-related issues. Without restricting the membership of such a group, it is advisable that representatives be drawn from public health bodies and research institutes, local government and community representatives.

The establishment of these partnerships reflects the Committee's belief that local communities have a distinct role to play in addressing and 'owning' the methamphetamine problem, especially in rural and regional communities as indicated throughout this Report. This is because:

- ◆ Many actions can only be taken at local level;

- ◆ Local effort can harness local community resources;
- ◆ Each community is different and responses will need to be tailored accordingly.

This Report discusses a number of models of community action on methamphetamine such as Mildura's Project Ice which can serve as models for the proposed Methamphetamine Community Partnerships.

Recommendation 5

The Committee recommends that the MCM through the regional Health Department offices establish and support, where required, Methamphetamine Community Partnerships across metropolitan and regional Victoria. The primary function of such partnerships should be to develop and implement local level methamphetamine action plans.

(Chapter 31)

Recommendation 6

The Committee recommends that the role of the Methamphetamine Community Partnerships include:

- *Developing and implementing local level Methamphetamine Action Plans*
- *Identifying existing networks and groups in the community who might be concerned about methamphetamine-related harm*
- *Identifying the nature and extent of methamphetamine-related problems in the local community*
- *Establishing a mechanism for coordination (eg. working group or coordinator) that provides a focal point for local planning and implementation of community action targeting the identified problem(s).*

(Chapter 31)

Further Recommendations to address methamphetamine use

In addition to the recommendations to establish a Ministerial Council on Methamphetamine and a Methamphetamine Action Plan, the Committee has made a number of other recommendations based on evidence gathered during the Inquiry. The Committee particularly acknowledges the importance of demand reduction strategies to address methamphetamine use. This section therefore commences with a number of recommendations that aim to *prevent* the uptake of the use of this drug.

Prevention, Education and Information Strategies

The Importance of Prevention

Addressing methamphetamine should not be about dealing with the problems once they have occurred. One of the key themes running throughout this Report is that *prevention* of drug-related harms is an important strategy to pursue.

The Committee adopts the definition of prevention preferred by Loxley et al. in the authoritative evidence based monograph: *The prevention of substance use, risk and harm in Australia: A review of the evidence*:

Prevention in this context refers to measures that prevent or delay the onset of drug use, as well as measures that protect against risk and reduce harm associated with drug supply and use (Loxley et al. 2004, p.3).

Too often, however, commentators have regretted that prevention is viewed as a 'poor cousin' to the other pillars of drug strategy such as supply side (law enforcement and control of drugs) and harm reduction (minimising, reducing or treating the harms associated with

drug use) measures. New Zealand is one jurisdiction where demand reduction approaches based on prevention strategies take a paramount position in drug policy. This emphasis on prevention underpins New Zealand's *Tackling Methamphetamine: an Action Plan* developed in 2009. It is a 'top-down' cross-agency policy led out of the Department of Prime Minister and Cabinet. The Committee has been impressed by New Zealand's approach to addressing the problems associated with methamphetamine in that country. The Committee met with the New Zealand MP Mike Sabin, who has had experience in addressing methamphetamine issues in his country. Mr Sabin stressed to the Committee how important prevention was as a strategy to address methamphetamine use. He believed that it was often ignored in favour of supply side and treatment approaches:

I guess that is the overarching message I have come to the conclusion with over 15 or 18 years working in this area — that the big gains come in a policy focus when you look at total harm and the fact that it is a preventable problem, take a prevention-centred approach and run everything through a prevention lens.⁹

Especially important in terms of demand reduction are policies and programs that help build resilience, especially in young people, reduce risk factors and augment protective factors.

The Interplay between Risk, Protective and Developmental Factors

Modern approaches to prevention strategies focus on a number of issues and factors that are not specifically focussed on drug use per se but may be related to the reasons why some people may (or may not) use drugs. These can then be taken into account when strategies to prevent such use are being developed. Such factors include an analysis of:

social determinants of health; risk and protective factors through the life span; developmental milestones, transitions and trajectories; and systems approaches to drug prevention (Loxley et al. 2004, p.3).

Drawing from the work of a number of researchers, the Committee has noted the importance of a 'developmental pathways' model in informing the development of drug policy and strategies. This approach to drug prevention also does not necessarily concentrate on drug use per se. Rather its emphasis is on developing healthy and resilient children who will not feel the need to use illicit drugs. The developmental approach to prevention suggests that there are different and varied 'pathways' that people, and particularly young people, can choose in life which are shaped by the choices and experiences offered them. While this model is not necessarily applicable only to the field of drug prevention it can be of great benefit in informing the development of a Methamphetamine Action Plan.

Recommendation 7

The Committee recommends that programs and initiatives that have been shown to be successful in preventing or reducing the uptake and use of drugs including methamphetamine continue to be financially supported by the Victorian Government.

(Chapter 22)

The Committee supports youth mentoring, outreach, peer support and community support programs such as the Good Sports Program as successful preventative and intervention tools when working with young people at risk of substance abuse.

(Chapter 22)

Schools can be particularly effective in developing programs that address risk factors leading to drug use and other antisocial behaviours of young people. The aim of any school or youth oriented prevention program should be to develop resilience and encourage school retention or provide pathways to employment opportunities.

9 Mr Mike Sabin MP, Member for Northland, New Zealand Parliament, Public Hearing, Melbourne, 5 June 2014.

Recommendation 8

The Committee recommends the Victorian Government develop programs and resources for schools and school communities to support children identified as at-risk.

(Chapter 23)

The Committee acknowledges the evidence received that there are children impacted by the use of methamphetamine by their parents or carers. The Committee has received considerable evidence that child protection workers are struggling to address the complex issues faced by these children and in some cases grandparents who may be required to care for them. Clearly responses will be required to address the safety and wellbeing of children affected by the drug use of their carers or significant others.

Recommendation 9

The Committee recommends that the Victorian Government support the development of programs and resources that encourage and empower parents to have a positive influence in developing their children's resilience and good decision making skills.

(Chapter 22)

The Committee also acknowledges that children in the-out-of-home care and child protection system can be affected by methamphetamine use including from their own use of the drug. Evidence given to the Committee suggests the Victorian child protection system is stretched and finding it difficult to always adequately address the needs of children in their care with drug-related issues.

Recommendation 10

The Committee recommends that the Victorian Government undertake an Inquiry into the Victorian child protection system and its capacity to respond to all high-risk cases involving children and young people impacted by methamphetamine use.

(Chapter 14)

Drug Education and Information Provision

In any area of drug use, comprehensive and appropriately tailored policies and strategies with regard to education and information provision are an essential aspect of a comprehensive demand and harm reduction policy. Yet providing information or 'educating' people with regard to both the nature and potential harms associated with a drug such as methamphetamine is no straightforward task. A number of questions need to be raised in the sometimes contentious area of drug education. These include:

- ◆ To whom should education be targeted?
- ◆ What should this education consist of?
- ◆ At what stage should such education be delivered?
- ◆ How does education fit in as part of a wider prevention strategy with regard to methamphetamine?
- ◆ What role does drug education have in schools?
- ◆ How can parents be best educated about the dangers drugs such as methamphetamine may pose to their children?
- ◆ What do professionals such as medical and ambulance officers, the police community, drug and alcohol and youth workers need to know about methamphetamine?

- ◆ What place does the concept of harm reduction have in providing information about methamphetamine?
- ◆ And how effective are education strategies in addressing drug-taking behaviours?

These and other issues are canvassed thoroughly in this Report.

Current Initiatives in Drug Education and Information Provision for Young People at School

In general terms there have been many debates as to whether education strategies are particularly effective in reducing drug taking, particularly in schools and among young people generally. Nonetheless, with regard to school based education, researchers agree that schools can, at least in theory, make useful contributions to drug prevention strategies through education. This has been reflected in a number of federal and state drug education programs. However, the evidence, research and literature do not favour the provision of *specific* information on methamphetamine in the lower/intermediate school years.

Before an education project can be stated conclusively to be of value it needs to have been comprehensively evaluated. Some Australian researchers in the area of drug policy regret the lack of sophisticated evaluation studies of drug education programs in this country, particularly those that are schools based. The Committee believes it is essential that each school education program funded, developed or implemented through the state sector be subject to formal and ongoing evaluation.

Recommendation 11

The Committee recommends that the Victorian Education Department evaluate its current generic school programs which provide information, resilience training and skills that empower young people with the aim of continuing the ones that have proven to have success in this area.

(Chapter 23)

Information for Young People outside the School System

While education programs delivered through the school system are important, not all young people will be at school some or all of the time. For example, they may have left school at the minimum leaving age, a time when experimentation with alcohol and other drugs is common.

For young people who have fallen out of the 'education loop', for example often those in state residential care or through expulsion, suspension, intolerance to truancy or 'self removal', the strategies needed to address their drug use are complex. It is important to have drug information alternatives for children who find mainstream education inappropriate or who have already left the school sector. Peer education approaches and models that incorporate the views and experiences of young people may be particularly important for young people who are outside the loop of conventional drug education delivery. The provision of a diverse range of relevant and available information and harm reduction messages should be facilitated through a variety of media including written guidelines, websites, online advice modules, low literacy resources, social networking tools, email alerts and mobile telephone messages, and be accessible through peer networks and especially available in places where young people may frequent (skate parks, parks, shopping areas and other public places).

Recommendation 12

The Committee recommends that the Victorian Government in conjunction with relevant Victorian Alcohol and Other Drug agencies provide information, particularly with regard to harm reduction of methamphetamine, which is delivered in innovative and creative ways that engage young people. Such approaches should include peer education networks and outreach services.

(Chapters 23 and 26)

The Need for Targeted Information on Methamphetamine

The need for education and information that addresses the needs of young people and can be implemented through school and non-school environments is clearly essential. Nonetheless, it is also crucial to examine some other groups who have been identified by the Committee as those for whom targeted education strategies need to be developed. They include but are not restricted to:

- ◆ Parents and caregivers
- ◆ Health and allied professionals
- ◆ Teachers and educators
- ◆ Police and law enforcement officials
- ◆ Culturally and linguistically diverse communities
- ◆ Aboriginal elders and communities.

The Report discusses at length the need for a targeted approach to information provision on methamphetamine. In particular, such targeted groups and individuals need to be thoroughly informed of the nature and consequences of methamphetamine. Of course, this education/training should be prioritised according to the degree to which each group is affected.

Recommendation 13

The Committee recommends that education and information provision with regard to methamphetamine is most usefully developed for targeted user groups each with their own specific needs. These groups would include:

- *Young people in schools who are at risk using methamphetamine*
- *Young people who are disconnected from schools*
- *Young people in out-of-home care*
- *Women*
- *Prisoners, parolees and people on community corrections orders*
- *Aboriginal people*
- *People in Gay, Lesbian, Bisexual and Transgender communities*
- *People from rural and regional communities*
- *Culturally and linguistically diverse communities*
- *Recreational users including ‘clubbers’*
- *Road users.*

(Chapter 23)

Information for Families

As with any form of problematic licit or illicit drug, the use of methamphetamine can take a heavy toll on the families of the users. Evidence given to the Committee indicated that community family support groups are reporting a pronounced increase in the number of family members seeking support due to a family member using methamphetamine. The Committee also received evidence from a number of family members who spoke of their experience with loved ones who had Methamphetamine-related problems. Some of these witnesses spoke publicly and openly, others chose to give evidence *in camera*. All, however,

spoke of the anguish and bewilderment they felt in the face of the methamphetamine use by the family member. Many witnesses spoke of the helplessness felt when they couldn't access help or information on the drug and its effects. As a mother of a young woman with a methamphetamine addiction told the Committee:

We need education to families so they know how to become aware of what the kids are doing, what the drug does, the mood changes, that type of thing. We need — education, education, education.¹⁰

The Committee acknowledges the excellent work done by family drug support groups in Victoria. It believes, however, on the basis of the evidence presented that further education and information provision for families is crucial.

Recommendation 14

The Committee recommends that the Victorian Government in conjunction with relevant family drug support groups, develop targeted information and education on methamphetamine for the families of methamphetamine users.

(Chapter 23)

Workforce Development

The Committee also believes it is essential that people working with or otherwise connected, however peripherally, with people with drug-related problems have a comprehensive understanding of the issues pertaining to methamphetamine even if they do not work in the specialist alcohol and other drugs sector.

There are currently three organisations in Victoria that are offering methamphetamine-specific training: Odyssey House Victoria, Anex and LeeJenn Health Consultants. The need for more comprehensive workforce development and training for both generalist and specialist workers in the drug field was raised by many witnesses to the Inquiry. It is therefore essential that comprehensive AOD education content, which includes methamphetamine, be part of the training requirements of a wide range of professionals, both those in paid employment and those working as volunteers. This is also true of those professionals whose contact with a person presenting with a methamphetamine-related problem may be only a peripheral part of their day-to-day working environment. Good examples of this include police dealing with persons displaying symptoms of methamphetamine psychosis.

Recommendation 15

The Committee recommends that the Victorian Government in conjunction with relevant Victorian Alcohol and Other Drug agencies provide intensive tailor-made training on methamphetamine for frontline workers including:

- *Alcohol and drug agency workers*
- *Doctors, nurses and allied health professionals*
- *Ambulance officers*
- *Victoria Police officers*
- *Community health service staff*
- *Aboriginal community organisation staff including Aboriginal elders*
- *Gay, Lesbian, Bisexual and Transgender community organisation staff*
- *Rural and regional service providers*
- *Pharmacists and pharmacy workers*
- *Magistrates, judges and court workers*

- *Youth, social and community workers*
- *Teachers*
- *Workers from culturally and linguistically diverse communities and agencies*
- *Residential care and child protection workers*
- *Nightclub/Entertainment venue owners and staff*
- *Crowd controllers*
- *User organisation staff*
- *Local government staff, particularly those working in environmental health*
- *Journalists and media representatives.*

(Chapter 25)

One group of professionals that require specific mention are those working in the primary health field. The need for primary care health workers such as general practitioners, nurses and social workers to be able to address methamphetamine-related issues was frequently impressed upon the Committee during the course of this Inquiry. This is particularly the case given some witnesses to the Inquiry have stated that primary health care providers have shown on occasion a lack of knowledge about methamphetamine and its effects and in some cases even displayed judgemental and critical attitudes towards methamphetamine users. It is seen as crucial for such professionals to be able to screen patients for potential problems and provide them with 'brief interventions' to address these problems. Ongoing training may be a useful adjunct in this regard. It is also thought that professionals who specialise in AOD treatment services should also have their specialist skills and talents continually developed through ongoing training and education.

Recommendation 16

The Committee recommends that the Victorian Government:

- Ensure that the available guidelines on methamphetamine are updated and disseminated widely to practitioners and services*
- Ensure staff such as primary health workers that need to respond to methamphetamine users have had sufficient training, and have access to ongoing training opportunities*
- Ensure all workers in alcohol and other drug treatment settings have available to them appropriate and regular professional supervision*
- Ensure that agencies have policy and procedures in place to support the implementation of methamphetamine-specific treatment.*

(Chapters 25 and 28)

Finally, the Committee acknowledges the important role that schools and teachers have in a young person's life. It is therefore also crucial that teachers and relevant school support staff are supported to receive training and workforce development on delivering school drug education and addressing appropriately young people who may have problems associated with alcohol and drug use, including methamphetamine, in accordance with school guidelines.

Recommendation 17

The Committee recommends that teachers should receive comprehensive training on how to recognise and support young people who are affected by drug use including methamphetamine.

(Chapter 25)

Awareness Campaigns and Community Education Strategies

Prevention based approaches aimed at informing the general public about drugs are a common educational strategy, and the prime resource used to facilitate such approaches is usually the media. The evidence suggests, however, that public or community education campaigns to raise awareness about methamphetamine, particularly those run through the media, have a mixed 'report card'. On the negative side, some evidence has suggested that mass media campaigns can be counterproductive and can risk *increasing* interest in methamphetamine use among those who currently don't use. Similarly, those based on scare tactics need to be regarded with caution.

In this Report the Committee examines various types of awareness campaigns or strategies, including:

- ◆ National and state government education campaigns
- ◆ Counter advertising campaigns based on social marketing principles (usually launched by government agencies)
- ◆ Community advocacy strategies
- ◆ Targeted awareness campaigns.

On balance the Committee believes the evidence indicates that campaigns, particularly national campaigns, do need to form *one part* of an overall comprehensive education and information provision strategy. These should include general messages on methamphetamine prevention in addition to targeted approaches for specific high-risk groups within the community. However such campaigns can be ineffective when used by themselves with no other form of community support or educative materials. Knowledge alone doesn't usually translate into behaviour change.

A key part of promoting public awareness campaigns with regard to methamphetamine use is engaging the media. The Committee recognises the role the media plays in disseminating information on important issues and its contribution to social policy debates. The Committee also recognises that the responsible use of the media, including new media technologies, is particularly important in 'getting the message across' to young people about the dangers of methamphetamine. The use of social media can play a particularly useful role in this regard.

Recommendation 18

The Committee recommends that the Victorian Government ensure that any government funded awareness or education campaigns on methamphetamine be targeted at current or potential high-risk users.

(Chapter 24)

Harm Reduction

Harm reduction is one of the key principles underpinning Australia's longstanding national strategic approach to drug policy of 'harm minimisation'. One aspect of awareness raising that has been particularly important in the area of methamphetamine has been the use of community advocacy and harm reduction organisations and user groups. The Committee believes that non-governmental organisations and networks have a specific role to play in informing society with respect to methamphetamine, lobbying for policy change and effective implementation of policy at government level.

As a discrete principle, harm reduction refers to 'the policies and programs aimed at reducing drug-related harm and improving the health, social and economic outcomes for both the community and the individual' (Commonwealth of Australia 2006 p.56). Harm reduction

measures, including Needle and Syringe programs (NSPs), have been effective in reducing short and long-term physical and social consequences of licit and illicit drug use. Research has shown, for example, that harm reduction interventions can result in a tapering off and eventual cessation of drug use over time.

Harm reduction approaches can be targeted at the general population, for example recommendations for safe drinking guidelines to reduce risk among people who consume alcohol. It can also be tailored to specific groups within the community, such as Aboriginal Australians, school students, pregnant women or injecting drug users. It is a concept that is based on the premise that for some users stopping their drug use is, at least in the short term, not an option.

There are a number of ways in which harm reduction measures can be used to address methamphetamine use for both occasional and chronic or dependent users. These include focusing on the mode of administration (swallowing the drug as opposed to injecting or smoking) as well as addressing the effects of and harms arising from the type of use (occasional, regular or dependent use).

A particularly important aspect of harm reduction is the use of NSPs and their contribution to reducing the risk of blood borne diseases. Harm reduction bodies such as the Penington Institute have argued that the rise of crystal methamphetamine across Victoria and its challenges to rural communities demonstrate a need for NSP services to continually evolve. In particular, the Institute believes that the current system whereby there is a division between primary and secondary NSPs is outdated and ineffective. Primary NSPs are funded for NSP dedicated staff. At primary NSPs, clients have opportunities for face-to-face engagement and education, as well as referral to other health and welfare services. Secondary NSPs, however, whilst increasing in number throughout Victoria, are unfunded and clients have limited if any opportunity for face-to-face engagement and education. It is argued that secondary NSPs, particularly in rural areas, should be staffed and funded on the same basis as primary NSPs.

Recommendation 19

The Committee endorses harm reduction programs aimed at minimising the spread of blood borne viruses amongst methamphetamine users. In particular the Committee believes that any funded needle and syringe program (NSP) as part of its brief must also engage in face-to-face education and information provision including treatment referrals where appropriate. On this basis the **Committee recommends** that the Victorian Government continue to support the provision of NSPs including the staffing and funding of secondary NSPs.

(Chapter 26)

Supply side strategies

In developing a response to methamphetamine it is important to address large-scale drug importation, manufacturing and trafficking. These areas and the relationship of methamphetamine to organised crime are discussed in the Report.

Global Perspectives on Methamphetamine Markets

The United Nations Office on Drugs and Crime (UNODC) World Drug Report for 2014 states that the global market for amphetamine type stimulants (ATS) is expanding across most regions, particularly China, Indonesia, Malaysia and Thailand. Methamphetamine has replaced heroin as the most problematic drug in Asia. Most methamphetamine production in Australia is local, although precursors are sourced from overseas, particularly South-East Asia. According to the Australian Customs and Border Protection Service (ACBPS) both the number and weight of seizures at the Victorian border increased substantially between 2011

and 2013 compared with previous years. Law enforcement agencies at the Australian border are increasingly finding innovative and sophisticated techniques of concealment adopted by drug traffickers engaged in the importation of illicit drugs and precursors. Given these developments, it is important that Australian authorities continue to work closely with international and regional bodies to address the methamphetamine trade and markets affecting Australia and the local region.

Recommendation 20

The Committee recommends that the Australian Crime Commission (ACC) Board consider the establishment of a Special Operation in collaboration with the UNODC into the short and long-term implications for Australia of the substantial growth in the methamphetamine market within the South-East Asian region.

(Chapters 4 and 15)

Direct Importation

There are few controls on the sale and supply of precursor chemicals in many South-East Asian and East-Asian countries, which, coupled with the relatively low prices, make importation attractive for criminals involved in illicit trade. For example, criminals overseas will purchase pseudoephedrine or ephedrine in bulk and send multiple smaller packages back to Australia by mail in order to ensure that at least some of the packages will not be detected. Victoria Police indicated that legislation around precursor chemicals and reacting agents is complicated, as most have a legitimate purpose other than ATS manufacture. While possession of amounts of these chemicals is regulated under the *Drugs, Poisons and Controlled Substances Act 1981 (Vic)* concerns have been expressed that precursor regulation in Victoria and nationally needs to be reviewed including the current penalties applicable to precursor possession and trafficking.

Recommendation 21

The Committee recommends that the Victorian Government in conjunction with the Commonwealth Government examine the issue of precursor control. This should include an examination of new legislation pertaining to precursors used for illicit drug manufacture and the sufficiency of current penalties for the possession and trafficking of precursor materials.

Such a working group should include representatives of Victoria Police and the Australian Federal Police and the State and Commonwealth Attorney –General/Justice Departments.

(Chapters 15 and 20)

Involvement of Organised Crime

Organised criminal activities exist on a continuum of seriousness and complexity of activity. At the lower end of the scale of seriousness are instances of small-scale street crime committed by small groups of individuals, often young people or family members who become involved in low-level property or violent crime, often associated with drug markets. At the upper echelons organised crime groups are large-scale, criminal enterprises including traditional groups involved in the illicit drug trade such as the Mafia or Asian Triads, as well as Middle-Eastern, East-European, West-African and Southeast-Asian organised crime groups.

Members of Outlaw Motor Cycle Gangs (OMCGs) and small networks of individuals can also be involved in the production, sale and distribution of drugs within communities on a local level. Like other organisations, effective criminal organisations are those that can adapt to changes in illicit markets. In the case of drug-related crime, the availability of new drug types, new techniques of manufacture and new distribution channels all provide opportunities for organised criminal groups to develop their criminal enterprises to generate new sources of income. In the case

of methamphetamine production in Australia, a changing mix of criminal activity is present ranging from highly sophisticated and structured criminal organisations to individuals operating within small, local markets and friendship circles. A particularly disturbing development that has been apparent in recent years has been that of organised crime groups using online networks to facilitate the sale and distribution of drugs such as methamphetamine.

Recommendation 22

The Committee recommends that the Australian Crime Commission Board consider the establishment of a Special Operation to examine organised crime involvement in online illicit drug marketplaces, particularly relating to the sale of methamphetamine including crystal methamphetamine.

(Chapter 15)

Responses to Organised Crime

There are various Commonwealth entities such as the ACC, Australian Federal Police (AFP), ACBPS and the Australian Transaction Reports and Analysis Centre (AUSTRAC) that engage in specialised activities relating to the control of organised crime in Australia. Initiatives such as unexplained wealth laws have been implemented in some Australian jurisdictions including recently in Victoria.

In Victoria, the Victoria Police Crime Command Department has specialist investigative skills to undertake inquiries into serious crime and is supported by technical, intelligence and forensic services. Specific legislative measures in Victoria such as organised crime control orders, anti-fortification laws, proceeds of crime and asset confiscation legislation, and anti-money laundering provisions have also been implemented to deal with aspects of drug-related organised crime. These are discussed throughout the Report.

On 19 August 2014, the Victorian Parliament passed the *Criminal Organisations Control and Other Acts Amendment Bill 2014* that introduced unexplained wealth provisions into Victoria's asset confiscation laws. There is a need for efforts to be made to ensure harmonisation of all laws on unexplained wealth that are enacted across different jurisdictions in Australia.

Recommendation 23

The Committee recommends that the Victorian Government continue its active participation in the Standing Council on Law and Justice concerning the development of model unexplained wealth laws that would be suitable for implementation in Victoria and most effective for addressing organised crime in Australia.

(Chapter 19)

In order to address drug related and other forms of organised crime Victoria Police operates Taskforce Trident, a multi-agency effort comprised of members from Victoria Police, Australian Customs and Border Protection and the Australian Federal Police to disrupt and reduce organised crime in Victoria's maritime sector including Victoria's ports and docks. One of the issues that Trident is addressing is the need for better security in Victorian ports to prevent the importation of illicit drugs into the state. In particular, Victoria Police has advised that there is limited effectiveness to the Maritime Security Identification Card (MSIC) program operating in maritime sectors. The MSIC is a nationally consistent identification card which is issued to identify a person who has been the subject of a background check. It shows that the holder has met the minimum security requirements and needs to work unescorted or unmonitored in a maritime security zone. The MSIC is not an access card and the relevant authority at each port or facility still controls access to its maritime security zones.

Given these concerns the Committee makes the following recommendation:

Recommendation 24

The Committee recommends that the Victorian Government in conjunction with the Commonwealth Government undertake a review of the MSIC system to disrupt and reduce organised crime in Victoria's maritime sector.

(Chapter 19)

Research conducted on the use of situational crime prevention approaches to the control of organised crime in the Netherlands has shown promising results. The key premise of the approach is that, in the course of engaging in illegal activities or investing illicitly acquired assets, criminal groups will need to use public services and facilities. The approach targets these supporting activities for organised crime rather than its core business since the fact that the opportunity structure can facilitate organised crime also means that the way the opportunity structure is approached can hinder or frustrate organised crime. Victoria already has legislation in place regarding the issue of permits and the assessment of the fitness of individuals to engage in various activities relevant to organised criminality such as arise in the construction, hospitality, waste processing, transport and sex industries. However, enhanced scrutiny of such applications could be one way of limiting the criminal opportunities available to organised crime. Further research is needed to explore the adoption of such administrative approaches to organised crime in Victoria based on local issues.

Recommendation 25

The Committee recommends that the Victorian Government investigate the appropriateness of using administrative regulatory measures, such as those used in the Netherlands, to reduce the opportunities available to organised crime groups for engaging in illegal activities in Victoria.

(Chapter 19)

International and Domestic Precursor Controls

A number of policy responses have been developed and implemented at Commonwealth and state and territory level to address the diversion of precursor chemicals. These include 'Project STOP' to monitor the diversion of pseudoephedrine-based products for use in illicit drug manufacture, and the Code of Practice for the Supply Diversion into Illicit Drug Manufacture, which was developed in 1994 and, inter alia, requires chemical manufacturers and suppliers, including retail pharmacies, to record transactions involving high risk chemicals and equipment through the use of 'End User Declarations' (EUD). The EUD process is voluntary in Victoria and currently enables law enforcement agencies, to some extent, to monitor the sale of chemicals that are associated with the production of illicit drugs including methamphetamine. EUDs must be kept for two years and provided to Victoria Police upon request. At present, EUDs are recorded in hard-copy rather than electronically. Victoria Police, in its submission to the Committee, supported mandatory submission of EUDs to law enforcement, although it was aware of the resource implications of this. Mandatory EUD reporting to Victoria Police would be beneficial and a system of secure electronic recording and transmission should be examined in order to minimise administrative costs. An electronic EUD notification system could be maintained by Police Chemical Diversion Desks that would make national communication of notification data more efficient.

Recommendation 26

The Committee recommends that the Victorian Government require all pharmacies in Victoria to participate in Project STOP. This would enable the sales of pseudoephedrine-based medications to be recorded.

(Chapter 20)

Recommendation 27

The Committee recommends that the Victorian Government introduce legislation to make the use of End User Declarations relating to the recording of sales of precursor chemicals and equipment that could be used to manufacture illicit drugs mandatory and for such Declarations in all cases to be sent to Victoria Police for use in investigations and prosecutions relating to serious drug offences.

(Chapter 20)

Recommendation 28

The Committee recommends that the Victorian Government establish technology that would enable End User Declarations to be recorded and transmitted securely to Victoria Police.

(Chapter 20)

Recommendation 29

The Committee recommends that the CrimTrac Board of Management consider the establishment of a coordinated national approach to the collection and dissemination amongst law enforcement of Project STOP reports and End User Declarations to be managed by CrimTrac.

(Chapter 20)

Law and legal issues

There is no one law pertaining specifically to methamphetamine. Methamphetamine is simply one listed or prohibited substance type included in most state and territory drugs schedules for which standard penalties for use, possession and trafficking apply.

Domestic criminal laws with regard to methamphetamine need to be examined in the context of both national and international legal regulation. International conventions in particular direct and shape Australian drug law. This is particularly important in the context of the supply and production of methamphetamine.

Drug-related Road Trauma

It is only relatively recently that laws and procedures have been enacted that penalise drivers who drive with illicit (and licit pharmaceutical) drugs in their system, in ways comparable to driving under the influence of alcohol provisions.

In Victoria the *Road Safety (Drug Driving) Act 2003* amended the parent *Road Safety Act 1986* (RSA) to include drugs in addition to alcohol, for the purposes of random breath testing and the provision of drug-driving infringement penalties. In 2006, the Victorian Government extended the drug-driving provisions of the RSA to authorise the implementation of a program that randomly selected motorists for mandatory roadside drug tests (RDT). Under the amended Act, any motorists tested positive to cannabis, methamphetamine or ecstasy at any detected level by the tests will be prosecuted for drug driving.

More recently the *Road Safety Act* has been amended to allow for the introduction of 'cocktail' laws. A driver may now be charged for being under the influence of *both* alcohol and illicit drugs in the one encounter. The amendments were premised on research indicating that when drivers combine alcohol and illicit drugs they are on average 23 times more likely to be killed in a crash compared with drivers who are drug and alcohol free. The fact that drivers killed with both alcohol and illicit drugs in their system are said to be more likely to be responsible for the crash than those who only have alcohol in their system was also seen as justifying the changes.

Under the previous law offenders could only be charged separately with drink-driving and drug-driving offences. The penalties for the new combined offence will reflect the

seriousness of the offending behaviour. Offenders will incur a mandatory minimum 12-month licence cancellation, with longer periods for higher blood alcohol content and for repeat offences. The maximum fines for the combined offence will be 50 percent higher than the maximum fines for drink driving *alone*.

Victoria Police has told the Committee that it is 'keen to expand the drug testing capability'.¹¹ However, it cautions that the resource implications, both financial and human, are significant. In particular a detailed analysis of the training of operational police, administrative support, logistics and forensic services to expand drug testing capability across Victoria Police is needed.

Drug Transit Laws

The Report considers the proposal for drug transit laws similar to those enacted in South Australia. These laws allow police to more readily search vehicles suspected of trafficking drugs across and within state borders. A unique feature of the search and seizure provisions of the South Australian legislation relates to the ability of a senior police officer to declare an area that is reasonably suspected of being a conduit for drug trafficking as a 'drug transit route'. In the exercise of such a power a police officer may under Section 52B (5) of the *South Australian Controlled Substances Act 1984*:

- ◆ Require the driver of a vehicle within the area to stop the vehicle (whether at a drug detection point established in accordance with subsection (7) or at any other location); and
- ◆ Detain the vehicle and carry out general drug detection in relation to the vehicle and any persons or property in or on the vehicle; and
- ◆ Allow a drug detection dog to enter any part of the vehicle not designed for the purpose of carrying passengers while the vehicle is moving; and
- ◆ Direct a person to open any part of the vehicle and give such other directions as are reasonably necessary for, or incidental to, the effective exercise of powers under this section.

Witnesses to the Inquiry, particularly those from Victoria Police, spoke favourably about this legislative provision and commented that a similar parallel law operating in Victoria would assist in cross-border detection and seizure of illicit drugs on intra and interstate roads. Clearly safeguards will be required to protect privacy and to ensure that innocent people are not implicated by mistake.

Recommendation 30

The Committee recommends that the Victorian Government introduce legislation allowing for the declaration of 'drug transit routes' to assist in cross-border detection and seizure of illicit drugs on intrastate and interstate roads.

(Chapter 18)

Child Endangerment Laws

A high proportion of clandestine laboratories are located in residential premises which pose hazards for residents including children. Children exposed to clandestine laboratory environments are particularly susceptible to chemical exposure due to direct contact with contaminated surfaces through crawling and putting objects in their mouths. Victoria Police noted that in Victoria there is no legislation in place dealing specifically with offenders who are responsible for children being in laboratory environments. The *Crimes Act 1958* offences of Conduct Endangering Persons and Conduct Endangering Life are not considered appropriate for this situation.

11 Mr Martin Boorman, Impaired Driving Programs Advisor, Road Policing Command, Victoria Police, Correspondence, 22 August 2014.

Recommendation 31

The Committee recommends that the Victorian Government introduce legislation to prohibit persons from exposing children to environments that contain clandestine illicit drug laboratories.

(Chapter 18)

Criminal justice, law enforcement and diversion strategies

There has been a substantial rise in drug-related crime since the 1970s as a result of worldwide social, political and economic change. This has been accompanied by a growth in community concern about the links between illicit drug use and crime, especially violent crime. Consequently, significant challenges face policing and the administration of the criminal justice system, both for investigating and combating large-scale trafficking and the importation of drugs and the domestic policing of local level use and dealing.

There are also challenges once a person has become involved in the criminal justice system. In cases of drug use or relatively low level possession and supply, the following questions should be asked. Is the criminal justice system the best structure in addressing drug-related crime? Is drug use and the consequences that flow from that a law enforcement or a health issue? When is a health-related approach suitable and when are more severe law enforcement measures desirable?

Clearly, large-scale trafficking and supply offences need to be addressed as law enforcement interventions worthy of severe sanction. At the lower end of the spectrum, however, it has been increasingly recognised that for minor drug-related crimes, interventions that prevent relatively low level offenders from being imprisoned are more appropriate than custodial terms. This alternative justice approach may also be coupled with dispositions that involve, where appropriate, diversion into a form of drug treatment or therapy. This may be particularly suitable for people who are either in the early 'stages' of their drug using and/or criminal activities or alternatively are drug dependent.

Some of the options available in Victoria to divert drug users from the criminal justice system are grounded in this alternative justice approach. Interventions such as the Drug Court of Victoria, the Illicit Drug Diversion Initiative and the Court Integrated Services Program (CISP) are important measures to address drug-related crime. They are, however, relatively limited in their current capacity to cover much of Victoria. After reviewing the evidence including the evaluations of these programs and the views of witnesses in the field, the Committee believes these are valuable programs for addressing methamphetamine use and related crime and should therefore be expanded.

Recommendation 32

The Committee recommends that the Victorian Government expand the CISP program operating in the Victorian Magistrates' Courts (currently in Melbourne, Sunshine and Latrobe Valley).

(Chapter 21)

Recommendation 33

The Committee recommends that the Victorian Government expands the operation of the Drug Court of Victoria (DCV).

The Committee suggests that further work be conducted (by the Department of Justice) to see whether Drug Courts could be established in Melbourne, Geelong, Sunshine and Gippsland, as recommended in a submission received from DCV Magistrate Tony Parsons.

(Chapter 21)

Recommendation 34

The Committee recommends that the jurisdiction of the Drug Court of Victoria be extended to allow the DCV in appropriate circumstances to hear cases and make Drug Treatment Orders for offences that may result in a maximum sentence of up to five years imprisonment.

Currently the jurisdiction of the DCV is limited to hearing cases and making Drug Treatment Orders where a client's offence receives a maximum two year imprisonment sentence or less.

(Chapter 21)

In addressing drug-related crime, the Committee has also examined the concept of justice reinvestment (JR) — a relatively new approach in addressing crime, including drug-related offending. The essential premise of JR is that scarce resources that would otherwise be invested in Corrections infrastructure would be redirected to local communities 'from where the offenders originate and to which they will undoubtedly return'. Increasingly in countries such as the United States and the United Kingdom, JR is attracting bi-partisan support from both progressives and conservatives due to a perception that imprisonment is an inefficient and wasteful use of scarce public resources. The Committee believes there is merit in the concepts of justice reinvestment and therapeutic justice. It has therefore recommended that the Victorian Government investigate how these concepts could best be utilised in drug-related diversion and treatment programs.

Recommendation 35

The Committee sees merit in the concepts of justice reinvestment. **The Committee recommends** that the Victorian Government investigate how these concepts could best be utilised in drug-related diversion and treatment programs.

(Chapter 21)

One issue that has been raised during the Inquiry has been the use of illicit drugs in nightclubs and entertainment venues and the law enforcement response to this. Representatives of licensees and nightclubs have indicated that they may be penalised for utilising harm minimisation practices such as calling an ambulance when a patron has become ill subsequent to using a drug such as methamphetamine. Victoria Police however gave evidence to the Committee that licensees are not penalised by way of demerit points against their licenses in such circumstances. Given this confusion, the Committee believes there is merit in encouraging stronger relationships between Victoria Police and nightclubs and entertainment venues particularly regarding illicit drug use. One way this might occur is through a protocol between Victoria Police and nightclub owners.

Recommendation 36

The Committee recommends that Victoria Police establish a formal mechanism to further develop working relationships with the clubs and entertainment industry including peak bodies such as the Nightclubs Owners Association.

(Chapter 13)

Methamphetamine use among specific populations

There are some specific population groups in which the use of methamphetamine is becoming increasingly common and problematic. Following the Terms of Reference, the Report examines in particular the methamphetamine use of young people, Aboriginal people and methamphetamine use in rural and regional communities. It also examines some other discrete groups in Victoria for whom methamphetamine use is or may become problematic including culturally and linguistically diverse (CALD) communities and Gay, Lesbian, Bisexual and Transgender (GLBT) people.

The Committee has not made specific recommendations with regard to some groups such as women and people from CALD or GLBT communities. It has also not made specific recommendations with regard to methamphetamine use in rural and regional issues in this section. This is not because it believes the issue is not relevant to these populations. Indeed in many respects methamphetamine disproportionately impacts on rural and regional Victoria more intensely than in metropolitan areas. Because of this, almost all of the recommendations the Committee have made are relevant to and apply to people in regional Victoria and specific populations of users as outlined in this section. In addition, the recommendations with regard to treatment later in this Executive Summary outline particular instances where the specific needs of rural Victoria need to be taken into account.

Young People

Drug use, especially alcohol, plays a significant role in the lives of young people. The use of illicit drugs such as methamphetamine by young people under the age of 20 is fortunately, however, relatively low.

Certainly the Committee shares concerns about *any* use of drugs that are injurious to young people's health. There is some, admittedly sketchy, evidence that young people may be increasingly transitioning from smoking of methamphetamine to the more dangerous methods of injecting the drug. There has also been some anecdotal evidence presented that in some circumstances, particularly in rural and regional Victoria, young people may be bypassing traditional drugs such as cannabis for methamphetamine. This may be due to methamphetamine being relatively cheap and easy to access, in some areas of Victoria at least. It also needs to be acknowledged that for some young people drug use including methamphetamine is increasingly a 'normalised' aspect of life.

The Committee has also received evidence that young people in out-of-home care or otherwise involved in the child protection system may be vulnerable to using drugs such as methamphetamine. Children may be particularly at risk when their parents or caregivers themselves use methamphetamine, particularly crystal methamphetamine. The Committee notes that collaboration and information sharing between drug and alcohol and child protection services is essential.

Finally, the Committee believes that whatever interventions are developed to address crystal methamphetamine use by young people it is essential that, wherever possible, young people themselves play a significant role in developing and implementing these strategies or initiatives.

Recommendation 37

The Committee acknowledges the impact on and risks to children when their parents use methamphetamine, particularly crystal methamphetamine. The Committee recommends that the Victorian Government investigate measures to address the continuing need to enhance and support the capacity of adult-focused drug and alcohol services to have a more child inclusive approach. **The Committee further recommends** support for child protection services to better assess risks and provide support to children in these situations.

(Chapter 13)

Aboriginal Communities

While clearly methamphetamine use may cause significant harm to Aboriginal people and their communities, the Committee recognises that drug use is, in many instances, symptomatic of a complex web of issues relating to the general health and wellbeing of Indigenous people including a history of colonialism and dispossession.

The Committee believes that the most appropriate and successful strategies to address Aboriginal methamphetamine use are those that are culturally appropriate and/or developed within communities themselves and involving Aboriginal people in their implementation and management. In particular, treatment strategies are an essential component of successful interventions to address drug use. Indigenous people have long called for culturally appropriate health services for Kooris across Victoria that incorporate a holistic approach to healing and recovery. This was impressed upon the Committee during discussions with various Koori drug and alcohol workers from across the state who spoke of the Koori understanding of health as encompassing culture, treatment, education and spiritual wellbeing.

Recommendation 38

The Committee recommends that the Victorian Government provides a raft of culturally appropriate programs and resources on methamphetamine to the Aboriginal community including Aboriginal elders, alcohol and drug, justice, health, youth and other workers. Such resources should include:

- *Aboriginal specific holistic healing centres to adequately cater for the specific cultural needs of Aboriginal communities with regard to substance abuse including methamphetamine*
- *Incentives for the employment of greater numbers of Aboriginal health workers, drug and alcohol workers to address problems of substance abuse within Aboriginal communities*
- *Comprehensive and culturally appropriate training for Aboriginal health, welfare and AOD workers*
- *Additional Aboriginal specific leisure facilities, including youth, sport and recreational clubs and programs, that will provide structured activities, engage young people, enhance their self-esteem, promote Aboriginal culture and tradition and develop a sense of community*
- *Further support for families in undertaking Aboriginal foster care.*

(Chapter 12)

The Committee also recognises that a key strategy to prevent the uptake of drugs in Aboriginal communities is to retain young people in education for as long as possible and to provide ongoing employment and training opportunities. Whilst such considerations also apply to non-Aboriginal young people, the evidence suggests that young Aboriginal people are particularly vulnerable when there are insufficient education, employment or training opportunities to act as a buffer against the uptake of problematic alcohol and other drug use.

Recommendation 39

The Committee recognises that a key strategy to prevent the uptake of drugs in Aboriginal communities is to retain young people in education for as long as possible and to provide ongoing employment and training opportunities. **The Committee therefore recommends** that the Victorian Government investigate best practice models for retaining Aboriginal young people within the education and/or employment sectors.

(Chapter 12)

Rural and Regional Victorians

Throughout the course of the Inquiry the Committee has become aware of the relative paucity of research and lack of attention given to drug use and misuse in rural and regional Victoria. This is particularly the case with regard to data.

There are many studies, research reports and prevalence data that focus on general (ie. state or national) or urban/metropolitan use of illicit and licit drugs. However, as discussed in this Report, there is very little data that gives specific information on drug use patterns and prevalence within rural and regional Victoria. One thing that can be stated with certainty,

however, is that, as in Melbourne, despite growing concerns about methamphetamine use in local communities, in rural and regional areas of the state the drug of most concern according to numerous indicia (economic, health and social costs) is alcohol. This is also testified to by a number of respondents to this Inquiry.

Clearly the demographics of rural and regional populations are different from those of the cities. It follows that the factors bearing on methamphetamine use and rural communities' capacity to respond to it are often different from those encountered in metropolitan contexts. Often the 'tyranny of distance' in country Victoria mitigates against the development of comprehensive service provision. On the other hand, sometimes the relative containment of provincial Victorian towns and communities can in fact lend itself to some innovative policy development. For example, the establishment of community partnerships on crystal methamphetamine in Mildura, Horsham and Geelong as discussed in this Report are innovative ways of bringing the community together to address drug-related problems.

Having stated this, the Committee also highlights the need to recognise the heterogeneity that distinguishes towns, cities and regions throughout Victoria as well as the common factors that have to be taken into consideration in addressing methamphetamine in rural Victoria. The Report discusses a number of issues that examine the specific problems faced by and responses needed for rural and regional communities in Victoria. These include:

- ◆ Access and availability of AOD services for people in regional Victoria
- ◆ Staffing issues
- ◆ The tyranny of distance
- ◆ Specialist versus generalist services
- ◆ Issues pertaining to anonymity and confidentiality in (small) rural communities
- ◆ Rural input into decision making.

Culturally and Linguistically Diverse Communities

With some exceptions, there seems to be a dearth of Australian academic research literature examining drug use among CALD communities generally and specific communities in particular.

Much academic and policy work pertaining to drug use tends to be generalist or assumes the problems of drug misuse among 'Anglo' communities (particularly with regard to males) can be simplistically extrapolated to people from different cultural and ethnic backgrounds. In the few studies undertaken of licit and illicit drug use among people from CALD communities, it is also unclear whether such drug use can be related to issues such as ethnicity or migration or due to confounding variables such as socio-economic status.

The need for strategies that address methamphetamine use among CALD communities is clear. Unfortunately, despite trying to elicit information in this area, with some notable exceptions, the Committee received little information about methamphetamine use in CALD communities.

Recommendation 40

The Committee recommends that the Victorian Government in conjunction with ethnic specific agencies provide culturally appropriate training and resources on methamphetamine use to parents, families, agencies and personnel working with people from culturally and linguistically diverse communities.

(Chapters 14 and 23)

The Use of Methamphetamine by Women

Methamphetamine use by women remains seriously under-represented in the research literature on alcohol and drugs. The Committee found not only is there a paucity of literature on methamphetamine use among women, there has been very little response or input from the community by way of submission or other evidence that details the specificity of female experience with regard to these drugs.

Of the limited ethnographic and qualitative work that does examine gender difference in drug use patterns few studies examine methamphetamine specific issues. Research and policy needs to recognise that for both biological and social reasons there are distinct differences in the way men and women use and are affected by drugs. Moreover, it has also generally been the case that there has been far more disdain shown to women who misuse drugs, both illicit and licit (particularly alcohol), than to males.

Whilst the evidence suggests that men are more likely to be users of illicit drugs than women (although the gap is decreasing), it does not mean that the effects of such drugs on the women who do so use are any less severe. Indeed for both physiological and social/cultural reasons, it is arguable that the effects may be more profound on women.

Therefore, gender differences in the use of methamphetamine may require specialist strategies in education, prevention and treatment that are tailored to meet different audiences of men and women, in addition to different sub-groups within those broad categories, such as middle-class users versus street users or recreational users as opposed to 'functional' users.

Methamphetamine Use in the GLBT Communities

Methamphetamine use and harmful consequences associated with the drug generally only affect a minority of same sex attracted persons. Nonetheless, there is some evidence that the use of illicit drugs (including methamphetamine) may be in some instances higher among same sex attracted people than among heterosexual populations. In Australia, methamphetamine use may be especially high among young same sex attracted people and those living in rural communities. Lesbian and bisexual women have also been found to have high rates of drug use compared to heterosexual women.

Young gay men in particular, who spend much time in the 'gay community' or adopt a consciously gay oriented lifestyle, may be more likely to use illicit drugs including methamphetamine than those who do not follow these behaviours. As with the heterosexual population, the gay and lesbian communities are by no means heterogeneous; the needs of Aboriginal gay men or women for example or those from CALD communities who use methamphetamine may be quite different from 'mainstream' gay communities.

There may also be men who have sex with men who do not identify as being gay or part of the gay community. These men may engage in particularly risky behaviour with regard to both drug taking and their sexual practices. They can be at high risk of transmitting diseases such as HIV or Hepatitis to their heterosexual partners. Therefore strategies, particularly harm reduction approaches, may need to be tailored to address the specific needs of these populations.

Recommendation 41

The Committee recommends that the Victorian Government in developing drug policy and in the delivery of services, in the area of methamphetamine, ensure the specific needs and requirements of young people, women, and people from Gay Lesbian Bisexual and Transgender communities be taken into account.

(Chapter 14)

Other Groups

Finally there are a variety of other groups where specific problems or issues may arise and need to be accounted for in the development of any strategies or interventions to address methamphetamine use. Such groups may include the economically disadvantaged and homeless, for whom the use of the drug may be a ‘coping strategy’ for living ‘rough’ or on the streets. The Report recognises, however, that homelessness cannot be regarded as an overarching category. Generational cultural differences need to be considered. In other words, the culture and needs of homeless youth may be very different to those of the elderly homeless.

Treatment strategies

There are relatively few treatment interventions that have been trialled in Australia for methamphetamine users. Some interventions have been shown to be effective for some people who use methamphetamine, mostly evaluated in the United States. These include brief cognitive behaviour therapy, acceptance and commitment therapy, motivational enhancement therapy and contingency management. Programs such as Matrix and HOPE are also promising. Services should be using these evidence-based approaches as first-line options for treatment. However, as there has been very little research on these programs in the Australian context, evaluation of their application in Australian services is crucial. Likewise for novel and innovative interventions that build on the evidence base, proper evaluation of the programs and services is essential to ensure that these newer treatments work.

Recommendation 42

The Committee recommends that any methamphetamine-specific programs funded by the government should be funded to undertake a formal evaluation with key performance indicators, including clinical outcomes such as methamphetamine and other drug use dependence, mental health symptoms, quality of life and involvement in crime.

(Chapter 30)

Treatment in the Primary Care or Non-Specialist sectors

Although a broad range of risks and harms associated with the use of methamphetamine have been documented, including acute harms from toxicity even among occasional users, not every person who uses methamphetamine is dependent, nor do they need (or want) treatment from a specialist AOD treatment service. Many people who are beginning to have problems with methamphetamine use are likely to seek help from general practitioners and other generalist health and welfare services, therefore workers in these settings need training and support to assist those who require it. People need options to manage the adverse effects of methamphetamine use, therefore a broad range of treatment and support options are required in Victoria.

Many people who are dependent on methamphetamine may be reluctant to seek specialist help, and recent research conducted with a large group of Victorians who use methamphetamine confirms this view. Yet there is evidence that more people are seeking treatment than in previous years and the demand for accurate information about methamphetamine is growing, including among friends and family of people that use.

Recommendation 43

The Committee recommends that the Victorian Government in conjunction with the treatment sector develop non-tertiary treatment options to better respond to the larger group of users who are not dependent but are experiencing significant amphetamine-related harms. This should include:

- a) *Ensuring primary care services and community health services are aware of signs of possible methamphetamine use and undertake screening or brief assessment and interventions*

- b) *Raising awareness among health service consumers about signs of potential methamphetamine-related problems and encourage them to seek help*
- c) *Develop a broad release of a free online self-paced self-help intervention for methamphetamine users*
- d) *Encourage the use of a stepped care approach across health services*
- e) *Ensure NSPs and other community health centres are aware of and implement harm reduction interventions routinely for methamphetamine users.*

(Chapter 28)

Longer-term, Intensive and Specialist Treatment Interventions

Counselling has been shown to be the most effective, and cost-effective, treatment option for Australians who are dependent on methamphetamine. In a systematic review of the evidence for psychosocial therapies for methamphetamine dependence, Lee and Rawson (2008) found the greatest evidence for cognitive behaviour therapy (CBT) and contingency management. More recently, one study of acceptance and commitment therapy has also shown good outcomes.

For longer-term programs, the Matrix Model was developed in California during the 1980s. A detailed treatment manual was produced by the developers to guide the delivery of the intervention. A large-scale study conducted between 1999 and 2011 across eight sites in the United States showed the Matrix Model to be more effective than standard drug treatment. There are also a number of examples of successful approaches in dealing with those in the criminal justice system with drug and alcohol addictions. In the United States, the Hawaii Opportunity Probation with Enforcement (HOPE) project is an example of a highly successful probation program that looks to prevent those on probation from re-offending and ending up in prison.

Alcohol and other drug dependence, by nature is a chronic, relapsing condition, and people often require multiple attempts to change before they are able to fully meet their treatment goals. Methamphetamine's effects on cognitive function can leave the user with a reduced ability to control impulsive behavior and distractibility, make sequenced decisions or plan a course of action (such as getting to an appointment), and due to these problems with memory, attention and planning, assertive follow-up is vital for this group to ensure continuity of treatment.

Successful methamphetamine programs also address mental health issues. Australian research has found that around half of a sample of regular users of methamphetamine had been diagnosed or treated for a mental health problem, with about two-thirds emergent following onset of regular use. However, some had a pre-existing mental health problem that may have been aggravated by stimulant use.

The impact on families of problematic methamphetamine use by a family member can be profound, particularly in cases where the adverse effects of methamphetamine use are severe and the family member is reluctant to seek treatment. Families have needs for information and effective support in their own right, and evidence was provided about the increasing demand for both. Although family support and education is important, services may not be adequately resourced to provide these. Family sensitive and responsive practice should be seen as central to AOD treatment, particularly where the use of methamphetamine is involved. Services must be adequately resourced to provide effective support to families, and their capacity to do so in the context of the current sector reforms should be monitored.

Recommendation 44

In relation to specialist treatment services, **the Committee recommends** that the Victorian Government:

- a) *Ensure that all staff in specialist treatment services are trained in and utilise one of only two best practice brief therapies that have been tested in Australia — Motivational Interviewing/Relapse Prevention and Acceptance and Commitment Therapy*
- b) *Where services have the capacity for, and wish to implement, more intensive longer-term interventions with groups and individual therapy, they should consider the Matrix Model, which is the only intensive intervention with a good evidence base*
- c) *Provides a funding model for methamphetamine treatment that factors in the unique needs of users, including longer withdrawal and community treatment episodes, and the introduction of specific supported aftercare programs*
- d) *Ensure that mental health outcomes are routinely measured, responded to and reported on for methamphetamine users, including psychotic spectrum disorders, anxiety and depression*
- e) *Ensure that families' needs are considered as part of routine practice in methamphetamine treatment*
- f) *Ensure that aftercare programs are funded as a clinical priority, given that withdrawal is not effective on its own and there is a protracted and erratic recovery period for methamphetamine.*

(Chapter 28)

Pharmacotherapy Treatments

Methadone, buprenorphine and buprenorphine-naloxone combination, have been the mainstay of maintenance (or substitution) treatment for heroin and opioid dependence in Australia for decades. Nicotine replacement therapies (NRT) such as nicotine patches and gums are also effective in reducing nicotine withdrawal symptoms and cravings for cigarette smokers trying to quit. Pharmacotherapies are also available to treat alcohol dependence (e.g. acamprosate, naltrexone and disulfiram).

The success of agonist pharmacotherapies to treat opioid dependence has intensified research to find an equivalent pharmacotherapy for stimulant dependence. Despite more than a decade of clinical trials with about 20 different medicines, some conducted in Australia, none have demonstrated sufficient evidence of safety and effectiveness to be approved for routine use in either methamphetamine withdrawal or as a substitution therapy.

Contributing to the difficulty in identifying suitable, safe and effective medicines is the episodic nature of stimulant use (compared to regular daily use of heroin for example) and the variance in symptoms that may manifest in dependence and withdrawal (some of which can be quite vague and hard to measure at times) and the intensely euphoric effects of methamphetamine use. Clinical trials have also been limited by high drop-out rates and/or lack of adherence by study participants to medicine regimens.

The lack of appropriate pharmacotherapy as a treatment option for methamphetamine dependence was raised by many witnesses, and there was some support for further research into suitable medicines. The lack of available pharmacotherapy was also identified anecdotally as a potential barrier for people seeking treatment, although the evidence to support this is thin.

A recent review of pharmacotherapies for methamphetamine dependence was recently commissioned by the Australian Council on Drugs (ANCD). It discusses the range of drug trials in some detail and is due for release at the end of August. The review found that drugs such as dexamphetamine, modafinil, bupropion, methylphenidate and naltrexone show

some promise in addressing some symptoms and in some populations in the treatment of methamphetamine dependence under controlled research conditions, however none have shown sufficiently positive outcomes to be recommended for widespread use.

Recommendation 45

The Committee recommends that the Victorian Government through the Australian Health Ministers' Advisory Council (AHMAC) advocate for a national approach to funding for pharmacotherapy research for methamphetamine. This should be done in collaboration with the Federal Government, national funding agencies, research bodies and private industry. The aim of a national approach would be to continue to research and fund further pharmacotherapy interventions to address methamphetamine use, withdrawal and dependence, especially pharmacotherapies that have been shown to have promise such as dexamphetamine, modafinil, bupropion, naltrexone and methylphenidate.

(Chapter 28)

Barriers and Challenges in providing Methamphetamine Treatment

One of the barriers highlighted in the literature is that methamphetamine users have expressed concerns about the ability of treatment providers to meet their needs. Specialist AOD treatment services have a long history of treating alcohol, cannabis and heroin use problems, and treatment approaches for these conditions are extensively evaluated and well established, including protocols for medically supervised withdrawal. This is not the case for methamphetamine treatment, where treatment approaches tend to be highly variable.

The service structure and delivery style that has been established for other drug users may also pose problems for people who use methamphetamine regularly, who may be agitated, anxious, suspicious, and struggle to control impulsive behaviour.

Practitioners working with people who have been using methamphetamine regularly for a period of time must consider how to adjust usual treatment strategies for those who are likely to have difficulty initiating and completing tasks, taking on and recalling new information, predicting consequences of behaviour, setting and working towards goals, refraining from impulsive behaviour, moving flexibly from one topic of conversation to another, and regulating emotions.

However, although there are numerous resources currently in existence for a range of professionals including tertiary treatment providers, police, ambulance and primary care professionals, many treatment providers may be unaware of the resources available to them. Also, a significant amount of research has been undertaken in the last decade and many of these existing resources require updating, as do existing resources for people who use methamphetamine.

It is notable that no methamphetamine-specific resources have been produced within the past six years, probably reflecting the interest and financial investment in responding to concerns related to stimulant use that emerged during the early to middle years of the last decade. Many of the resources remain freely available for download from the Australian Government's website, although they may be largely unknown to the current workforce due to the time that has elapsed since their initial publication. Resources and guidelines are necessary to guide practice but planned and structured dissemination, including adequate training and support for ongoing workforce development such as professional supervision is equally as important.

In addition, although methamphetamine use is evident across all parts of our community, some groups have specific needs over and above those of the general population of users. Some, such as people in rural and regional areas, young people, and Aboriginal people have specific treatment barriers and needs that must be addressed for responses to be

effective. Others including same sex attracted communities and men who have sex with men, offenders, and some specific occupational groups have high rates of use, or use that puts them at greater risk of harms and dependence than the general population. There is very little research and few resources directed at supporting these specific populations.

Recommendation 46

The Committee recommends that the Victorian Government support the translation of research to practice through:

- a) *Encouraging a broad range of services that reflects the broad range of user and accompanying harms and includes but does not emphasise residential rehabilitation*
- b) *Expanding the evidence base by commissioning further psychosocial intervention trials in Australia as a priority, especially of those interventions that are currently evidence based*
- c) *Updating the range of existing resources, including clinical treatment guidelines and best practice guides. These need to be written by experts in the area of methamphetamine treatment incorporating new research knowledge developed in recent years, including brain science and new treatment outcomes literature*
- d) *Establishing an online portal that is a central repository for information, resources, treatment guides and treatment options (including online self-help interventions)*
- e) *Ensuring that more research is undertaken into the treatment needs of specific groups, such as Aboriginal methamphetamine users, young people, people in rural and regional communities and specific occupational groups at high risk.*

(Chapter 30)

Treatment Needs of Rural and Regional Populations

Whilst there are many barriers and challenges facing treatment providers in addressing the needs of clients who use methamphetamine, which will be the same regardless of location, there are some issues that may be particularly applicable in rural settings, such as issues with accessing services, the difficulty of maintaining anonymity in rural settings, and insufficient AOD specialists working in country areas. In addition, many rural and regional areas may not have previously experienced a significant problem with illicit drug use and are therefore not well equipped to address it.

Recommendation 47

Given that significant barriers exist in regional areas, **the Committee recommends** that the Victorian Government:

- a) *Ensure local withdrawal beds are available for dependent methamphetamine users*
- b) *Ensure better access to residential rehabilitation beds in the regional areas and develop protocols for transfer of clients from regional areas to metropolitan and larger centres*
- c) *Ensure that outpatient services in rural areas are well resourced to respond to methamphetamine users.*

(Chapter 29)

Setting the Research Agenda

Research plays a central role in shaping the direction of drug policy, programs and initiatives in Australia and internationally. This Report outlines a number of areas and subject matters in which research is essential. There is need for further research across a range of disciplines using a variety of methodologies. Just as there is a need for better quantitative data that can

gauge the extent of methamphetamine use and related problems, there is also a need for high quality qualitative (including ethnographic) studies to be undertaken.

Drug research also needs to be well coordinated. At present, studies can be conducted by many different government, academic and private organisations in isolation from each other.

At a state level, a coordinated research plan is also essential. A key element of any proposed state framework on methamphetamine is its capacity to undertake or commission research and make suggestions about priority research areas and innovative research interventions. Recommendation 47 outlines a number of areas in which the Committee believes the state government should be encouraging the commission of new research and data collection or the continuance of best practice research already in place.

Research into the Extent of the Problem

The Committee has found it difficult to quantify the prevalence of methamphetamine use, and particularly, crystal methamphetamine, in Victoria owing to data not being collected in sufficient detail to explain patterns of use in particular regions and include particular forms of methamphetamine. The Committee believes that the Victorian Crime Statistics Agency should work with Victoria Police to improve the statistical data holdings of Victoria Police relating to the use and impact of methamphetamine, particularly ice, in Victoria.

Recommendation 48

The Committee recommends that the Victorian Crime Statistics Agency collaborate with Victoria Police to improve data holdings of recorded crime relating to illicit drug use, including trends in specific sub-categories of drugs, including crystal methamphetamine, particularly in metropolitan, local, regional and remote locations.

(Chapter 30)

The Committee also recognises the concerns of many drug service agencies that they do not receive adequate information or data with regard to current trends in methamphetamine-related issues or they receive such information far too late to be of practical assistance. In particular it would be useful for AOD workers to be aware of any information with regard to the types of drugs in current markets so that they can inform users of any potential harms associated with these drugs.

Recommendation 49

The Committee recommends the timely and systematic dissemination and sharing of information, data, research findings, evidence of best practice and current trends in the area of methamphetamine. In addition Victoria Police should share relevant information and drug intelligence, where possible, with Victorian AOD agencies and treatment providers.

(Chapter 30)

There have also been concerns expressed that data with regard to methamphetamine use by those in police detention or custody is inconclusive. The Drug Use Monitoring Australia (DUMA) program is the only ongoing nationwide survey of police detainees conducted in Australia and provides information on the prevalence of drug use and perceptions among police detainees concerning different drug types, supply and usage within Australia. Following a mid-year budget review in January 2013, the Executive of the Australian Institute of Criminology that administers the DUMA program took a decision to temporarily suspend data collection to allow an opportunity to review the program's relevance as a criminological and public health data collection system. Data collection was subsequently recommenced, using a rationalised number of collection sites. Footscray in Victoria was among the sites where collection was ceased, owing primarily to the high costs

of administering that site compared with others and the relatively low number of detainees able to be accessed. DUMA is currently the only regularly-conducted survey of detainees in Australia. Without the participation of Victoria, trends in this state on recent patterns of methamphetamine use, drug market habits and preferences, and availability of drugs in the local market are no longer available.

Recommendation 50

The Committee recommends that the Australian Institute of Criminology explores options for funding to re-establish data collection sites in Victoria as part of its Drug Use Monitoring Australia research program.

(Chapter 30)

Recommendation 51

The Committee recommends that the Victorian Government

- *Examine the feasibility of contributing to a national database that would permit the monitoring of drug-related hospital admissions.*

The AIHW presented data to the Committee from the National Hospital Morbidity Database (NHMD) on drug-related hospital separation data including legal, accessible drugs such as alcohol and tobacco, drugs that are available by prescription or over the counter, such as analgesics and antidepressants, and drugs that are generally not obtained through legal means, such as heroin and ecstasy. Research conducted in 2008 on the epidemiology of methamphetamine use and harm in Australia included data from the NHMD, Australian Bureau of Statistics and New South Wales Emergency Department Information System. The Committee believes that such data collections need to be up-dated and published on a national basis.

- *Conduct an economic assessment of the cost and impact of methamphetamine use in Victoria.*

Although the Committee has examined prior research into the cost to the community of drug-related crime, further work is needed to quantify more precisely the costs of methamphetamine, and in particular crystal methamphetamine, to the community in Victoria.

- *Continue the Victorian Youth Alcohol and Drug Survey on a regular basis.*

The Committee notes that the Victorian Youth Alcohol and Drug Survey (VYADS) that provides further information on substance use among young users (i.e. adolescents 16 to 24 year olds) in Victoria was last conducted in 2009. These results demonstrate that the lifetime use of amphetamines among young people has decreased across the iterations of the survey and it would be desirable to obtain more recent survey data to show what has transpired since 2009.

- *Facilitate further research on poly-drug use by methamphetamine users, with a focus on improving opportunities for diversion and treatment.*

The Committee was made aware of a number of research studies that have indicated that many people, both recreational and dependent users, take methamphetamine as part of a suite of drugs they use. A number of these studies were undertaken some years ago. Whether the practice of poly-drug use among methamphetamine users is higher in Victoria than in other states, or whether it is becoming more prevalent is unclear and warrants further research.

- *Facilitate research into the role that psychological conditions, particularly psychosis, play in causing violent behaviour amongst methamphetamine users.*

The Committee received anecdotal evidence of drug users displaying increased aggression and engaging in violent acts, which they attribute to the use of methamphetamine. However, an association between methamphetamine use and violence has not been consistently shown in academic research, and establishing the causal relationship between drug use and crime remains unclear. Arguably there needs to be a synthesis between criminology-based and health-care research to understand and quantify underlying

causal relationships. In particular, the association between methamphetamine use and violence may be moderated by the presence of psychotic symptoms — that is, methamphetamine use may lead to psychotic symptoms, which in turn, may elevate risk of violent behaviour. Alternatively, short and long-term effects of methamphetamine use may interact with psychotic symptoms to produce an increased risk of violent behaviour. There is a need for further research to examine these specific pathways.

(Chapter 30)

Specific Research on Supply Side Issues

Online Drug Markets

Online drug markets have become an increasing concern for law enforcement agencies in recent years. Various internet forums and sites provide users with access to a range of information on the effects of various substances, the market for such drugs internationally and ways of avoiding detection by law enforcement agencies when importing drugs. In Australia, research has found that amphetamines (including methamphetamine) were ranked ninth out of 20 different types of drugs purchased online from Silk Road by country of residence. Research into the use of online drug markets and how they are being used for the importation of methamphetamine and its precursors into Australia presents definite methodological and ethical problems and therefore law enforcement research divisions could lead such projects. Online drug market research by academic scholars could be more readily undertaken to develop a general understanding of areas such as known websites which advertise drugs, preferred type of payment methods and delivery mechanisms.

Recommendation 52

The Committee recommends that the Law, Crime and Community Safety Council facilitate research into the nature, extent and control of online drug markets including their potential impact on the importation of methamphetamine into Australia.

(Chapters 15 and 30)

Organised Crime

During the course of its Inquiry, frequent reference was made to the role that organised crime groups play in all aspects of the market for illicit drugs, including methamphetamine and crystal methamphetamine. There is, however, a lack of information available to quantify precisely the extent of the involvement of organised crime, including members of OMCGs, in the methamphetamine market. The information collected as part of this Inquiry demonstrates some possible links in some areas of Victoria between OMCG members and illicit drug trade, but quantitative evidence is very limited. The Committee believes that further research needs to be conducted to obtain more conclusive evidence of the involvement of organised crime groups in the distribution of methamphetamine within Victoria and interstate.

Recommendation 53

The Committee recommends that Victoria Police collaborate with the Australian Crime Commission to obtain more conclusive evidence of the extent of the involvement of organised crime groups in the distribution of methamphetamine within Victoria and interstate.

(Chapters 17 and 30)

The importance of evaluation

Any program or intervention that is designed or implemented should, in the view of the Committee, have an in-built requirement for evaluation. Evaluative research of both a process and outcome nature is an essential component of developing good, effective

and relevant policy in this area. Moreover, in most cases funding grants to agencies who undertake drug programs should have specific allocations to enable them to conduct such evaluations. It is a crucial aspect of determining not only what works but what doesn't work or what at least could be improved upon. Having said that, it is also acknowledged that evaluation of drug-related programs is exceedingly difficult, as is the idea of what counts as 'success'. For example, the notion that getting users 'off drugs' the first time they enter a drug treatment or rehabilitation program may be somewhat simplistic and unrealistic, given the relapsing and episodic nature of drug use and dependence.

There is also a need for some objective key indicators that can measure the effectiveness (or otherwise) of efforts to reduce methamphetamine-related harms. Ideally, such indicators could be developed at national, state and local levels and include data on a wide range of subjects (crime rates, hospitalisation and ambulance attendances, school retention rates). The National Drug Strategy whilst not specific to methamphetamine use does provide an evaluative model that could possibly be adapted for specific drug use.

Recommendation 54

The Committee recommends that the Victorian Government require that all publicly funded programs established to address methamphetamine use have a requirement for evaluation to determine their effectiveness.

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List of Abbreviations

ACBPS	Australian Customs and Border Protection Service
ACC	Australian Crime Commission
ACID	Australian Criminal Intelligence Database
ACLEI	Australian Commission for Law Enforcement Integrity
ACN, ABN or ARBN	Australian Company Number, Australian Business Number, Australian Registered Business Number
ACSO	Australian Community Support Organisation
ACT	Acceptance and Commitment Therapy
ADCA	Alcohol and other Drugs Council of Australia
ADF	Australian Drug Foundation
ADHD	Attention Deficit Hyperactivity Disorder
ADIS	Alcohol and Drug Information System
AFL	Australian Football League
AFP	Australian Federal Police
AGD	Attorney General's Department
AIC	Australian Institute of Criminology
AIDDC	Australian Illicit Drug Data Centre
AIDIP	Australian Illicit Drug Intelligence Program
AIDS	Acquired Immunodeficiency Syndrome
AIHW	Australian Institute of Health and Welfare
AIS	Australian Institute of Sport
ALEIN	Australian Law Enforcement Intelligence Network
AMA	Australian Medical Association
AML/CTF	Anti-Money Laundering and Counter-Terrorism Financing Act
ANCD	Australian National Council on Drugs
ANFM	Australian Nursing & Midwifery Federation
ANSPS	The Australian Needle and Syringe Program Survey
AOD	Alcohol and Other Drugs
ARC	Australian Research Council
ARS	Alternative remittance sector
ASADA	Australian Sport Anti-Doping Authority
ASSAD	Australian Secondary Students Alcohol and Drug Survey
ASSIST	Alcohol, Smoking and Substance Involvement Test
ATS	Amphetamine type stimulant
AUSTRAC	Australian Transaction Reports and Analysis Centre
BBV	Blood-borne viruses
BMK	Benzyl methyl ketone
BOCSAR	Bureau of Crime Statistics and Research
CALD	Culturally and linguistically diverse communities

CATI	Computer Assisted Telephone Interviewing
CBT	Cognitive Behaviour Therapy
CCC	Corruption and Crime Commission of Western Australia
CCPM	Case Categorisation and Prioritisation Model
CCTO	Combined Custody and Treatment Order
CCTV	Closed-circuit television
CDPP	Office of the Commonwealth Director of Public Prosecutions
CDTCC	Compulsory Drug Treatment Correctional Centre
CDTP	Compulsory Drug Treatment Program
CEPS	Australian Research Council (ARC) Centre of Excellence in Policing and Security, Brisbane
CIRCA	Cultural and Indigenous Research Centre of Australia
CISP	Court Integrated Services Program
CJDP	Criminal Justice Diversion Program
Clan	Clandestine
CLS	Clandestine Laboratory Squad
CNS	Central Nervous System
COATS	Community Offenders Advice and Treatment Service
COT	Courses Of Treatment
CREDIT	Court Referral & Evaluation for Drug Intervention & Treatment
DACAS	Drug and Alcohol Consultations Service
DAFF	Department of Agriculture, Fisheries and Forestry
DANTE	Dealing with alcohol related harm in the night time economy
DAWN	Drug Abuse Warning Network
DCPC	Drug and Crime Prevention Committee
DCV	Drug Court of Victoria
DEA	Drug Enforcement Administration (US)
DEECD	Department of Education and Early Childhood Development
DEST	Department of Education, Science and Training
DEVS	Drug Education in Victorian Schools
DHS	Department of Human Services
DOHA	Department of Health and Ageing
DOJ	Department of Justice
DPCSA	<i>Drugs, Poisons and Controlled Substances Act 1981</i>
DPP	Director of Public Prosecutions
DSM –IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
DTO	Drug Treatment Order
DUMA	Drug Use Monitoring in Australia
DURC	Drug Users Resource Centre
ED	Emergency Department
EDRS	Ecstasy and Related Drug Reporting System

EHOs	Environmental Health Officers
EIDHP	Earlier Identification of Drug Harms Project
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ENIPID	The Enhanced National Intelligence Picture on Illicit Drugs
Eph/PSE	Ephedrine/pseudoephedrine
ERD	Ecstasy and related drugs
ERDRS	Ecstasy and Related Drug Reporting System
EU	European Union
EUD	End User Declarations
EUSOCTA	European Union Serious and Organised Crime Threat Assessment
FATF	Financial Action Task Force
FDI	Forensic Drug Intelligence team
FIU	Financial Intelligence Unit
GHB	Gamma-Hydroxybutyric acid
GGCCESA	Greater Geelong Collective Community Effort on Substance Abuse
GLBT	Gay, Lesbian, Bisexual and Transgender
GLBTI	Gay, Lesbian, Bisexual, Transgender and Intergender
GLCHADS	Gippsland Lakes Community Health Alcohol and Drug Service
GPs	General Practitioners
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HOPE	Hawaii Opportunity Probation with Enforcement
HRED	High Risk and Emerging Drugs Determination
HRV	Harm Reduction Victoria
IBAC	Independent Broad-based Anti-corruption Commission
ICD10	International Statistical Classification of Diseases and Related Health Problems (10th revision)
ICMS	Intensive Case Management Service
IDDI	Illicit Drug Diversion Initiative
IDDR	Illicit Drug Data Report
IDRS	Illicit Drug Reporting System
IDU	Injecting drug users
IGCD	The Intergovernmental Committee on Drugs
JR	Justice Reinvestment
JSS	Junction Support Services
KESO	Koori Engagement Support Officers
LEAD	Leading Education about Drugs
LEAP	Law Enforcement Assistance Program
LCMP	Leaving Care Mentoring Program
LGA	Local Government Areas
LSD	Lysergic acid diethylamide

MAGD	Ministerial Action Group on Drugs (NZ)
MCC	Model Criminal Code
MCCC	Model Criminal Code Committee
MCDS	Ministerial Council on Drug Strategy
MCM	Ministerial Council on Methamphetamine
MDAS	Mallee District Aboriginal Services
MDMA	3,4 methylenedioxyamphetamine (Ecstasy)
METH	Methamphetamine
MHCLS	Mental Health Court Liaison Service
MICA	Mobile Intensive Care Ambulance
MIRI	Monash Injury Research Institute
MMP	Montana Meth Project
MSIC	Medically Supervised Injecting Centre
MSM	Men who have Sex with Men
NAFIS	National Automated Fingerprint Identification System
NCADA	National Campaign against Drug Abuse
NCETA	National Centre for Education and Training on Addiction
NCIDD	National Criminal Investigation DNA Database
NCTL	National Criminal Target List
NDARC	National Drug and Alcohol Research Centre
NDC	National Drug Campaigns
NDLERF	National Drug Law Enforcement Research Fund
NDPRAC	National Drug Precursor Risk Assessment Capability
NDRI	National Drug Research Institute
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NESB	Non-English Speaking Background
NFID	National Firearms Identification Database
NHMD	National Hospital Morbidity Database
NIDAC	National Indigenous Drug and Alcohol Committee
NIDS	National Illicit Drug Strategy
NJC	Neighbourhood Justice Centre
NMCP	Northern Mallee Community Partnership
NPHDC	National Prisoner Health Data Collection
NPI	National Psychostimulants Initiative
NPRS	National Police Reference Services
NSDES	Nation School Drug Education Strategy
NSDUH	National Survey on Drug Use and Health
NSPs	Needle and Syringe Exchange Programs
NSSF	National Safe Schools Framework
OAM	Order of Australia Medal

OCGs	Organised Crime Groups
OCS	Office of Chemical Safety
OECD	Organisation for Economic Cooperation and Development
OHV	Odyssey House Victoria
OMCG	Outlaw Motor Cycle Gangs
P2P	Phenyl-Propane
PACIA	Plastics and Chemicals Industrial Association
PAG	Precursor Advisory Group
PCC	Primary Care Connect
PenDAP	Peninsula Health's Drug and Alcohol Program
PIRG	Precursor Industry Reference Group
POCA	<i>Proceeds of Crime Act 2002 (Cth.)</i>
POINTED	Patron Offending and Intoxication in Night-Time Entertainment Districts
PPA	Phenylpropanolamine
PSAs	Police Service Areas
PSDE	Principles for School Drug Education
PSE	Pseudoephedrine
PWID	People who inject drugs
QUAMBY	Glenelg Southern Grampians Drug Treatment Service
REU	Regular ecstasy users
RPU	Regular psychostimulant users
RSA	<i>Road Safety Act (Vic)</i>
S3	Pharmacist Only Medicines
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMS	Sexually Adventurous young Men
SCA	Second Chance Act (US)
SEADS	South East Alcohol and other Drug Service
SEP	Student Engagement Policy
SHARC	Self Help Addiction Resource Centre
SHarP	Strategic Harm Minimisation in Pharmacy
SHDHCD	Swan Hill District Health Counselling Department
SIA	Science Industry Australia
SPAG	School Policy and Advisory Guide
SR	Silk Road
SRU	Single Response Unit
SRWP	Students Resilience and Wellbeing Program
SSA	Same-sex attracted
Standard	Standard for the Uniform Scheduling of Medicines and Poisons
STRIDE	System to Retrieve Information from Drug Evidence (of the DEA)
SUSMP	Standard for the Uniform Scheduling of Medicines and Poisons

TAFE	Technical and Further Education
THC	Tetrahydrocannabinol
UK	United Kingdom
UN	United Nations
UNCAC	United Nations Convention against Corruption
UNODC	United Nations Office on Drugs and Crime
UNTOC	United Nations Conventions against Transnational and Organised Crime
USA	United States of America
VAADA	Victorian Alcohol and Drug Association
VACCA	Victorian Aboriginal Child Care Agency
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAED	Victorian Admitted Episodes Dataset
VAGO	Victorian Auditor General's Office
VALS	Victorian Aboriginal Legal Service
VEMD	Victorian Emergency Minimum Dataset
VISU	Victorian Injury Surveillance Unit
VYADS	Victorian Youth Alcohol and Drug Survey
WADS	Women's Alcohol and Drug Service
WDAT	Wimmera Drug Action Taskforce
WFD	Workforce Development
WHO	World Health Organization
WHOS	We Help Ourselves
YJ CAS	Youth Justice Court Advice Service
YoDAA	Youth Drug and Alcohol Advice
YSAS	Youth Support + Advocacy Service

Section One — Contextualising the Supply and Use of Methamphetamine

PART A

Background and History

1. Scope of the Inquiry: History and Background

Introduction

My name is crystal meth...
I destroy homes, I tear families apart
Take your children, and that's just the start.
I'm more costly than diamonds, more precious than gold
The sorrow I bring is a sight to behold.
If you need me, remember I'm easily found,
I live all around you — in schools and in town.
I live with the rich, I live with the poor,
I live down the street, and maybe next door.
I'm made in a lab, but not like you think,
I can be made under the kitchen sink.
In your child's closet, and even in the woods,
If this scares you to death, well it certainly should.
I have many names, but there's one you know best,
I'm sure you've heard of me, my name is crystal meth.¹

The poem above paints a distressing picture of the damage crystal methamphetamine can cause. It was written by an anonymous woman who was addicted to methamphetamine and wrote it whilst in gaol on drug charges. She died from drug-related causes some weeks after being released from jail. Whilst her experience is not typical of all methamphetamine users, there is little doubt that this drug and particularly the crystalline form known as 'ice' is capable of causing significant harms to individuals and the community.

Background

In September 2013, the Victorian Parliament requested the Law Reform, Drugs and Crime Prevention Committee to inquire into the supply and use of methamphetamine, particularly ice, in Victoria. The reference arose out of a perception in the media and from anecdotal evidence from law enforcement and health professionals that the use of this drug was increasing in Victoria and having detrimental effects on communities, especially those in regional and rural areas of the state. Although methamphetamine use has declined among the general Australian population during the last decade, the use of crystal methamphetamine among regular drug users has, according to the United Nations Office on Drugs and Crime (UNODC 2013), increased. It is the aim of the present Inquiry and Report to examine the evidence as it relates to Victoria, and to consider appropriate legislative, regulatory and policy responses.

1 The complete poem is reproduced at <http://www.drugfree.org.au/fileadmin/Media/Reference/MyNamesMeth.pdf>

The nature of methamphetamine and ice

Crystal methamphetamine, often referred to as ice, is a highly purified form of methamphetamine that is crystalline in appearance (Australian Crime Commission 2013c). Methamphetamine forms part of a group of drugs referred to as Amphetamine Type Stimulants (ATS) that 'comprise synthetic stimulants including amphetamine, methamphetamine, methcathinone, and ecstasy-group substances, such as MDMA and its analogues' (UNODC 2013a, p.xi). Methamphetamine comes in various forms including tablets, crystal, base and powder that can be ingested in different ways including by swallowing, snorting, smoking and injecting. In Australia there is some inconsistency in the terminology used to describe the drug with some official statistical collections referring to 'methamphetamine', while the Australian Crime Commission (ACC) uses the terms 'methamphetamine' and 'methamphetamine' interchangeably. Strictly speaking, however, methamphetamine is the chemical name whilst ice (and speed and base) are the forms it comes in. There is also a divergence in the plural and singular usage of the word. In this Report the Committee will employ the term 'methamphetamine' as the generic category, and crystal methamphetamine when referring to its crystalline form. Despite the colloquial use of 'ice' to denote the drug crystal methamphetamine, the Committee has decided to use the term crystal methamphetamine unless the context otherwise demands it. This is to avoid 'glamourising' or sensationalising the drug and its impact on society.

Methamphetamine — the perils of exaggeration

A considerable amount of media coverage has been given to the so-called 'ice epidemic', much of it responsible journalism but some of it alarmist, if not sensationalist.² One such example of alarmist reporting published in *The Age* under the heading 'Ice use devastating rural Victoria', stated:

Rampant methamphetamine use is devastating regional Victorian towns and some of Melbourne's outer suburbs, with senior police describing the drug as the most harmful they have seen and health workers reporting that children as young as 12 are being exposed to it.³

Whilst social media such as YouTube and popular dramatisations such as the television show *Breaking Bad* have contributed to knowledge about the harmful effects of crystal methamphetamine, they have also contributed to the glamour, even 'sexiness', associated with the drug.⁴

However, despite such perceptions of methamphetamine use, it remains the case that many witnesses who gave evidence to this Inquiry, particularly AOD workers, emergency clinicians, police and ambulance officers are primarily concerned about the effects of problematic alcohol consumption in the community — what they perceive as the 'real drug problem'.⁵

2 For example, see Chapter 24 for a discussion of media coverage of methamphetamine.

3 'Ice use devastating rural Victoria', *The Age*, Melbourne, 29 August 2013. <http://www.theage.com.au/victoria/ice-use-devastating-rural-victoria-20130829-2stc7.html>.

4 On the dual nature of media representation of 'ice' — the 'highlighting the horrors but romanticising the use of ice' — see Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014 and the discussion in Chapter 24.

5 This was expressed in a significant number of submissions and in oral testimony at public hearings including by Associate Professor Tony Walker, General Manager, Regional Services, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013; Professor Paul Dietze, Head, Alcohol and Other Drug Research, Centre for Research Excellence in Injecting Drug Use, Burnet Institute, Public Hearing, Melbourne, 30 September 2013; Dr Roger Volk, Forensic and Other Drugs Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014; Dr David Jacka, Addiction Medicine Specialist, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014; Mr Mark Allen, Team Manager, Morwell Mobile Intensive Care Ambulance (MICA) Unit and Single Response Unit (SRU), Ambulance Victoria, Public Hearing, Traralgon, 28 January 2014; Dr Tony Chan, Emergency Department Director, Latrobe Regional Hospital, Public Hearing, Traralgon, 28 January 2014; Ms Dianne Barker, Acting Senior Manager, ICMS and Residential Care, St Luke's Anglicare, Bendigo, Public Hearing, Bendigo, 25 October 2013; Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013; Mr Mike Fuery, Paramedic, Ambulance Victoria, Public Hearing, Wodonga, 24 February 2014.

Comparing methamphetamine use to alcohol consumption prompted many expert witnesses, particularly in the drug education and medical research fields, to warn the Committee of the perils of exaggerating the effects of what can undoubtedly be a problematic drug. According to Dr David Jacka, an addiction medicine specialist, talking in terms of ‘crises’ or ‘epidemics’ when they don’t exist is counterproductive.⁶ One of the key risks is that by focusing on the ‘hard end’ of drug use, we may miss opportunities to take a more preventative approach and address important but less severe issues among users. The Committee was also urged not to accept without reservation accounts suggesting all users behaved in a violent or psychotic manner, particularly after only occasional or short-term episodes of using the drug. For example, Dr Belinda Lloyd from Turning Point Alcohol and Drug Centre told the Committee:

If we give the impression that everybody who uses this drug is violent, antisocial and unable to be managed, that will [not only] actually reduce the likelihood of people accessing help if they feel they need it, but also reduce the likelihood of their listening to the public health messages around the harms associated with it, because it is not most people’s experience of using that drug themselves or with their friends. They do not see those kind of harms, so then they do not engage with a discussion if they start to experience problems.⁷

Nonetheless, the hyperbole surrounding crystal methamphetamine is easy to understand — the drug *can* give rise to the impression of a crisis because of the way in which a methamphetamine-related incident can present to the police or the emergency room.⁸ Moreover, none of the witnesses who warned against exaggerating the problem of methamphetamine wished to downplay the seriousness of the issue; they all viewed methamphetamine as a drug with potentially serious and damaging consequences. As drug educator Paul Dillon told the Committee: ‘Absolutely it’s an issue; it’s a significant issue, but let’s put it into context and try to sort out the hype from the reality.’⁹ An important aspect of this Inquiry is to seek to resolve the question as to the actual prevalence of methamphetamine use and harm based on available evidence.

The cyclical and changing nature of drug use

Other witnesses and commentators have warned about taking a ‘drug specific’ approach that concentrates on a specific drug such as methamphetamine rather than the patterns of use associated with the drug; the context of use; and the purpose for which the drug is used. As Peter Wearne from the Youth Support + Advocacy Service (YSAS) told the Committee: ‘Drugs change, people don’t.’¹⁰ This may be particularly the case given that many users of methamphetamine are poly-drug users, either using multiple licit and/or illicit drugs at one time or alternating between drugs depending on mood and availability. Moreover, as Allsop

6 Dr David Jacka, Addiction Medicine Specialist, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

7 Dr Belinda Lloyd, Strategic Lead, Population Health Research, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

On the counter-productiveness of exaggerating the effects of the drug see also:

Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013; Ms Donna Ribton-Turner, Director, Clinical Services, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013; Mr Paul Dillon, Director and Founder, Drug and Alcohol Research and Training Australia, Public Hearing, Melbourne, 3 February 2014.

8 Dr Roger Volk from the South East Alcohol and Drug Service told the Committee in this regard:

‘I think it is mistaken for a crisis because it is such a dramatic drug. ... It is the police at their houses and a divvy van down to the emergency room. It is a lot of drama. A man’s likely fate is he is going to be so dramatic that the police will shoot him to subdue him at some point. So I think it feels like a crisis because each incident is way more dramatic than an alcoholic perhaps falling asleep and ending up in the emergency room.’ Dr Roger Volk, Forensic and Other Drugs Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

9 Mr Paul Dillon, Director and Founder, Drug and Alcohol Research and Training Australia, Public Hearing, Melbourne, 3 February 2014.

10 Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

and Lee note, ‘drug specific approaches can artificially segment users, ignore common contributors to use and harm, and create divisions in care’ (2012, p.1).¹¹

Similarly, many witnesses to the Inquiry pointed out that whilst ‘ice’ may be a problem today, the dynamic nature of drug markets mean that it could well be replaced in favour by a new drug tomorrow.¹² For example, representatives of the Australian Drug Foundation told the Committee that:

[a] few months ago, the drug of the moment was new psychoactive substances, before that performance-enhancing drugs and before that alcohol, then we have had cocaine in the mix. The drugs move in and out of fashion in Victoria and in Australia for a whole range of different reasons, but drug use goes in cycles. Often that is associated with availability and price...

From our point of view, ice is [now] the drug of concern, almost the *drug of the day*. But if it was not ice, it would be ketamine, GHB or cocaine. What the Australian Drug Foundation wants to do is to get behind the drug of the day and to look at the drivers of drug use and the drivers of drug problems, because unless we do that, we are going to be sitting here in six months’ time or a year’s time talking about another drug. We think it is time that we looked at what is impelling people to use drugs successfully and generating these drug problems.¹³

What is most concerning is that these new drugs, particularly synthetic compounds, can be developed and manufactured quickly and outside the current legal frameworks, resulting in police and drug authorities playing a continuous game of ‘catch up’ to ensure new compounds are controlled (McKetin et al. 2012, p.17).

Thus whilst methamphetamine is undoubtedly a problem in the ‘here and now’, similar problems surrounding the drug’s use have existed in the past¹⁴ and no doubt will again. However, for some observers it is the potency of crystal methamphetamine and the intensity of the drug’s effects that may distinguish it from other drugs such as heroin.

‘I wish we could go back to the old days of heroin’¹⁵

Notwithstanding caveats about the need to place methamphetamine use in context and perspective, it is undoubtedly true that methamphetamine and particularly its crystallised form is not a benign drug. In the late 1990s/early 2000s there was an increase in popularity of these drugs (which were at that time, primarily amphetamine sulfate, rather than methamphetamine), but since 2001 there has been a gradual decline in population levels of recent use (used at least once in the last 12 months), from 3.7% of the population in 1998 to 2.1% at the last drug census in 2013.¹⁶ It has moved from the second most common illicit drug used after cannabis in 2001 to the fourth most common after cannabis, MDMA and non-therapeutic use of analgesics in 2010 (AIHW 2014). Similar patterns can be observed for lifetime use of the drug. There has been a small increase in the lifetime use

11 See Chapter 10 for a discussion of poly-drug use.

12 As senior Ambulance Victoria spokesperson Allan Eade told the Committee: ‘If you were to wave a magic wand and crystal methamphetamine went away, then we would be sitting here next week talking about another stimulant that had become super popular’. Mr Allan Eade, Intensive Care Paramedic, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013.

13 John Rogerson, Chief Executive Officer, Australian Drug Foundation and Mr Geoff Munro, National Policy Manager, Australian Drug Foundation, Public Hearing, Melbourne, 14 October 2013.

On the cyclical nature of drug use see also Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

14 See the history of methamphetamine and its use in Chapter 3.

15 Comment of a staff member cited in submission of Mr John Blewonski, Chief Executive Officer, VincentCare Victoria, 21 October 2013.

For a comparison of the differing properties of heroin versus methamphetamine and the impact the two drugs may have on the service sector, see Ms Sharon O’Reilly, Clinical Services Manager, Bayside Medicare Local, Submission, 21 October 2013.

16 Which was exactly the same figure as that in 2010. Thus effectively there has been no change in the figures for recent use in the intervening period.

of methamphetamine in 2010 and 2013 compared to 2007 (7.0 percent in both 2010 and 2013 compared to 6.3 percent in 2007). However usage in both 2010 and 2013 decreased compared to 2001 and 2004 in which lifetime use was 8.9 and 9.1 percent of the surveyed population respectively (AIHW 2014).

What *has* changed however has been a shift in the form of methamphetamine being used. While there was no significant increase in methamphetamine use in 2013, there was a change in the main form of methamphetamine used. The use of the powdered form of the drug decreased significantly from 51% to 29% while the use of crystal methamphetamine more than doubled, from 22% in 2010 to 50% in 2013. People also used methamphetamine more frequently in 2013. There was a significant increase in the proportion of users taking it daily or weekly (from 9.3% to 15.5%), particularly among ice users (from 12.4% to 25.3%) (AIHW 2014).¹⁷

Shifts in the use of methamphetamine may reflect marketing decisions made by illicit operations, the ease of production of synthetic compounds compared to plant based drugs,¹⁸ the prevalence of local manufacture, the availability of other drugs, and the acceptance and normalisation of methamphetamine as a party drug among young people. 'It is clear that the uptake and use of methamphetamine has become an established facet of the Australian illicit drug landscape' (Groves & Marmo 2009, p.417), keeping in mind that a relatively small proportion of the population are current users (2.1% at the last national drug household survey).

Moreover, whatever the extent of methamphetamine use compared to that of other drugs, witnesses have stressed that the effects and consequences of 'ice' can be so much more damaging than comparative drugs such as heroin. Dr Rebecca McKetin, suggested that in some respects the prevalence of the drug's use is less important than the impact the drug is having on society, including the healthcare system.¹⁹ According to a witness, if one were to be a futurist and look ahead to five years' time the damage done to the 'social fabric' through violence, ill health and family breakdown could be immense.²⁰ Methamphetamine is also a drug that is confusing many seasoned alcohol and other drugs (AOD) workers in Victoria. The challenges posed by methamphetamine for treatment services in particular are unique (Lee et al. 2007). As one witness told the Committee:

This whole new 'ball game'²¹ and the changing 'rules' when it comes to methamphetamine is disturbing: For the people who are working in this [AOD/Welfare] space methamphetamine use changes the practice domains and the way we operate because it is different to cannabis, heroin and other forms that we had been more used to dealing with.²²

Certainly evidence to the Inquiry, as indicated in the quote introducing this section, has suggested that the current alcohol and drug service system has been established for, and is more comfortable in dealing with, opiate based drugs.²³

17 See <http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs/2013/data-and-references/>

18 As one American law enforcement officer noted: 'Why spend millions of dollars paying peasants to pick coca leaves in Bolivia and planes and boats and all those overheads for transportation and custom bribes when all you need is 5000 dollars' worth of chemicals and you can make 50,000 worth of meth in a trailer outside Kansas City?' Quoted in Cherney, O'Reilly and Grabosky (2005, p.1).

19 Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

20 Mr Christofer Beal, Coordinator, Tanderra AOD Services, Bairnsdale, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

21 Cited in Ms Jacqui Watt, Director Client Services, Anglicare Victoria, Submission, 21 October 2013.

22 Ms Melanie Raymond, Chairperson, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

This sense of dealing with a 'different' drug and a different set of issues is not restricted to the AOD sector. Law enforcement and emergency services witnesses also reported a significant difference in the issues and consequences for police with regard to methamphetamine compared to 'older' drugs such as heroin. See, for example, Superintendent Paul Pottage, Division Commander, Division 1 (Geelong) Western Region, Victoria Police, Public Hearing, Geelong, 28 October 2013; Superintendent Andrew Allen, Divisional Commander, Ballarat Division, Western Region, Victoria Police, Public Hearing, Ballarat, 18 November 2013.

23 Ms Lyn Morgain, Chief Executive Officer, Western Regional Health Centre, Submission, 22 October 2013.

Contradictions surrounding methamphetamine

One of the perplexing aspects of undertaking this Inquiry is that there have been several accounts given to the Committee of aspects of methamphetamine use that seem to be contradicted by other testimony. Both methamphetamine users and service providers have divergent views on some characteristics of methamphetamine use including the harmfulness or otherwise of the drug (Topp et al 2002. McKetin, McLaren & Kelly 2005). Service providers also have divergent views on some features of methamphetamine use. For example, according to some witnesses crystal methamphetamine is an easily accessible and relatively inexpensive drug to obtain; for others it is very expensive and leads to financial and other damaging consequences for the individual user and those around him or her.²⁴ Although anecdotal opinion is important to consider, there will always be individuals and groups that have different experiences with methamphetamine. There are numerous data sets that should be drawn upon to ensure that the information gathered about facets of methamphetamine use, such as availability, purity and harms are accurate and reflect the 'big picture' rather than the 'slice of the world' that an individual might see. It may be that such differing accounts cannot be reconciled and that what is true in one Victorian community may not necessarily be the case elsewhere in the state.

An issue of public concern

Whatever the reality of the so-called methamphetamine 'crisis', it is fair to state that many people are worried about the perceived spread of the drug's use and the consequences flowing from that. This public concern is reflected in the number of information forums on methamphetamine being conducted across the state and the high numbers of people attending them.²⁵ These forums organised by the Department of Justice and presented by peak body Anex have shown that people know little about the drug and its effects but want to know more. The impact of the drug has been in the words of one witness 'nothing short of enormous'.²⁶ It is hoped that the establishment of this Inquiry and the provision of this Report will add to the level of credible information about methamphetamine, the consequences that may flow from its use and the best ways in which to address these.

This inquiry

On 3 September 2013, the Legislative Council acting under section 33 of the *Parliamentary Committees Act 2003* (Vic.) passed a resolution requiring the Law Reform, Drugs and Crime Prevention Committee to conduct an Inquiry into the supply and use of methamphetamine, particularly 'ice', in Victoria according to the following Terms of Reference.

Terms of Reference

That pursuant to the *Parliamentary Committees Act 2003* (Vic.), the Law Reform, Drugs and Crime Prevention Committee be required to inquire into and report to Parliament on the supply and use of methamphetamine, particularly 'ice'. In particular the Committee is required to:

1. examine the channels of supply of methamphetamine including direct importation and local manufacture of final product and raw constituent chemical precursors and ingredients;
2. examine the supply and distribution of methamphetamine and links to organised crime organisations including outlaw motorcycle gangs;

²⁴ See discussion in Chapter 7.

²⁵ See discussion in Chapter 24.

²⁶ Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates Court, Public Hearing, Traralgon, 28 January 2014.

3. examine the nature, prevalence and culture of methamphetamine use in Victoria, particularly amongst young people, indigenous people and those who live in rural areas;
4. examine the links between methamphetamine use and crime, in particular crimes against the person;
5. examine the short and long term consequences of methamphetamine use;
6. examine the relationship of methamphetamine use to other forms of illicit and licit substances;
7. review the adequacy of past and existing state and federal strategies for dealing with methamphetamine use;
8. consider best practice strategies to address methamphetamine use and associated crime, including regulatory, law enforcement, education and treatment responses (particularly for groups outlined above).

Principles guiding the inquiry

The work of the Committee

The previous discussion has indicated that addressing methamphetamine use is complex, challenging and requires measured consideration rather than 'knee-jerk' responses. The Committee has therefore embarked upon an extensive research process in order to canvass the issues and receive input and information from as many individuals, agencies and organisations as possible that have an interest in the issues raised in the Terms of Reference.

The Committee has undertaken an extensive literature review, called for and received submissions from the community, sought expert opinion, visited various organisations, spoken to key stakeholders in Victoria, held public hearings in Melbourne and regional Victoria, undertaken a series of site visits and travelled to Canberra to meet with the key government agencies and experts based there. The Committee has employed a variety of processes and methodologies in researching and writing this Report to produce what it hopes is a comprehensive picture of supply and use of methamphetamine in Victoria. The following sections give a more detailed account of the processes involved.

Background briefings, literature review and statistical analysis

The Committee commenced the Inquiry by receiving background briefings from the Victoria Police and YSAS.²⁷ An extensive review of the academic and policy-relevant literature dealing with the issues contained within the Inquiry's Terms of Reference was undertaken. This review was constantly updated throughout the Inquiry.

Official statistics on police investigations, convictions and sanctions imposed on offenders for the illicit manufacture, importation, distribution and use of methamphetamine and crystal methamphetamine were also obtained. In addition, reports of survey research conducted amongst the general population as well as amongst sentinel groups of drug users have been useful in gaining a, albeit limited, 'snapshot' on methamphetamine use in Victoria. It should be noted though that the statistics were often inadequate or out-dated. However, there was research available that the Committee could draw on.

Written submissions

Calls for written submissions were published on 21 September, 2013 in the *Herald Sun*, *The Age* and in selected regional newspapers. Letters inviting submissions to the Inquiry

²⁷ For a list of those who gave briefings to the Committee see Appendix 1.

LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

INQUIRY INTO THE SUPPLY AND USE OF METHAMPHETAMINE IN VICTORIA

Addendum:

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Statement of Principles underlying the Recommendations

The Committee's recommendations have been guided by a series of principles. These Principles have been drawn from the research literature on methamphetamine use; evidence based best practice on 'what works'; national and state drug policies and frameworks; and the evidence given to the Law Reform, Drugs and Crime Prevention Committee, including written submissions and oral testimony given at public hearings.

1. An effective response to methamphetamine use and supply requires a multi-faceted approach.
2. An effective response to methamphetamine use and supply must also engage Commonwealth, state and local government, and should enlist the private and non-government (community) sectors and the general community.
3. An effective response to methamphetamine use must give equal (balanced) emphasis to supply, demand and harm reduction, consistent with the National Drug Strategy.
4. Methamphetamine abuse should be primarily regarded as a health issue.
5. Laws and legislation pertaining to drug-related crime should reflect the seriousness of the harms associated with methamphetamine.
6. An effective law enforcement response to methamphetamine must involve the collaborative engagement of all branches of the law enforcement apparatus including local, state and federal authorities.
7. Demand reduction for both illicit and licit drugs requires the development and dissemination of best practice strategies and information to diverse audiences.
8. An effective response to methamphetamine use and supply must address its underlying causes, such as the economic, social and personal problems encountered by people with drug dependence.
9. An effective response to methamphetamine use must be culturally sensitive, gender specific and tailored to take into account a range of individual needs.
10. An effective response to methamphetamine use in Aboriginal communities must be culturally sensitive and specific to particular community needs and be developed in partnership with affected communities.
11. An effective response to methamphetamine use in rural and regional communities requires tailored interventions that take into account the specific, evidenced based needs of the community.
12. An effective response to methamphetamine use must be based on recognition of the prevalence of poly-drug use.
13. An effective response to methamphetamine use must be based on an understanding that methamphetamine users consist of those who are dependent and 'non-dependent'.
14. An effective response to methamphetamine use must be informed by the views, opinions and input of drug users and take account of the cultures in which they live.
15. An effective response to methamphetamine use and supply must be informed by robust, quantitative, qualitative and evaluative research.

were sent to all local councils and shires in Victoria and key stakeholder groups including government and non-government agencies in Victoria and interstate. In all, the Committee has received written 78 submissions. These submissions came from a broad range of individuals and organisations.²⁸

Public hearings in Melbourne, Regional Victoria and Interstate

The Committee conducted a number of public hearings in Melbourne.²⁹ As important as these metropolitan hearings were, concerns had also been expressed that methamphetamine were having a serious effect on rural and Aboriginal communities. It was therefore essential to travel to Regional Victoria to take evidence and gain an understanding of the concerns at first hand. Consequently, the Committee held public hearings in Ballarat, Bendigo, Geelong, Gippsland, Wodonga, Shepparton and Warrnambool.³⁰

The Committee also visited Canberra to conduct public hearings with representatives from the relevant units of the Australian Federal Police, the United Nations Office on Drugs and Crime, the Australian National Council on Drugs, the Australian Crime Commission, the Australian Institute of Health and Welfare and other relevant federal departments. The Committee also met with representatives from relevant peak bodies and other key experts based in Canberra.³¹ The Australian Institute of Criminology made its IT resources available, which enabled video conferences to be conducted with prominent overseas academics that have expertise in both the supply side of methamphetamine and the best practice policy responses employed in Europe and the United Kingdom.³²

Not only has the Committee taken evidence from experts in the field it has also welcomed input from those directly affected by methamphetamine abuse such as users, ex-users and their family and friends. It is their evidence that has provided very personal insights into the effects that these drugs can have.

In all, the Committee conducted 113 public hearings and has heard evidence from individuals and organisations with expertise in treatment, public health, research, data and statistics, justice, law enforcement, crime, marketing, night club owners, government administration and relevant policy across Victoria, Australia and internationally. In total, the Committee received formal oral evidence from 220 witnesses.

Forums and site visits

Throughout the Inquiry the Committee made numerous site visits to agencies such as Odyssey House, Birribi Residential Rehabilitation (YSAS) and Ozanam House and Community Centre. It also attended a case management session with Magistrate Tony Parsons and staff at the Drug Court at Dandenong and observed a session of the Drug Court in action. The Committee's researcher also attended a meeting of the Matrix Program, an initiative implemented by South East Alcohol and Drug Service (SEADS). This psychological therapy program addresses the methamphetamine and other drug use of people subject to Drug Treatment Orders.³³

The Committee attended community 'Ice' Forums in Bendigo, Benalla, Cobram, Horsham, Moama, Geelong and Echuca. These forums in regional centres in Victoria were conducted by Anex and Victorian Government Departments of Health and Justice.

28 For a list of those who made a submission to the Committee see Appendix 2.

29 For a list of those who gave evidence to the Committee in Melbourne see Appendix 3.

30 For a list of those who gave evidence to the Committee in Regional Victoria see Appendix 4.

31 For a list of those who gave evidence to the Committee at Interstate Public Hearings see Appendix 5.

32 For a list of overseas witnesses with whom the Committee consulted see Appendix 6.

33 For a list of site visits undertaken by the Committee, see Appendix 7.

In addition, the Committee participated in a summit conducted by Rangatira Management Consultancy which focussed on discussing best practice strategies for addressing the prevention of methamphetamine use. The seminar aimed to commence the process of developing an action plan for future initiatives and solutions. The outcomes of the forum and the recommendations for future directions were made to the Committee in a submission to the Inquiry.

Additional witnesses

In order to gain expert opinion and complement the information and testimony received from witnesses at the public hearings, visits to various facilities and information gained from submissions, the Committee periodically invited expert witnesses to address it regarding a range of pertinent matters and issues.

Consultants

To assist in undertaking what has turned out to be a very time-consuming and complex task, the Committee has engaged consultants to assist it with its research work.

Specifically, the Committee sought the assistance of the Australian Institute of Criminology (AIC) and Associate Professor Nicole Lee to conduct research and draft chapters on a number of aspects of the Inquiry.

The work of the Australian Institute of Criminology

The Committee requested the AIC to undertake work particularly on issues relating to the manufacture, supply and distribution of methamphetamine and the incidence and harms associated with its use. The AIC has specialist knowledge with respect to organised crime in Australia, the incidence and impact of illicit drug use in Australia and the application of crime reduction strategies to prevent the harms associated with illicit drug use. Accordingly, the Committee asked the AIC to examine the following questions:

- ◆ What are the channels of supply of methamphetamine into Victoria, including direct importation and local manufacture of final product and raw constituent chemical precursors and ingredients?
- ◆ How is methamphetamine supplied and distributed in Victoria and to what extent are organised crime organisations including outlaw motor cycle gangs involved?
- ◆ What is the relationship between methamphetamine use and crime, in particular crimes against the person?
- ◆ What is the prevalence of methamphetamine use and its relationship to other forms of illicit and licit substances according to available statistical data?
- ◆ What are the consequences of methamphetamine use using available statistics?
- ◆ What best practice strategies can be used to address the involvement of organised crime groups in the illicit manufacture, distribution and use of methamphetamine, particularly ice in Victoria?

The AIC undertook research for the Committee that included a review of national and international literature concerning the above questions; the identification and presentation of statistics on methamphetamine-related offences collected by police, the coroner's office and other official agencies; the extraction, analysis and presentation of data from national drug use monitoring surveys; the review of submissions and transcripts from committee hearings and the facilitation of interviews between committee members and key experts from the academic and law enforcement sectors in Australia and overseas.

Associate Professor Nicole Lee

Assoc. Prof. Nicole Lee of LeeJenn Health Consultants and the National Centre for Education and Training on Addiction (NCETA) at Flinders University also assisted the Committee in undertaking research and drafting chapters of the Report. She was primarily responsible for the sections of the Report that deal with the treatment of methamphetamine users, the adequacy of state and federal policies to address use, and best practice strategies to address use. Assoc. Prof. Lee is considered to be one of Australia's leading experts in the field of drug treatment and was well placed to undertake this highly specialised work. She was assisted by Linda Jenner, who also has significant expertise and experience in methamphetamine treatment.

The Committee asked Assoc. Prof. Lee to examine the following questions:

- ◆ How is methamphetamine different to other drugs and how does it impact on treatment?
- ◆ What do we know about methamphetamine users and what does it mean for treatment?
- ◆ What are the specific needs of people with methamphetamine use issues?
- ◆ Are there specific groups that require greater or different care?
- ◆ What is the intersect between methamphetamine and mental and physical health?
- ◆ What do we know about effective policy and practice strategies to address amphetamine type stimulants (ATS) use, and are these reflected in policy and practice in Australia?
- ◆ What are the policy, workforce and service facilitators and barriers, and the challengers for services and consumers, to implementing these strategies?
- ◆ What federal and state government strategies have been implemented for dealing with methamphetamine use and how effective have they been in reducing illicit use and the harms associated with it?

Community input into the Inquiry

In carrying out this Inquiry, the Committee has drawn upon the views and expertise of a broad range of people. The submissions, public hearings and interstate meetings have provided valuable insights into the excellent work of various community and government organisations and provided significant knowledge into what has turned out to be an extremely complex and challenging issue. The Committee is most appreciative of the time, effort and valuable contribution that all the individuals and organisations made during the progress of this Inquiry.

Challenges associated with undertaking the inquiry

The Committee has been presented with a number of challenges in undertaking this Inquiry. These include:

- ◆ *The breadth and complexity of the Inquiry* — The Terms of Reference for this inquiry are extremely broad and required the Committee to investigate a wide range of complex issues. The Committee had a very intense workload to undertake in a relatively short timeline. The amount of information that had to be obtained, examined, sorted through and presented was consequently a daunting task. There was also much public interest expressed throughout this Inquiry, reflected by the total number of public hearings held.
- ◆ *Confusion over terminology* — It has been apparent that there is some confusion as to the terminology associated with amphetamine type stimulant drugs. Some people

may use the term methamphetamine interchangeably with the term ice, even though ice specifically denotes the crystallised form of the drug. Confusion is also apparent for example with regard to the use of the term speed, with some people ascribing it as the generic term for amphetamines whilst others note that it should be used specifically for the powdered form of the drug known as amphetamine sulphate.³⁴

- ◆ *Ascertaining the 'truth of the matter'* — For a number of reasons the Committee found it difficult to discover the actual extent of methamphetamine use and the impact it is having in Victoria. These reasons included the lack of accurate statistics on methamphetamine use and the time lag between when drug use data is recorded and what is happening in 'real time'; methodological limitations in collating the data; the reporting of ice use by the media, which in some cases may have suggested the problem is greater than it actually may be; and the seemingly contradictory evidence of some witnesses as to the extent of the problem. The Committee does not wish to imply that such contradictory evidence indicates that one view is right and the other is wrong. It may, for example, reflect regional variations in patterns or prevalence of use — what is a problem in one region is not necessarily an issue in another. Nonetheless, all the above considerations made getting an accurate snapshot of crystal methamphetamine use in Victoria in 2014 very difficult.
- ◆ *Difficulties in gaining information* — With regard to gaining information on the supply and trafficking of methamphetamine, the Committee was unable to access sensitive operational information gathered by law enforcement and intelligence agencies. This particularly concerned the activities of organised crime groups and outlaw motor cycle gangs. Whilst the Committee understands that disclosure by Victoria Police and other intelligence agencies of operational details and intelligence could jeopardise investigations, the lack of disclosure has prevented the Committee examining and revealing relevant and sensitive information publicly.
- ◆ *Reluctance or inability to 'go on the record'* — For some people, the stigma and shame associated with methamphetamine use meant that in some cases witnesses, particularly family members of ice users, were reluctant to give evidence or preferred to either make confidential submissions or give their oral evidence *in camera*. Whilst the Committee gained many insights from the witnesses who did give their evidence in this way; the practical outcome has been that valuable material has not been able to be included in this Report.
- ◆ *A lack of evidence* — Some groups in the community were not forthcoming with information about crystal methamphetamine use. This was especially the case for people from culturally and linguistically diverse (CALD) communities despite the Committee being proactive in seeking the views of CALD community agencies in this regard.
- ◆ *Reconciling conflicting viewpoints* — On occasion it was difficult to reconcile 'impressionistic' evidence, findings in academic literature, and the opinions of experts in the field with one another. For example, some witnesses from a medical or AOD treatment background gave evidence that crystal methamphetamine use could be occasional or recreational with few, if any, short or long-term negative consequences for the user. Such a viewpoint, however, was in contrast to that of many witnesses who believed strongly that crystal methamphetamine was a highly addictive drug with serious negative effects even after first time use. The Committee acknowledges that such differing opinions are held and by no means wished to dismiss the views of

34 Inconsistency of use in drug terminology and the difference between chemical and slang names for amphetamine type stimulants is discussed further in Chapter 3.

‘non experts’. All evidence received by the Committee was welcome and treated on its merit. Ultimately, however, it is crucial that any strategies recommended to address methamphetamine use are grounded in evidence based research.

- ◆ *Maintaining ‘balance’* — Finally, a key challenge for the Committee throughout this Inquiry was keeping matters ‘in perspective’. In many ways the subject matter of the Inquiry was emotionally charged and conducted in an atmosphere of heightened media interest. The Committee certainly understands and empathises with the evidence of many witnesses, particularly family members, whose lives have been adversely affected by methamphetamine use. As the Committee mentions several times throughout this Report crystal methamphetamine is *not* by any means a benign drug. Nonetheless, as indicated at the start of this chapter, in terms of the physical, psychological and social consequences associated with its use, alcohol is by far a greater drug problem than most illicit drugs including methamphetamine.

Structure of the Report

Chapters in the Report are grouped under three Sections and nine Parts. Part A in Section One, ‘Contextualising the Supply and Use of Methamphetamine’ begins the Report with a description of the background and scope of the Inquiry (Chapter 1) and of the current national and state policy responses to methamphetamine use (Chapter 2). Part B examines the nature of methamphetamine and its use, including its pharmacology, price and how it is consumed (Chapter 3) and looks at its use and associated problems in other countries (Chapter 4). Chapter 5 concludes Part B with a close investigation of the prevalence of methamphetamine use and the harms that may result.

The chapters in Part C discuss the medical and psychological effects of methamphetamine (Chapter 6) as well as the social and environments impacts of methamphetamine use and production, such as family stress and breakdown and environmental hazards. (Chapter 7) Chapter 8 disseminates statistical evidence on the extent to which methamphetamine manufacture and use are linked to crime, as well as reports on pertinent academic research.

Part D, ‘The Patterns, Culture and Profiles of Methamphetamine Use’ opens with a discussion of the patterns of use (Chapter 9) and is followed by a chapter on poly-drug use, investigating the prevalence of and reasons for such use (Chapter 10). The next three chapters in this Part discuss use of the drug by specific groups of people who may be more vulnerable to such drug use: those in rural and regional Victoria, those in Aboriginal communities and young people. Chapter 14 concludes this Part with an outline of other sections of the community who may also be more susceptible to methamphetamine use, such as women and prisoners, among others discussed in this chapter.

Part E, the last part in Section One, examines the nature and extent of the production and distribution pathways of methamphetamine and ice in Victoria, beginning in Chapter 15 with evidence concerning direct importation of both final drug product and precursor chemicals such as ephedrine and pseudoephedrine. Chapter 16 examines the processes of manufacture of methamphetamine and ice in local clandestine drug laboratories in Victoria and the distribution of drugs and precursors, while Chapter 17 focuses on the evidence of involvement of organised crime groups in manufacturing, importing and distributing these drugs and precursors. It also investigates the extent to which specific organised crime groups such as outlaw motor cycle gangs and Asian crime gangs play a role.

The second Section of the Report, ‘Strategies and Approaches to Address Methamphetamine Use’ first looks at the current international, federal and state laws pertaining to methamphetamine (Chapter 18), then at various national, state and domestic responses to organised crime (Chapter 19) and the controls in place, internationally and nationally,

to prevent precursor importation (Chapter 20). A variety of law enforcement methods are described in Chapter 21, including local level policing and alternative criminal justice approaches such as diversion programs.

Part G, the second Part in this Section shifts the focus to 'Prevention, Education, Training and Information Provision', outlining prevention strategies such as promoting resilience in young people and connecting them to the community (Chapter 22), providing drug education for young people and their families (Chapter 23) and conducting awareness and education campaigns, including through the media, to provide relevant information. The emphasis in Chapter 25 is on providing training and resources for personnel working in all drug-related fields, and ensuring that it is methamphetamine-specific. The final chapter in Part G canvasses the various harm reduction approaches available for preventing dependency and/or other serious outcomes and points to the barriers which may inhibit their adoption.

Treatment issues are the subject of the three chapters in Part H, covering the barriers to treatment and the challenges needing to be overcome (Chapter 27), the best practice treatment options available, including residential rehabilitation, follow-up and after-care services, and family-centred services (Chapter 28). Whilst many treatment needs are the same for all users, there are areas of the population who have specific needs, such as those in rural and regional communities, Aboriginal people, young people and others. The needs of such groups are highlighted in Chapter 29.

The third Section, 'The Way Forward' contains the final three chapters comprising Part I, 'Future Directions'. These chapters point the way towards developing a new Victorian strategy to address methamphetamine use, one which will encompass a structure and action plan capable of meeting this task, as well as improving the extent of research and evaluation methods. The final chapter summarises the Committee's position on key issues.

2. National and State Policy Responses to Methamphetamine Use

Introduction

Drug use is influenced by a complex interaction of physical, social and economic factors... No one strategy on its own can prevent and reduce the demand for drugs. Rather, broad-based, multidisciplinary and flexible strategies are needed to meet the varied needs of individuals and communities (Ministerial Council on Drug Strategy 2011, *National Drug Strategy 2010–2015*).

Policy development occurs at many jurisdictional levels and is directed at different parts of the community (Ritter & Lancaster 2013). As with all drugs, supply and demand issues are also intertwined, so potential policy responses need to take into consideration the complex nature of methamphetamine use and a coordinated policy approach between federal, state, local community and service providers is required.

It is important to have a detailed understanding of Australia's alcohol and drug policy because it sets the context for the various responses to alcohol and other drug issues across jurisdictions and sectors.

This chapter outlines the history of Australia's drug policy to 2014, the effectiveness of the policy and its relationship to methamphetamine responses at Australian and State government level.

Australia's national drug policy

Australia's national drug policy, the National Drug Strategy (NDS) 2010–2015, provides a vision and direction for governments and non-government organisations in developing strategies and allocating resources for the prevention and reduction of alcohol, tobacco and other drug-related harms in Australian society. It provides a coordinated framework for implementing drug policy both nationally and in the states and territories.

Early development of Australia's National Drug Strategy

Prior to 1985, Australia's drug policy was haphazard. In the 1970s and 1980s, there was growing community concern about the effects of apparently increasing drug use among young people, especially around Australia's hotspots, such as Kings Cross in Sydney. Ian Webster wrote at the time:

...there is a feeling abroad that the drug problem is undermining our society: threatening the future of young people, escalating drug and organised crime and corrupting our social institutions of law and order and politics. How sensible that perception is, and whether and how we should respond are crucial questions which need to be answered (Webster 1995 p.1).

In the lead up to the development of the policy the new Hawke Government held a Drug Summit on 2 April 1985, and just prior to that the Minister for Health Dr Neal Blewett and the Australian Drug Foundation hosted a National Action Workshop. The workshop recommended the following in considering the development of a national drug policy:¹

The objective of a national drug policy on drug use should be to minimise the harmful consequences of the use of drugs to individuals, their families, and the community as a whole including the needs of special groups. Therefore a national, comprehensive approach will be required (Webster 1995, p.2).

The Prime Minister Bob Hawke then announced the introduction of the National Campaign against Drug Abuse (NCADA) which led to the development of Australia's first coordinated drug policy, the National Drug Strategy (NDS). At the time, two important developments added weight to the introduction of this policy: The prime minister announced publicly that his daughter was a heroin user, and the rapid spread of a new disease, HIV/AIDS, was just becoming evident, with injecting drug users being a key group affected through sharing of injecting equipment.

Both NCADA and NDS were created with bipartisan political support and involved a cooperative venture between Australian and state/territory governments as well as the non-government sector.³⁵

The policy was one of the first in the world to specifically articulate a harm minimisation approach, an explicit approach that continues today. Harm minimisation acknowledges that there will always be some people in society who will use alcohol and other drugs and, therefore, it incorporates policies that aim to prevent or reduce drug-related harms, rather than having a sole focus on reducing drug use itself.³⁶

At various times, there have been sub-strategies to the NDS, including the National Illicit Drug Strategy, National Alcohol Strategy and the National Tobacco Strategy. There have been illicit drug-specific strategies including the National Cannabis Strategy (2006–2009) and the National Amphetamine-Type Stimulants Strategy (2008–2011). There has also been a population specific strategy for Aboriginal and Torres Strait Islander people (2006–2009). The two most recent strategies are the updated National Tobacco Strategy (2012–2018) and the new National Pharmaceutical Drug Misuse Framework for Action (2012–2015). The national Aboriginal and Torres Strait Islander, alcohol and other illicit drug strategies have yet to be updated.³⁷ There is a general shift away from developing drug-specific strategies, with the Australian Government tending towards use of the term 'frameworks' for responding to specific drug types. As such there are no plans to update the lapsed National Amphetamine-Type Stimulants Strategy (2008–2011).

Evaluation of Australia's previous National Drug Strategies

There have been two formal evaluations of the NDS, one in 2003 and one in 2009. Other independent studies by researchers have evaluated specific approaches, programs and measures related to the application of the NDS. These have included evaluations of harm reduction strategies such as needle syringe programs (NSP).³⁸ These are referred to in other chapters of this report with only the official formal evaluation of the national drug strategy itself outlined here.

In the 2003 evaluation of the NDS, SuccessWorks noted:

Based on the data and literature analysis as well as the consultations for this evaluation, the NDSF [National Drug Strategic Framework] is considered to be successful by having created an environment

35 See www.nationaldrugstrategy.gov.au

36 [www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/33B3F1FD97B13446CA2575B4001353A3/\\$File/ndsf_eval.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/33B3F1FD97B13446CA2575B4001353A3/$File/ndsf_eval.pdf).

See also the discussion in Chapter 26.

37 [www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/9C52D7D6E2C14A72CA257C3F001F009D/\\$File/National%20PDM%20Framework.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/9C52D7D6E2C14A72CA257C3F001F009D/$File/National%20PDM%20Framework.pdf)

[www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/2D1717263A2129CACA2574C50010A827/\\$File/ats-strategy08.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/2D1717263A2129CACA2574C50010A827/$File/ats-strategy08.pdf)

38 For a discussion of NSP and other harm reduction program evaluations see Chapter 26.

for a consistent national approach while providing the flexibility to respond to State and Territory issues. This has been achieved through: cooperation by State, Territory and Commonwealth governments; bipartisan support; and through being visionary in providing leadership within Australia without being too mired in ideologically driven approaches and activities in dealing with drug use. There is universal agreement that the three pillars underpinning harm minimisation remain the appropriate foci for the national drug strategy (SuccessWorks 2003, p.3).

A further evaluation in 2009 for Siggins Miller noted:

The NDS policy framework has successfully informed development and implementation of drug policies and strategies at many levels and across government and the public, private and non-government domains. The NDS is broad and flexible enough to enable State and Territory and local drug strategies to be tailored to local needs and priorities. This is an effect of a consistent approach to harm minimisation, partnerships and the use of evidence over a long period (Miller, Siggins et al. 2009, p.viii).

The evaluation also noted that the initiatives of the NDS have successfully achieved many of their goals, including strengthening partnerships, effective intervention, improved access to treatment, research and best practice resource development and workforce development (especially work undertaken by the National Centre for Education and Training on Addiction). However, in the area of program performance and monitoring, Siggins Miller noted that more work needs to be done. In other enhancements to the NDS, Siggins Miller highlighted the following areas for attention:

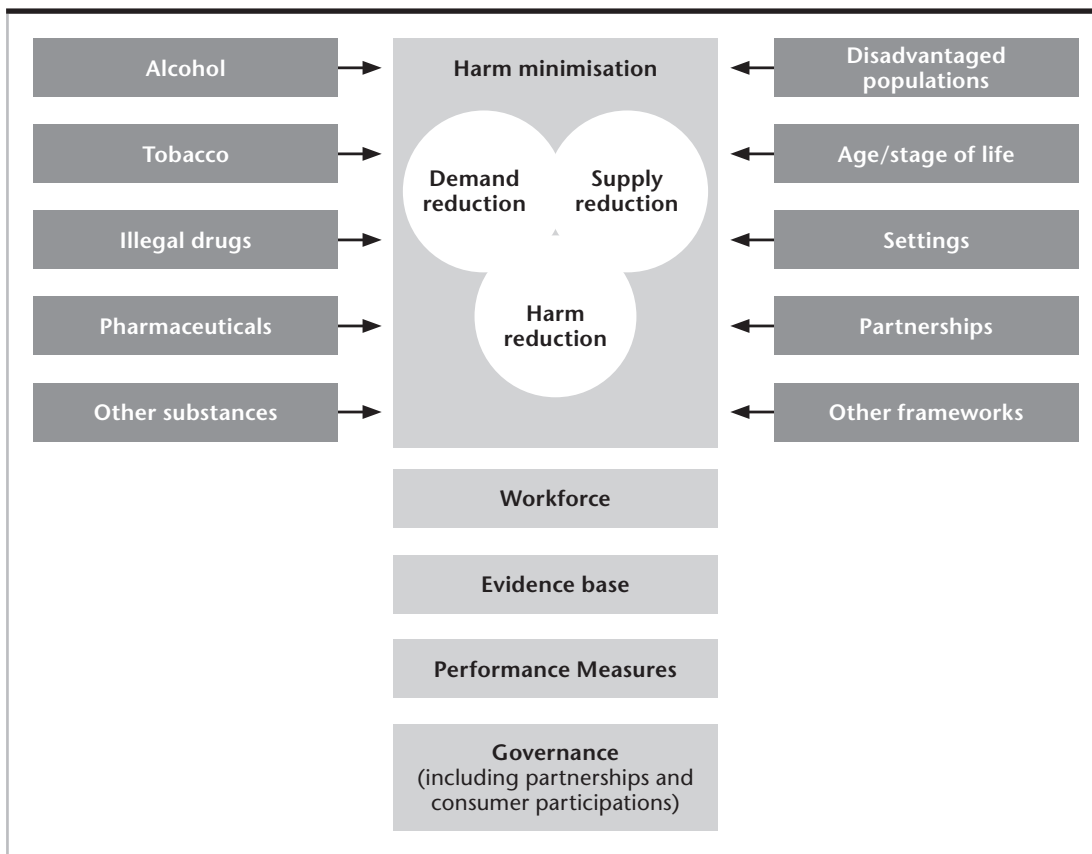
- ◆ Finding a more appropriate term than ‘harm minimisation’ to communicate the essence of the NDS, with greater emphasis on prevention
- ◆ Enhancing partnerships and engagement
- ◆ Rectifying the imbalance of investment among drug types and intervention sectors
- ◆ Further developing and using research-based evidence more effectively in developing and implementing policies and programs
- ◆ Strengthening capacity within the NDS framework for evidence-based policy debate in the public arena
- ◆ Focusing greater attention on the social determinants of health and drug-related harm, in part through the development of a comprehensive prevention agenda
- ◆ Enhancing the role of monitoring and evaluation within the NDS (Siggins Miller 2009).

Australia’s current National Drug Strategy: The three pillars of harm minimisation

The current iteration of Australia’s drug policy, the National Drug Strategy 2010–2015, was approved by the Ministerial Council on Drug Strategy (MCDS) in February 2011 and adopted in March 2011.

The overarching aim for this framework for action on alcohol, tobacco and other drugs is to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic consequences among individuals, families and communities (Ministerial Council on Drug Strategy 2011, *National Drug Strategy 2010–2015*). Figure 2.1 overviews the main components of the National Drug Strategy and the harm minimisation approach.

Figure 2.1: Main components of Australia’s National Drug Strategy



Source: Ministerial Council on Drug Strategy 2011, *National Drug Strategy 2010–2015*, p.3.

Australia’s drug policy achieves the minimisation of harm through three ‘pillars’: demand reduction, supply reduction and harm reduction.³⁹ Harm minimisation is a broader term that encompasses all three strategies. Demand reduction includes prevention and treatment with a focus on reducing the number of people using drugs. Supply reduction refers to policing and customs activities that aim to reduce the availability of drugs. Harm reduction refers to the strategies aimed at those who continue to use drugs to effect the minimisation of harms to individuals, families and the community from drug use.

Demand reduction

Demand reduction strategies focus on preventing the uptake of drug use, delaying the first use of drugs, and reducing the misuse of alcohol, and the use of tobacco and other drugs across society. Demand reduction acknowledges that people use drugs for a range of reasons influenced by social norms, need to experiment, as well as to cope with past and present stressors.

There are four key objectives of Australia’s current demand reduction pillar:

1. Prevent uptake and delay onset of drug use primarily through influencing cultural change. Specific strategies include: information and education, such as through school-based programs or public-awareness campaigns; implementing strategies that encourage a culture of healthy living; developing family support strategies to break the cycle of intergenerational drug use; limiting exposure to alcohol and tobacco advertising; and encouraging responsible media reporting.

39 [www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/DB4076D49F13309FCA257854007B AF30/\\$File/nds2015.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/DB4076D49F13309FCA257854007B AF30/$File/nds2015.pdf)

2. Reduce use of drugs in the community primarily through the provision of best practice intervention. Specific strategies include: increasing awareness of and access to evidence based treatment options to help current drug users reduce or cease their drug use and previous drug users to prevent relapse; implementing early intervention programs, including strengthening the capacity of the primary care sector to intervene early through routine detection and brief intervention; and increasing efforts to divert people who use drugs to treatment rather than to the criminal justice system through police and court diversion programs.
3. Support people to recover from dependence and reconnect with the community, primarily through ensuring structures and resources are available to enable best practice and effective partnerships. Specific strategies include: developing evidence-based national planning tools to assist jurisdictions to better estimate need and demand for services; developing clinical standards and quality frameworks for specialist services; improving links and coordination between primary care and specialist sectors and between specialist sector and human services and welfare sectors (such as housing, education and employment services); and developing strategies to reduce stigma.
4. Support efforts to promote social inclusion and resilient individuals, families and communities through building parenting capacity and improving individual coping skills, as well as encouraging engagement of individuals in community life. Specific strategies include support services to parents in recovery to ensure the needs of their children are met, and support programs that encourage resilience, coping skills and life transition skills to build individual capacity to resist drug use (Ministerial Council on Drug Strategy 2011, *National Drug Strategy 2010–2015*).

Supply reduction

Supply reduction strategies entail enforcing the prohibition of illegal drugs and regulating and enforcing access to legal drugs, including alcohol, tobacco, pharmaceuticals and other drugs. Supply reduction activities, including both border and domestic policing, extend to controlling the availability of precursor chemicals and equipment used for manufacturing drugs. It also extends to compliance with Australia's obligations under international drug control treaties.

The two objectives of supply reduction are:

1. Reduce the supply of illegal drugs (both current and emerging) by strengthening ability of police and customs services to prevent the importation, cultivation and manufacture of illicit drugs and their precursor chemicals, improving information and intelligence flow between law enforcement agencies, developing closer links with international partner agencies to better meet Australia's obligations under International drug control treaties, and regular review of legislation and regulation to ensure it keeps up with the changing nature of drug markets (such as the newly introduced laws for new psychoactive substances).
2. Control and manage the supply of alcohol, tobacco and other legal drugs through regulation of the sale of these drugs, including enforcing responsible service of alcohol regulations, and enforcing laws relating to the supply of alcohol and tobacco to minors, supporting ability of a range of sectors to respond to inappropriate use of legal drugs (for example, monitoring systems for pharmaceutical drugs and responsible service of alcohol regulations), and increase training and support for pharmacists and medical practitioners to reduce the misuse and diversion of pharmaceutical drugs to the black market (Ministerial Council on Drug Strategy 2011, *National Drug Strategy 2010–2015*).

Harm reduction⁴⁰

Aims and objectives of harm reduction

The aim of harm reduction is to reduce the adverse health, social and economic impacts of drug use on communities, families and individuals.

Three key objectives of harm reduction are:

1. Reduce harms to community safety and amenity through, for example, improving safety of public places, especially in high risk drug use areas, managing outlet density for alcohol supply, supporting workers to respond to aggressive behaviours.
2. Reduce harms to families through providing support to families of drug users and including families in treatment where appropriate, linking with other strategies such as Australia's domestic violence strategy.
3. Reduce harms to individuals through education to drug users, enhancing treatment systems, raising awareness of drug harms in the workplace, encouraging users into treatment, drug diversion programs, peer support and support for clean needle provision (Ministerial Council on Drug Strategy 2011, *National Drug Strategy 2010–2015*).

What is harm reduction?

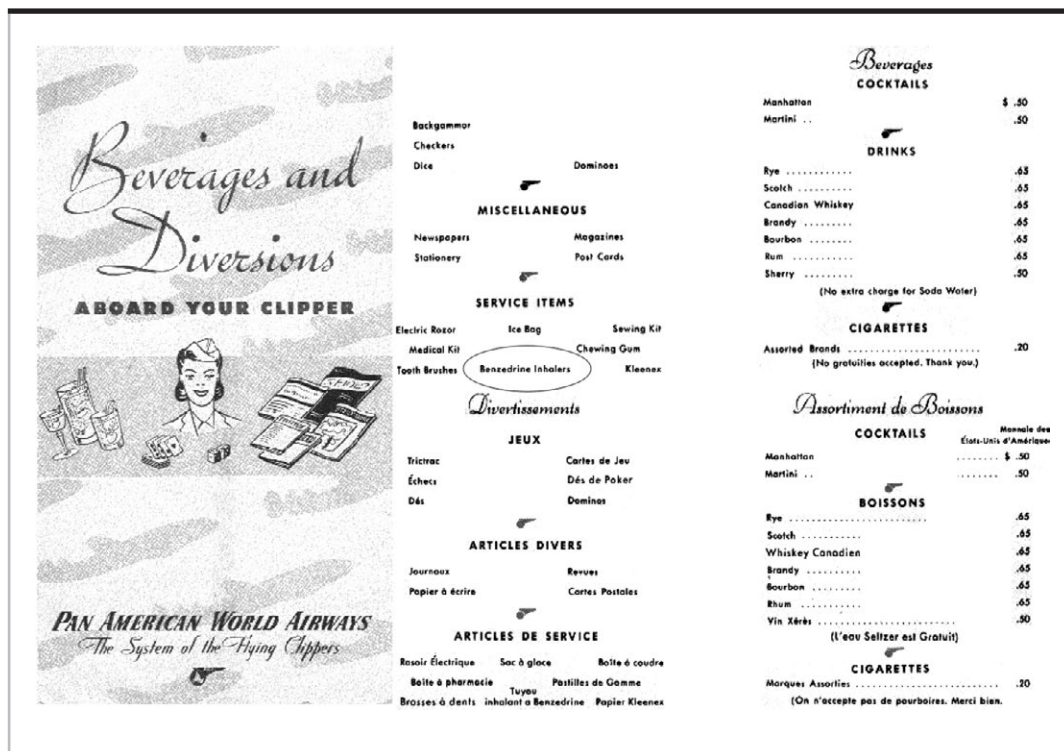
Marlatt et al. describe harm reduction as 'more of an attitude than a fixed set of rules or regulations' (2012, p.6). The response, then, is one that is respectful of the drug user, takes into account a person's freedom of choice, even for activities that others may find disagreeable, and recognises that it may be impossible to eliminate drugs from the community. Such a perspective results in a set of compassionate and pragmatic strategies that aim to reduce harm to the person and the community in which he or she lives.

According to Marlatt et al., harm reduction reflects the humanistic idea that people will make healthy choices for themselves when provided with adequate support, empowerment and education. This is an important point to reduce and prevent further marginalisation of people who use drugs in the community. Marginalisation can lead to reluctance to enter treatment for fear of the stigma attached to being a 'problematic drug user'.

The authors also note that high-risk behaviours, such as drug use, are a 'social construct'. That is, our beliefs about the use of drugs, including amphetamines, has changed over time. For example, Figure 2.2 shows availability of amphetamine inhalers on the Pan Am flight menu. Benzedrine is a form of amphetamine available as an inhaler. The use of such inhalers historically demonstrated a much more open attitude to the use of amphetamines. Therefore, how a high-risk behaviour is defined is constructed around current community belief systems. It is not possible to eliminate these high-risk behaviours in the community. Drug use is an activity that humans have engaged in as far back as recorded history. Moreover, attempts to eliminate drug using have historically failed. The alcohol prohibitionist era in the USA is one example of this.

40 For a further discussion of harm reduction in the context of prevention, education and treatment, see Chapters 22, 23 and 26 respectively.

Figure 2.2: Availability of amphetamine inhalers on Pan Am flight menu in the 1940s



Source: Unknown⁴¹

Strategies of harm reduction

Many people find the concept of harm reduction difficult to fully understand because it seems to some that it is condoning drug use. Therefore, many myths have grown up around harm reduction including: it encourages drug use; it prevents drug users from getting out of the drug lifestyle; and it doesn't reduce harms.⁴² None of these ideas have been substantiated in research. Indeed, harm reduction has been shown to be an effective strategy through extensive research in Australia since 1985, as outlined below.

Australia's prevalence of drug use is less than the USA, which has prohibitionist policies, and rates of HIV/AIDS and other blood borne infections (BBI) are 3–4 times lower than those in the USA.⁴³ If it were true that harm reduction policies and strategies encouraged drug use and prevented people who use drugs from getting out of the drug lifestyle, we would expect to see that countries with strict prohibitionist policies and penalties for drug use, such as the USA and Sweden, would have much lower rates of drug use than those with harm reduction policies, but in fact the opposite is true. We would expect them to have lower rates of harms to individuals and communities, such as blood borne viruses (BBVs), death and crime; again, the opposite is true. Researchers have demonstrated significant reductions in crime, mortality (death)⁴⁴ and morbidity (illness such as blood borne infections)⁴⁵ as a result of the range of harm reduction policies in place in Australia.

One of the significant harms of illicit drugs is that, in Australia, they are not just illegal, but are specifically a *criminal* offence. An offence may be illegal and attract a civil fine or a criminal sanction. Most drug use, possession and trafficking is contained in crimes legislation.

41 For further examples of historical advertisements relating to the acceptance of amphetamines as a legitimate 'product', see Chapter 3.

42 Hunt 2003, < <http://www.forward-thinking-on-drugs.org/review2-print.html>>.

43 See www.alp.org.au/cm12_120813.

44 For example, www.kirby.unsw.edu.au/sites/default/files/hiv/attachment/EvalRep4SMSIC.pdf

45 For example, see Hilton et al. 2001.

Australia's cannabis law reform provides a recent example of the pragmatic nature of harm reduction policy in Australia. The assumed benefit of the criminalisation of cannabis is the deterrence of its use; however there is little evidence that there is a strong deterrent effect with these types of laws (Single et al. 2000). Research on deterrence of other forms of behaviour suggests that if the risk of detection and punishment is low, there is little deterrence effect, such as the case with cannabis use, which is typically used in private settings (Single et al. 2000). Since 1987 there have been progressive changes, starting in South Australia, moving towards the decriminalisation of possession of small amounts of cannabis for personal use. Consequences for possession include civil fines (ACT and NT) and mandatory counselling (WA). In NSW, Queensland, Victoria and Tasmania, possession of cannabis is still a criminal offence but diversion programs operate to divert offenders into treatment or education programs and out of the criminal justice system. Since the introduction of these changes there has been no discernible increase in cannabis use in that time. In fact, between 1995 and 2013 recent cannabis use has decreased among people over 14 years old from 17.6% to around 10%.⁴⁶ However, a large number of Australian citizens have been able to avoid a criminal conviction, which may have affected their travel and employment prospects for the rest of their lives.

In another example, in 2001 Portugal changed their drug laws to reduce the consequences of arrest for small amounts of *any* drug to a civil fine rather than a criminal offence. Possession of large quantities is still a criminal offence and possession is still illegal. Between 2001 and 2007 Portugal recorded increased uptake of treatment, reductions in new HIV cases, reductions in drug-related deaths, and a reduction in use among young people and 'problem' drug users that have been attributed to the new laws. In the same period, use of illicit drugs rose at approximately the same rate as surrounding countries without harm reduction laws (Hughes & Stevens 2010).

Therefore without condoning drug use, these legal approaches have been able to significantly reduce harms and have been active at a time of decreasing use.

Other drug-related harm reduction strategies include:

- ◆ Needle and syringe programs to reduce the spread of blood borne infections
- ◆ Programs to divert offenders from the criminal justice system to improve chances of recovery
- ◆ Overdose prevention activities, such as safe injecting rooms
- ◆ 'Chillout' spaces, supply of water and availability of peer support and medical facilities at festivals and dance parties
- ◆ Drink and drug drive testing (Ministerial Council on Drug Strategy 2011, *National Drug Strategy 2010–2015*).

National amphetamine-specific policies and initiatives

National Amphetamine Type Stimulant Strategy 2008-2011

In May 2006, the MCDS initiated development of a National Amphetamine Type Stimulants (ATS) Strategy, the first ATS-specific strategy to be developed in Australia (at the national and/or state/territory level). A consultation paper for the strategy was developed by the National Drug Research Institute and the Australian Institute of Criminology, with the

⁴⁶ See <http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs/2013/illicit-drug-use/> and Australian Institute of Health and Welfare 2011, *National Drug Strategy Household Survey report 2010*, Drug statistics series no. 25. Cat. no. PHE 145. Canberra: AIHW.

National Amphetamine Type Stimulants (ATS) Strategy Consultation Paper released in March 2007. In May 2008, the MCDS endorsed the first National Amphetamine-Type Stimulants Strategy 2008–2011.

The National Amphetamine-Type Stimulant Strategy 2008–2011 was developed within the existing National Drug Strategy framework. The National Amphetamine-Type Stimulant Strategy focused on prevention, supply reduction and treatment within a partnership framework. The overall goal of the ATS Strategy was to guide all levels of government in Australia to work collaboratively to reduce the availability and demand for illicit ATS and prevent use and harms across the Australian community. In doing so, it sought to reflect the National Drug Strategy: Australia's integrated framework 2004–2009, the current NDS at the time.

The strategy identified five priority areas:

1. *Community awareness and understanding of ATS use and related problems.* This priority area focused on identifying and communicating risks of use to the general community as well as high risk groups, and using social marketing to raise awareness of risks among those at risk of using.
2. *Supply of ATS.* This priority area focused on disrupting criminal groups and activities in the production, supply and trafficking of ATS, including importation of ATS and supply of precursor chemicals. It also focused on improving intelligence and information sharing among law enforcement agencies and ensuring that effective legislation existed to respond to ATS supply.
3. *Use of ATS.* This priority area focused on developing a strong evidence base for prevention activities. This included identifying strategies that impact on the broad determinants of health and social outcomes among illicit drug users, and improving the capacity of the education sector to implement prevention responses to ATS.
4. *Reduce problems associated with ATS.* This priority area focused on ensuring good information and education for the community, but particularly users, to prevent and reduce problems. This included introducing opportunistic brief interventions in the primary care sector especially for low level users; implementing effective assessment and referral protocols between agencies; broadening the range of best practice treatment options and access to treatment; better linking of offenders to treatment through police and court diversion to avoid risks of criminal record for minor offences (such as possession of small amounts for personal use); and developing strategies to reduce ATS intoxication and driving and in the workplace.
5. *Organisation and system capacity to respond to ATS problems.* This priority area focused on improving the capacity of the broader drug and alcohol workforce, including specialist and primary care sectors, to better respond to ATS use. It included addressing the needs of families and children affected by ATS problems; improving partnerships between mental health services and alcohol and other drug services; supporting clinical research capacity; and improving the understanding of other sectors about best practice treatment options.

As part of this strategy, the Australian Government offered substantial grants to a wide variety of agencies to develop and trial a range of new strategies to respond to ATS. These included the establishment of the Access Point Stimulant Treatment Centre,⁴⁷ websites, such as bluebelly⁴⁸ and meth.org.au to provide information to users. A range of trial treatment programs were also established.

47 www.accesspoint.org.au.

48 www.bluebelly.org.au.

In line with the general trend away from drug specific strategies, at both Australian and state/territory government levels, the National Amphetamine-Type Stimulant Strategy has not been renewed since it lapsed in 2011, and as such there is no current national strategy specifically focusing on ATS use, manufacture and related issues. Nor has there been a formal evaluation of this strategy.

In his evidence to the Inquiry, Professor Steve Allsop noted:

I think though it would serve us well to actually develop a new strategy with current concerns, and I think I would be particularly interested in focusing on what is happening in relation to methamphetamine. But I think we should also look at what is happening with other amphetamine-type stimulants as well. I do think it is a good time to actually look at the issue.⁴⁹

Treatment and services initiatives

In 2003, the Federal Government provided over \$300 million dollars in new funding for the National Illicit Drugs Strategy (over four years) to develop better amphetamine treatment and services program to respond to ATS use. This is in response to an increase in use from the 1980s, just prior to the heroin drought, which became apparent around 2001. While it is now clear that the rise in amphetamine use at that time was not related to the heroin drought, the significant reduction in heroin-related harms, including fatal and non-fatal overdoses, as a result of the reduced supply of heroin shifted the focus of drug policy and funding to the issue of amphetamines.

As such, a range of ATS-relevant policy and activity were initiated, including:

- ◆ \$2 million for the National Psychostimulants Initiative (NPI)⁵⁰ to identify good practice models for treatment and provide training and support for general practitioners and health workers. Over \$15 million has been provided to the NPI from 2003-04 to 2009-10 to undertake prevention, harm reduction and educational activities. The 2006–2010 phase of the NPI focused on strengthening the capacity of frontline workers to deal more effectively with users of psychostimulants.
- ◆ \$4.4 million for the National Comorbidity Initiative to improve coordination and responses to individuals who had both mental health and drug use issues.

In May 2007, the federal government committed \$150 million in new funding for drug and alcohol issues (for 2007-08 to 2010-11) as part of the 2007-2008 budget, including:

- ◆ \$22.9 million for Amphetamine-Type Stimulants Grants Program
- ◆ \$9.2 million to add to the National Drug Campaign.

Manufacture and importation initiatives

In 2002, the 'National Working Group on the Prevention of the Diversion of Precursor Chemicals' (the Precursor Working Group), was established.⁵¹ It focused on addressing the diversion of pseudoephedrine and other precursor chemicals from both legitimate and illegitimate sources, including pharmacies.⁵²

In 2003, \$5.4 million was allocated from new National Illicit Drugs Strategy funding for a National Strategy to Prevent the Diversion of Precursor Chemicals into Illicit Drug Manufacture (2003-04 to 2007-08). In 2008, the National Strategy to Prevent the Diversion

49 Professor Steve Allsop, Professor and Director, National Drug Research Institute, Curtin University, Public Hearing (via video conference), Canberra, 11 February 2014.

50 www.health.gov.au/internet/main/publishing.nsf/Content/phd-npi-index.

51 www.pc.gov.au/__data/assets/pdf_file/0011/69356/sub032.pdf.

52 For further discussion of this initiative see Chapter 20.

of Precursor Chemicals into Illicit Drug Manufacture (National Precursor Strategy) received recurrent funding of \$1.068m.

In December 2005, the Parliamentary Joint Committee on the Australian Crime Commission initiated an inquiry into the manufacture, importation and use of Amphetamines and Other Synthetic Drugs (AOSD) in Australia.⁵³ The report from this inquiry was released in February 2007. Recommendations of this report included the standardisation of analysis and data collection, continuation of Project STOP (the system to track pharmacy sales of pseudoephedrine), national constancy in legislative approaches and greater attention to harm reduction and prevention strategies.⁵⁴

In May 2007, \$37.9 was allocated to improve law enforcement response to amphetamines production/supply through the federal government's \$150 million in new funding for drug and alcohol issues (for 2007-08 to 2010-11) as part of the 2007-2008 budget. The same year, Project STOP was rolled out nationally (after being piloted in QLD) as part of the 'National Strategy to Prevent the Diversion of Precursor Chemicals into Illicit Drug Manufacture'.

In May 2010, the 'National Framework For The Control Of Precursor Chemicals And Equipment'⁵⁵ was endorsed, aiming to deliver a nationally consistent approach to the control of precursor chemicals. The Framework was considered an important strategy to disrupt the production and supply of illicit drugs (as aligned with NDS supply reduction pillar). The lack of consistent regulation of key precursor chemicals used in the illegal production of ATS was emphasised as part of the background and development of the Framework.

The continuing domestic production of ATS (including the involvement of organised crime), increases in ATS arrests, and manifestations of extreme behaviour in ATS users have been identified as challenges for the 2010–2015 NDS.

Table 2.1: Timeline of ATS policy initiatives in Australia

2002	<ul style="list-style-type: none"> • National Working Group on the Prevention of the Diversion of Precursor Chemicals' established
2003	<ul style="list-style-type: none"> • National Psychostimulants Initiative • National Comorbidity Initiative • National Strategy to Prevent the Diversion of Precursor Chemicals into Illicit Drug Manufacture
2005	<ul style="list-style-type: none"> • Parliamentary Joint Committee on the Australian Crime Commission initiated an inquiry into the manufacture, importation and use of Amphetamines and Other Synthetic Drugs (AOSD) in Australia
2007	<ul style="list-style-type: none"> • Additional funds to assist in ATS-related law enforcement • Project STOP • National ATS Grants Program • Additional funding to support ATS related activities to the National Drug Campaign
2008	<ul style="list-style-type: none"> • National Amphetamine-Type Stimulants Strategy 2008-2011
2010	<ul style="list-style-type: none"> • National Framework For The Control Of Precursor Chemicals And Equipment endorsed

53 www.dldocs.stir.ac.uk/documents/australaosd.pdf.

54 See Chapter 20 for further discussion of Program Stop.

55 www.nicnas.gov.au/about-nicnas/regulatory-partners/illegal-drugs-precursor-chemicals.

Drug policy in states/territories other than Victoria

Each jurisdiction operates its own local strategy responses according to local conditions. Each sits under the umbrella provided by the NDS, including the harm minimisation framework, but focuses on specific issues relevant to the jurisdictional priorities. Any account of specific state drug strategies also needs to be read in conjunction with Chapter 18 which gives a comprehensive account of drug laws federally and in each of the states and territories. Law and legal policy is an important component of addressing issues pertaining to substance use including methamphetamine. The law both shapes and is shaped by drug policy. For example, as discussed in Chapter 18 each state has laws which ascribe lower penalties for cannabis use, most commonly through a cautioning program. This is an instance of the law reflecting the policy evidence that the use of cannabis is relatively less harmful to both the user and society as a whole than 'hard' drugs such as heroin or methamphetamine. The following section provides a brief overview of key policy initiatives related to methamphetamine in each state.

ACT

The current ACT policy is the 'ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014'. It is a general drug policy operating under six key principles:

- ◆ Harm minimisation, addressing all drugs, and implementing interventions across drug demand reduction, supply reduction and harm reduction
- ◆ Applying evidence-informed practice
- ◆ Enhancing health promotion, early intervention and resilience building
- ◆ Recognition of social determinants of health and well-being
- ◆ Increasing access to welcoming services, and
- ◆ Strengthening partnerships, collaborations and ownership.

ACT does not currently have a specific methamphetamine strategy, but the current Strategy notes a problematic trend of young illicit drug users moving to more potent forms of amphetamines as a key area to address (ACT Government 2010).

New South Wales

NSW currently has no active drug and alcohol policy. The previous 'NSW Health Drug and Alcohol Plan 2006–2010', based around three priority areas (prevention, brief and early intervention, and treatment and extended care) has now lapsed. A new policy is in development and due to be completed in 2014. NSW has no specific methamphetamine-related policy.⁵⁶

Northern Territory

NT's most recent strategy, 'Strategic Directions for 2009–12 Priority Action Area — Targeting Smoking, Alcohol and Substance Abuse', has now lapsed. There are no ATS specific actions contained in the policy.

In 2013, in response to evidence of significant increases in the manufacture and distribution of methamphetamine across Australia, the NT Government introduced the *Misuse of Drugs Amendment (Methamphetamine) Act 2013*. Passed in March 2014, this amendment removed methamphetamine from Schedule 2 of the Act and placed it in Schedule 1. This increased penalties for the possession or supply of trafficable and commercial quantities of the drug. This Act allows for police to charge a person not only with 'supply to a person' but for the aggravated circumstance of 'supplying to a place that was at the time of the offending an

⁵⁶ Department of Health, NSW Government (personal communication, July 2014).

“Indigenous community” when it involves cannabis or amphetamines. The Act increases the maximum penalty for such actions, from five to nine years imprisonment (Hughes 2014).

Queensland

The most recent Queensland Drug Action Plan (2011-2012) has expired. Despite the relatively high rates of methamphetamine use in Queensland, there were no ATS specific priorities or actions, apart from one action related to curtail diversion of precursor chemicals. Previously, in December 2006, the Queensland Premier and Minister for Health established an ‘Ice Breaker Strategy Taskforce’ to oversee the development and implementation of a Queensland Government’s Ice-Breaker Strategy to reduce uptake, use and harms associated with methamphetamine use, but this Strategy has not been renewed (Queensland Government 2011).

South Australia

The current SA drug strategy is ‘South Australian Alcohol and Other Drug Strategy 2011–2016’. The strategy has four primary objectives: 1) reduce illicit drug use and harms; 2) reduce the rate of alcohol-related harm; 3) reduce drug-related harm to young people and families of those with substance misuse issues; and 4) reduce harm from substance misuse among Aboriginal people.

Although there are general actions on illicit drugs there are no actions relating to methamphetamine specifically.

Previously the SA Drug Summit held in June 2002 identified new directions for SA and gave rise to 51 recommendations, with responses to amphetamines a key focus. In October 2008, amendments to the *Controlled Substances Act* 1984 made possession of 30 different pieces of equipment involved in amphetamine or cannabis manufacturing or cultivation (e.g. high intensity lamps, carbon filters, tablet presses and distilling devices and possession of documents containing instructions for the manufacture or cultivation of illicit substances) punishable with \$10,000 fine and/or two years imprisonment (Drug and Alcohol Services South Australia 2011).⁵⁷

Tasmania

The current policy in Tasmania is the ‘Tasmanian Drug Strategy 2013–2018’. There are no specific methamphetamine actions or priority areas. Previously the Tasmanian Inter Agency Working Group on Drugs developed the Tasmanian Psychostimulants Action Plan 2007–2009 as a sub-strategy of the Tasmanian Drug Strategy. Following two internal reviews it continued to be identified as a priority and was extended to the end of 2013. The current ‘Tasmanian Drug Strategy 2013–2018’ notes that drug use trends have since changed in Tasmania, and they are moving to develop a broader Illicit Drugs (including Pharmaceuticals) Action Plan (Tasmanian Government 2013).

Western Australia

The WA Illicit Amphetamine Drug Summit was held in July 2007 to identify and develop strategies to respond to amphetamines. Following the summit a Government Action Plan was adopted, including 49 initiatives arising from the Drug Summit. In 2012, the Illicit Drug Support Plan 2012–2015, a supporting document to the Drug and Alcohol Interagency Strategic Framework for Western Australia 2011–2015, was released. This outlines the priority areas and strategies for the coming years. The priority drugs of concern are: 1) Cannabis and synthetic cannabinoids; 2) amphetamines and amphetamine-type substances (including ecstasy); and 3) heroin and other opioids (WA Drug and Alcohol Office 2011).

57 See Chapter 18 and Appendix 11.

Victorian drug policy

Reducing the alcohol and drug toll: Victoria's plan 2013–2017

Victoria's first alcohol and drug strategy was released in 1985, and since that time various iterations have been developed and implemented, with 'Reducing the alcohol and drug toll: Victoria's plan 2013–2017' currently in place. The strategy is based around a 15-point plan including responses to alcohol, pharmaceutical and illicit drugs⁵⁸ and is consistent with the NDS framework. The 15 points are:

Alcohol

1. Reducing alcohol-related violence, antisocial behaviour and drink-driving
2. Effective liquor regulation
3. Changing drinking culture
4. Better health promotion in education
5. Better, earlier healthcare for alcohol problems

Pharmaceutical drugs

6. Better controls and evidence on misused pharmaceutical drugs
7. Improved clinical, prescribing and dispensing practices

Illegal drugs

8. Strong laws to protect the community from drug trafficking
9. Better referral of drug users to treatment
10. Improved harm-reduction services and targeted prevention

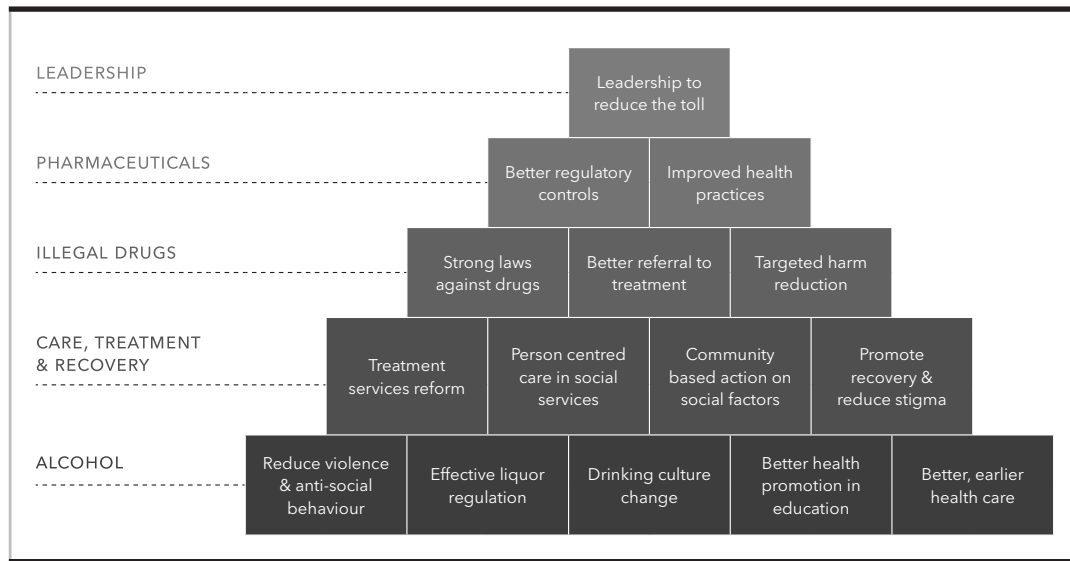
Care, treatment and recovery

11. New directions in alcohol and drug treatment services
12. Better person-centred care through social services, especially for vulnerable families
13. Community-based action on social factors driving substance misuse
14. Promoting successful recovery and reducing stigma in the community

Leadership

15. Leadership to reduce the toll (Department of Health (Vic) 2012).

58 [docs.health.vic.gov.au/docs/doc/1D4BF7FF3C551C4DCA257AFD00707A93/\\$FILE/Reducing-AOD-toll.pdf](https://docs.health.vic.gov.au/docs/doc/1D4BF7FF3C551C4DCA257AFD00707A93/$FILE/Reducing-AOD-toll.pdf).

Figure 2.3: Victoria's 15-point alcohol and drug plan

Source: Department of Health (2012) Reducing the alcohol and drug toll: Victoria's plan 2013-2017. Melbourne: State of Victoria.

There are no specific interventions or programs addressing the supply, demand or harms associated with methamphetamine, and the key performance indicators for the strategy do not include reduction in harms from illicit drugs.

However, points 8–10 refer to strategies for illicit drugs including a focus on trafficking, better referral of drug users into treatment and improved harm reduction services which will have potential impacts on methamphetamine responses. The redevelopment of the service system to be more responsive and person-centred (points 11, 12) and promoting successful recovery (point 13) has the potential to improve services for methamphetamine users. Although not specifically related to methamphetamine, better controls and improved prescribing practices (points 6 and 7) may assist with reducing potential diversion of pharmaceutical amphetamines to the street market.

Drug driving

In December 2004, Victoria Police commenced a pilot of roadside drug saliva testing for cannabis and amphetamines. The pilot testing targeted heavy vehicle drivers, rave party patrons and the general public. This was the first roadside drug saliva testing program in Australia, with other jurisdictions subsequently implementing comparable initiatives (Tasmania in 2005, NSW, QLD and WA in 2007, NT in 2008, and ACT in 2010). See Chapter 7 for discussion on methamphetamine and driving.

Victorian amphetamine-type stimulant (ATS) and related drugs strategy

In March 2007 the New Mental Health and Drugs Division commenced operation and the Minister for Mental Health convened Victoria's first drug taskforce on 'ice' and amphetamines to guide the state government's strategy. In September 2007, the Victorian Department of Human Services released the discussion paper '*Victorian amphetamine-type stimulant (ATS) and related drugs strategy 2007–2010*'.

In April 2009, the first Victorian Amphetamine-Type Stimulants and Related Drugs Strategy 2009–2012 was adopted. The strategy had five priorities: prevention and early intervention; treatment; workforce development; justice and law enforcement; and new knowledge collection and dissemination. Since this strategy expired in 2012, Victoria has been without an ATS-specific policy.

The specific versus general drug policy debate

As previously noted, there has been a general move away from the development of specific drug policies at both Commonwealth and state/territory level to a system of frameworks and action plans that sit under the broader National Drug Strategy. As an example, most recently the development of the intended National Pharmaceutical Misuse Strategy was recently endorsed as the National Pharmaceutical Misuse *Framework for Action* 2012–2015.

Ms Judith Abbott from the Victorian Department of Health, noted:

In the past we did quite a few substance specific strategies...Over recent years there has been a move, both at a national and a state level, towards a broader approach to illegal drugs that recognises that intervention is the kind of response required across all illegal drug types for reduction of supply, reduction of demand and harm reduction. We have seen a shift away from substance specific approaches to those broader approaches that give the framework and then move on all the actions that go underneath that. That is the approach adopted in the National Drug Strategy and it is also the approach adopted in the current government's Whole of Government Victorian Alcohol and Drug Strategy that was released in January last year: 'Reducing the alcohol and drug toll: Victoria's plan 2013-2017'.

However, at least one specific national strategy is being continued and appears to be effective; the Australian Government continues to commit to a National Tobacco Strategy (currently 2012–2018), and the reduction in smoking prevalence has been significant in Australia. New data shows the smoking rate continues to decline, with percentage of daily smokers declining from 15.1% in 2010 to 12.8% in 2013, a reduction in uptake of smoking among young people and a reduction in average number of cigarettes smoked per week (from 111 in 2010 to 96 in 2013).⁵⁹ These data also show that daily smoking rates have almost halved since 1991 (then 24.3%).

The policy contains both strategy and targets for reduction of smoking and smoking-related harms. Arguably, Australia needs a specific tobacco policy because smoking is the leading cause of death and disease in Australia. This is compared to the impact of other drugs, such as methamphetamine, which have less widespread impacts in the community and on health budgets.

However, while national frameworks provide the 'big picture' direction for responses across Australia, in the absence of drug-specific strategies, specific frameworks and action plans are still required to provide more detailed direction for the community (including the treatment, research and policy) in their responses to methamphetamine-related issues. Without Commonwealth or state-based specific strategies there is a significant gap between the current NDS and the application of the strategy in the community in Victoria.⁶⁰

Concerns among the community about different drugs come and go, largely influenced by community interest. That is, even though specific drugs come to the attention of the community at various times (now methamphetamine) there has actually been little change in the population use of most drugs in the last 10 years and statistically significant shifts have been relatively minor, suggesting interest in specific drugs is not related to significant changes in patterns.

But specific drugs do have different drug use prevalence rates, routes of administration and harms associated with their use. There is an argument, therefore, for a consistent set of national and state action plans for specific drugs that are maintained over time, but can be updated to respond to changes in use as needed, such as the recent shift from powder methamphetamine (speed) to crystalline methamphetamine (ice).

59 <http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs/>

60 Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

In his evidence to the Inquiry, Gino Vumbuca noted:

It [a policy] can provide a broad outline of how government should respond at a strategic level; what is needed is almost like an action plan or the next level down from there of what services should do.

The need for a strategic approach with a clear action plan is discussed further in Chapter 31.

Conclusion

Australia has relied on a harm minimisation approach, which includes demand reduction, supply reduction and harm reduction measures, in its NDS since its inception. It is a pragmatic and compassionate stance that seeks to balance effective responding to problems of drug use among individuals and the community with reducing the risk of stigma and marginalisation to users themselves.

While the harm minimisation approach has its critics, the evidence is clear that it has been effective in reducing both drug use and harms to the community and among individuals.

Previously, at both the state and national level there was a focus on the development of specific drug policies, such as the National Amphetamine-Type Stimulant Strategy, in conjunction with the NDS and state strategies. However, most of these specific drug strategies have lapsed and there is a general move away from specific drug strategies to relying on a single overarching alcohol and other drug strategy at both levels of government.

This approach leaves a significant gap between the overarching drug strategies and the application of the strategies for specific drugs in the community in Victoria. There is currently no document that assists health, justice or other sectors to implement policy with respect to methamphetamine (or other drugs). There is a need for a consistent set of national and state action plans for specific drugs that are maintained over time but can be regularly updated to respond to shifts in drug use patterns, such as the recent shifts from methamphetamine powder to crystalline methamphetamine.

PART B

The Nature and Extent of Methamphetamine Use

3. Understanding Methamphetamine — the Drug and its Use

Introduction

Methamphetamine is by no means a ‘new’ drug, even if fears about an ‘ice epidemic’ sweeping the country are a relatively recent phenomenon. It is important to note that just as morphine/heroin may have been included in patent cough medicines early in the 20th century, so too amphetamine and methamphetamine enjoyed widespread acceptance as legitimate, safe and therapeutic drugs among the medical profession and the general public well into the 1950s (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2009).

Nonetheless, in recent years there has been ‘a steady worldwide increase in amphetamine type stimulants [including methamphetamine] use over the last decade or so, and a significant number of people consume these drugs’ (Allsop & Lee 2012, p.1). The United Nations Office on Drugs and Crime (UNODC) have estimated that between 15 million and 53 million people worldwide have used amphetamine type stimulants at least once in the previous year (UNODC 2010).⁶¹ Despite this high prevalence, evidence about the effects of the drug and associated risks and harms are still accumulating (Allsop & Lee 2012).

The use and effects of methamphetamine are influenced by a wide range of factors. As with all drugs, such factors include the composition, pharmacology, mode of use and purity of the drug. The use of methamphetamine must also be seen within a social context, including the background and history of the drug’s use.

A history of amphetamines and methamphetamine⁶²

To understand the evolution of methamphetamine it is necessary to comprehend the history of the parent amphetamine class of drug.

Amphetamine (amphetamine sulphate) was originally synthesised in 1887 by German and Romanian chemists. It was first marketed and used in the 1920s as a decongestant and to treat obesity and depression, although even during these years it was recognised that the drug could be abused by some people for mood elevation purposes rather than as a decongestant (Majumder & White 2012). Because of its effects in bronchial passage dilation, however, it was also used in the 1930s as a nasal spray for treating asthma and the common cold:

Subsequent studies showed that the drug was also helpful in providing relief from narcolepsy, reducing activity in hyperactive children, suppressing appetite and enabling individuals (such as students and truck drivers) to stay awake for extended periods of time. In the 1930s and 1940s, amphetamine

61 See Chapter 5.

62 Rasmussen (2008) gives a comprehensive account of the history, evolution and associated politics of amphetamine and methamphetamine. Rasmussen traces the various ‘epidemics’ associated with methamphetamine starting in 1929 and re-occurring in the 1940s, 1960s and to the present day. Fascinating parallels are made between these epidemics past and present and how they were (and are being) addressed. Other useful historical overviews include that of Anglin et al. 2000. For an account of why methamphetamine may not have been as prevalent or popular in Europe as in the United States or Australia, see EMCDDA 2009.

was used in treating a variety of other conditions and disorders including schizophrenia, morphine addiction, tobacco smoking, low blood pressure, radiation sickness, and even persistent hiccups (Anglin et al. 2000, p.138).

In the early 1930s the American chemist Gordon Alles resynthesised amphetamine into orally available sulphate and hydrochloride forms, later to be marketed under the trade name Benzedrine by pharmaceutical company Smith, Kline & French (Carson et al. 2012).

During World War II and the Korean and Vietnam Wars, soldiers on all sides of the conflicts were given amphetamine to keep them awake, to give them more energy and to suppress their appetites (Anglin et al. 2000). In Germany, amphetamines became colloquially known as 'Pilot's salt' or Pilot's chocolate' (EMCDDA 2009; Zabransky 2007). Historical evidence suggests that Adolf Hitler used amphetamines and methamphetamine as an energy supplement to assist in the prosecution of the war (Rasmussen 2008).⁶³ It was also used for the same reasons by astronauts in the American space program (Grinspoon & Hedblom 1975; Rasmussen 2008).⁶⁴

Amphetamine was readily available without a prescription in the United States until the early 1950s, and Benzedrine (amphetamine) inhalers were available over the counter until 1960 and even for sale on commercial airline flights. During this period women were predominant users of amphetamines, particularly for weight loss, depression and anxiety or tiredness and non-specific pain (Rasmussen 2008). Prescriptions for amphetamine tablets were one of the major ways of treating obesity and depression during the 1960s. It was only by the 1970s that:

[t]he dangers associated with the use of amphetamine were better understood, and additional restrictions were placed on the amount that could be legally produced and how it could be distributed. Increased levels of illicit production ensued, originally limited to motorcycle gangs and other independent groups... At the same time, the typical user population changed from white, blue-collar workers to include college students, young professionals, minorities, and women (Anglin et al. 2000, p.138).⁶⁵

That amphetamines were being marketed as legitimate products for weight loss and depression, particularly for stay at home 'housewives' can be seen from the range of 1950s and 1960s magazine advertisements presented in Figure 3.1:

-
- 63 Another world leader who allegedly took methamphetamine was President John Kennedy. In this case to assuage the pain of his back injuries received in wartime combat and to assist in maintaining the air of youthful vigour he wished to promote (Rasmussen 2008).
- 64 Rasmussen recounts that in the immediate postwar years military prisoners in the United States were found to be eating the contents of Benzedrine inhalers which then contained 250 grams of amphetamine base. Strong evidence existed that Benzedrine abuse 'although an existing practice was multiplied many times by military exposure' (2008, p.2).
- 65 Jenkins states that before the 1960s, law enforcement agencies such as the FBI were almost totally uninterested in amphetamine pills. Such agencies were much more focused on heroin, cocaine and marijuana. By 1970, however, the Commissioner of the Food and Drug Administration was to state that half of the legally produced amphetamine pills were being diverted for illicit purposes: 'an amazing four or five billion pills each year' (Jenkins 1999, p.32).

Figure 3.1: Magazine advertisements for amphetamine products from the 1950s and 1960s



Source: Reproduced in <http://www.decodog.com/inven/MD/md30563.jpg>.

Methamphetamine

Methamphetamine was first synthesised from ephedrine, itself a form of amphetamine, in Japan by chemist Nagayoshi Nagai in 1893. The crystallised form of the drug was produced in 1918 by Akira Ogata and marketed under the trade name Pervitin by German pharmaceutical company Temmler (Carson et al. 2012). However:

Methamphetamine did not become widely used until World War 2 when Japan, Germany and the United States provided the drug to military personnel to increase endurance and performance... [it] was also used in Japan to improve productivity of civilian factory workers in military support

industries. Beginning in 1941, methamphetamine was sold over the counter [and] advertised as a product 'to fight sleepiness and enhance vitality'. Widespread abuse occurred only after the war when methamphetamine from surplus army stocks flooded the market leading [in Japan] to the so-called 'First Epidemic' (Anglin et al. 2000, p.138).

It was estimated that at the peak of this 'epidemic' 1.5 million Japanese were injecting methamphetamine (Grinspoon & Hedblom 1975). In a review of the history of amphetamine and methamphetamine abuse, Hall and Hando state that similar epidemics of amphetamine and methamphetamine use occurred in Sweden in the 1940s, 1950s and 1960s, the United States in the late 1960s and early 1970s, Japan again in the 1970s (the 'Second Epidemic'), and the United Kingdom in the late 1950s and the late 1960s (Hall & Hando 1993):

There are indications that there was a smaller epidemic of amphetamine use in Australia in the middle and late 1960s. During this time there was a large increase in the prescription of amphetamines by general practitioners, increased use of amphetamines among young offenders and young adults attending psychiatric hospitals...and an increase in the prevalence of persons diagnosed with amphetamine psychoses (Hall & Hando 1993, p.59).

By the 1960s in the United States, widespread consumption of amphetamines and to a lesser extent methamphetamine, largely fuelled by the sale of wartime surplus stocks, had begun to make the negative side effects of the drug more evident. Psychotic episodes, originally thought to be attributable to schizophrenia 'unmasked' by the drug's administration, were now being viewed as possibly part of a drug-related syndrome (Rasmussen 2008).⁶⁶ Later in the decade the market in amphetamines and methamphetamine had changed from being predominantly licit to illicit. The black market consisted first of the diversion of supplies from pharmaceutical companies, chemists and doctors. It then developed into the synthesis, manufacture and distribution of amphetamines and methamphetamine by motor cycle gangs and other criminal gangs and syndicates, particularly on the Pacific Coast of the United States. Clandestine laboratories in California and Mexico are now the primary sources of methamphetamine available in the United States (Anglin et al. 2000; Cherney, O'Reilly & Grabosky 2005).⁶⁷

A shift in attitude

In Australia, as in Britain, Europe and to a lesser extent the United States:

[a]mphetamine use was fuelled by a combination of ready availability and perceived safety by users and the medical profession (Hall & Hando 1993, p.60).

It was only when the medical profession began noticing links between heavy amphetamine use and an increase in paranoid psychoses (and to a lesser extent violence)⁶⁸ that questions were raised about the advisability of prescribing amphetamines and methamphetamine in a partially unregulated way. By the 1960s it was also becoming apparent that amphetamines and methamphetamine could be truly addictive rather than merely 'habituating' in the same manner as caffeine (Rasmussen 2008):

Once the abuse potential of amphetamines was recognised...their availability on medical prescription was severely restricted. This had two main consequences. First, the existence of a large market of users provided the incentive for the illicit manufacture and distribution of amphetamines, with a result that many of the later epidemics were supplied by the black market. Second, the development of a black market in turn changed the characteristics of the users. The proportion of amphetamine users who were middle class, middle aged women who used oral amphetamine declined while the proportion

66 See Chapter 6 for a discussion of methamphetamine related psychosis.

67 For a comprehensive account of the history of supply control measures for methamphetamine and its precursors see Cherney, O'Reilly and Grabosky (2005). See also the discussion in Chapter 20 of this Report.

68 For a discussion of the (somewhat tenuous) links between methamphetamine use and violent behaviour, see Chapter 6.

of younger male users correspondingly increased. The latter were primarily recruited from the drug subculture, where injection, the most hazardous form of administration, was the preferred route.⁶⁹ In this way the changes in the pattern of amphetamine use, and in the characteristics of users, mirrored that which occurred earlier in the century with morphine and heroin use (Hall & Hando 1993, p.60).

Given these concerns, amphetamines and methamphetamine were listed as controlled substances under the *United Nations Convention on Psychotropic Substances* in 1971. Consequently, as the legitimate use of methamphetamine was limited and there were fewer opportunities to obtain supplies through regular sources, illegally manufactured amphetamine and methamphetamine, often through diverted precursor chemicals such as pseudoephedrine, became more prevalent.

Historical perspectives on amphetamine and methamphetamine use in Australia

The evolution of amphetamine and methamphetamine use in Australia largely followed the trajectory of other countries such as the United States. Use of the drugs up until the 1960s was largely for legitimate medical purposes (controlling obesity, anxiety, depression etc). By the 1970s the therapeutic utility of amphetamine type stimulants was recognised to be limited and controls became more stringent (Cherney, O'Reilly & Grabosky 2005). Despite such developments, amphetamine abuse in Australia was never as much of a concern, at least in the public realm, as drug issues pertaining to heroin and to a lesser extent cocaine.

In the mid to late 1980s there was fear of a major cocaine epidemic in Australia. Hall and Hando argue that this was one of the reasons so little was known about amphetamine use in Australia. These fears turned out to be largely unfounded and 'distracted attention from an emerging home grown amphetamine epidemic' (Hall & Hando 1993 cited in Burrows, Flaherty & MacAvoy 1993, p.61).

As a consequence, most of what is known about amphetamine use in Australia has been gathered *en passant* in the course of research on the use of cocaine...or on the risks of HIV transmission among injecting drug users (Hall & Hando 1993 cited in Burrows, Flaherty & MacAvoy 1993, p.61).

As a result of growing concerns, in 1991 the Ministerial Council on Drug Strategy endorsed a *National Action Plan on Problems Associated with Amphetamine Use*. Under the plan, research into the extent, nature, use and treatment of amphetamines/methamphetamine and methamphetamine-related problems became a priority.

By the mid-1990s the use of methamphetamine and other amphetamine type stimulants (ATS) was being viewed with growing concern in Australia and from a global perspective. In 1996 the United Nations convened two expert meetings to consider ATS use and related problems. Following this, a number of regional and global Action Plans dealing with supply and demand reduction of ATS were developed (see Henry-Edwards & Ali 2000).

Notwithstanding such approaches, by the late-1990s–early-2000s, the crystallised form of methamphetamine or 'ice' was becoming more prevalent in Australia. This was partly due to the so-called 'heroin drought' with methamphetamine supplanting heroin in both use and popularity. It was also being portrayed in media accounts as the new 'demon drug' (Groves & Marmo 2009; McKetin et al. 2013b).⁷⁰ Greater availability of the precursor pseudoephedrine and an increase in domestic manufacture of methamphetamine also fuelled the change to 'ice' as a preferred drug of choice in Australia (Groves & Marmo 2009, pp.416-417).

69 This was not helped by the fact that a liquid form of methamphetamine was being used in the 1960s as a treatment for heroin addiction and 'quickly contributed to a new abuse pattern involving injections of methamphetamine, either alone or with heroin' (Ray & Ksir 1996 cited in Anglin et al. 2000, p.138).

70 See Chapter 24 for a discussion of the media and its reporting of methamphetamine.

Despite the somewhat chequered history of ATS, even today they are still legitimately used therapeutically for some forms of anxiety, mood and neurological disorders⁷¹ particularly in the United States (Carson et al. 2012).⁷² But such use is nonetheless controversial 'given evidence that long term outcomes with chronic stimulant treatment may not necessarily be beneficial and may even lead to further health problems' (Carson et al. 2012, p.34).⁷³ However, the ongoing therapeutic use of methamphetamine does not occur to the same degree in Australia.

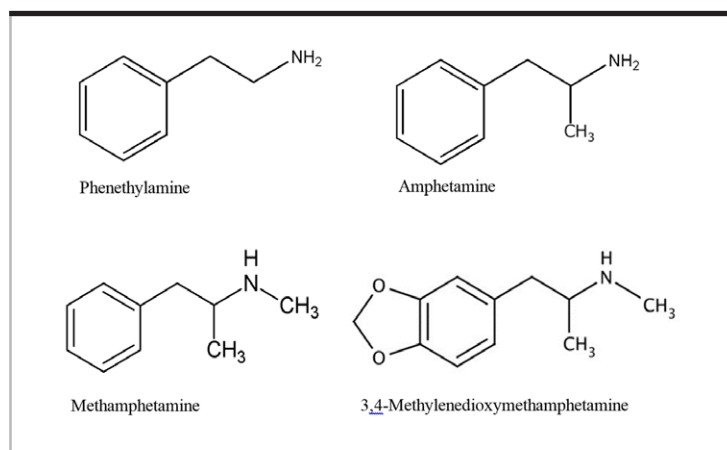
Pharmacology of methamphetamine⁷⁴

Methamphetamine is part of the family of drugs broadly referred to as amphetamine type stimulants (ATS). They are similar to the naturally occurring phenethylamines in the central nervous system and include the parent compound amphetamine, methamphetamine, 3,4-methylenedioxymethamphetamine (MDMA or Ecstasy) and methylphenidate (Ritalin) (Figure 3.2 shows the differences in molecular structure between the different amphetamine and methamphetamine compounds). S-methamphetamine hydrochloride is the crystallised version of methamphetamine commonly known as crystal meth or 'ice':

Chemically, amphetamine and methamphetamine are closely related. Both exert their effects indirectly by stimulating the release of peripheral and central monoamines (principally dopamine, noradrenaline, adrenaline and serotonin) and both have psychomotor, cardiovascular, anorexogenic and hyperthermic properties (Topp, Degenhardt et al. 2002, p.342).

Methamphetamine, unlike cocaine, cannabis or other plant based drugs, is a purely synthetic substance. It differs from amphetamine only in the addition of a methyl group on the chemical chain (Dean 2004; Lee et al. 2007). Because of this slight structural difference and greater lipophilic properties (its ability to cross the blood brain barrier more easily) methamphetamine produces a stronger central nervous system response than amphetamine (Australian Crime Commission 2013a; Rose & Grant 2008). The elimination half-life of methamphetamine is approximately 10 hours (Majumder & White 2012; Cruickshank & Dyer 2009):

Figure 3.2: Chemical structure of phenethylamine and typical amphetamine type stimulants



Source: Carson et al. in Allsop and Lee 2012, p.34.

71 Including treatment of obsessive compulsive disorders and ADHD, see discussion in Chapter 14.

72 In the United States under the trade name of *Dexosyn* (see McKetin et al. 2013b, p.690).

73 See also discussion in Chapter 14.

74 For an expert overview of the chemical and molecular pharmacology and clinical pharmacokinetics of methamphetamine, see Topp, Degenhardt et al. 2002; Darke et al. 2008; Cruickshank and Dyer 2009; Majumder and White 2012; McKetin et al. 2013b; Carson et al. 2012.

Methamphetamine is more potent than amphetamine and therefore has a stronger effect on the central nervous system. The primary action of methamphetamine is on dopamine neurotransmitters, with increases in released dopamine in the brain's pathways resulting in the euphoric and pleasurable effects of the drug (McKetin 2013b). When a person stops using methamphetamine and the body has been depleted of its dopamine and serotonin levels, the pleasurable feelings wane and the body craves more of the drug to stimulate the euphoria. Depending on the level of use and the health of the user, it may take up to two months for the neurotransmitter balance of dopamine, noradrenaline and serotonin to normalise without further drug use. In the meantime, because of the depletion of these naturally occurring 'feel good' chemicals, the person using the drug may feel quite substantial levels of depression until the serotonin and dopamine systems recover.⁷⁵

Terminology

Medical and drug policy names and classifications for ATS differ from the names for drugs that are used on the street. The former systems use chemical names whilst street names incorporate slang. Moreover, street drug terminology is location specific, not standardised, and continues to change over time (McKetin, McLaren & Kelly 2005). Confusion sometimes arises relating to the difference between amphetamines and methamphetamine and particularly the use of the term 'speed'. Traditionally this was used for the powdered form of the drug amphetamine sulphate but now more readily used in the context of methamphetamine. To confuse matters further sometimes 'speed' may be used to refer to the generic or collective form of amphetamine or methamphetamine. In this Report the term amphetamine denotes the sulphate salt amphetamine (amphetamine sulphate) whilst methamphetamine includes all forms of methamphetamine but not derivatives such as MDMA (Ecstasy). When specifically referring to the crystallised highly pure form of methamphetamine, the Report uses the term crystal methamphetamine unless the context specifies otherwise.

Challenges posed by drug terminology

Drug terminology is highly colloquial. As indicated above, it is unlikely that 'street' users of methamphetamine, as with any other type of drug, will refer to the formal chemical name of the drug or its compounds. That street terms may not accurately reflect or refer to the actual drugs used is clearly problematic as referred to in the following quotes from medical witnesses to the Inquiry:

People call it [the drug they have taken] different things. There is a whole evolution of names from ice to shard but if they present, 'I've taken shard', that might be all that they know it is, when in fact it is methamphetamine. The naming is an issue as well.

...Sometimes doctors do not feel comfortable saying, 'Sorry, what is shard?' If I hear a term I do not know, I feel quite comfortable saying, 'Sorry, what is that?' whereas a lot of our doctors do not feel comfortable talking about illicit substances. There may be some judgment on their behalf or they do not want to offend the person or look like they do not know. 'Speed' was the term that we used to see used only for amphetamines locally but now a lot of people when they say 'speed' they mean methamphetamine. That is what is being produced locally and used locally. Terms can mean different things in different areas and people use the same term to mean different things. It is also the fact that the colloquialisms or vernacular can change or mean different things to different people.⁷⁶

⁷⁵ See discussion in Chapter 6 of this Report.

⁷⁶ Dr Cath Peake, Clinical Coordinator and Dr David Eddey, Director of Emergency Medicine, Barwon Health, Public Hearing, Geelong, 28 October 2013.

Sometimes ATS, particularly derivatives such as MDMA, but also on occasion methamphetamine, including ‘ice’, are termed ‘party drugs’. Some witnesses to this Inquiry have criticised the use of the term ‘party drugs’. For example, the Australian Medical Association (AMA) in its submission stated that methamphetamine should never be referred to in the media (or elsewhere) as ‘party’ or ‘soft’ given the serious medical and other consequences that can result from their use.⁷⁷ Other commentators have argued that even the term ‘recreational drug’ should be avoided as the term ‘recreational’ to describe illicit drug use may imply that it is ‘harm-free’ (Cherney, O’Reilly & Grabosky 2005).

Notwithstanding these reservations, many agencies have stated that ‘party drug use’ is an appropriate term or descriptor given the context in which much ATS use — predominantly but not only methamphetamine and MDMA — takes place.⁷⁸ In a previous Inquiry into amphetamine use by the Drugs and Crime Prevention Committee of the 56th Victorian Parliament, Professor Margaret Hamilton, former Director of Turning Point Alcohol and Drug Centre, advised that:

We note that there is some concern about the use of the term ‘party drugs’. We are not especially fussed by that, to be honest. It is a phrase that those who use them use and therefore understand. Once you start spending a lot of time on deciding what words we will use and how we will describe this class of drugs, the time can be diverted from some of the other things. It is not something that we want to make a case for, not using that term. We recognise some of the controversy, if you like, about it, but there is some advantage in using the terms that the users use and there are disadvantages in inventing new terminology that then becomes distant from users.⁷⁹

Inconsistencies with regard to drug terminology are not merely semantic; they can have practical consequences. As discussed in Chapter 5 too often there is a lack of specificity in coding and data systems used in hospitals, by police, ambulance and alcohol and other drug (AOD) agencies. For example, a hospital emergency room may simply classify a patient’s admission as drug-related without specifying the drug administered. This results in a lack of accurate statistical information being produced for research and other purposes. As McKetin, McLaren and Kelly note, the fluctuating nature of drug terminology is likely to ‘compromise the comparability of data on methamphetamine trends if only the specific forms of methamphetamine are monitored using their street terms’ (2005, p.xiv). The authors consequently recommend that medical and other data collection systems classify the various physical forms of methamphetamine as sub-categories within a broader all-inclusive category of methamphetamine.

Table 3.1 outlines the various street names for the different forms of methamphetamine available in drug markets in Australia.

Form and composition

Amphetamines and methamphetamine come in many different forms, sizes, colours, shapes and purities.

The following discussion draws from the widely used taxonomy of Topp and Churchill (2002a) in discussing the different forms of methamphetamine. The authors classify the various forms

77 Ms Rachael Edginton, Director of Policy and Public Affairs, Australian Medical Association (Victoria) Limited (AMA Victoria), Submission, 31 October 2013.

78 Professor Margaret Hamilton, Turning Point Alcohol and Drug Centre, evidence given to the Drugs and Crime Prevention Committee Inquiry into Amphetamines and ‘Party Drug’ Use in Victoria, Public Hearing, Melbourne, 27 October 2003.

79 Ethnographic and other studies of drug use indicate that generally there is a fairly common and widely understood vocabulary or lexicography of drug terminology. For example, a qualitative study of methamphetamine use in Sydney showed that methamphetamine users in that city could clearly distinguish ‘ice’ from other forms of methamphetamine and that the street terms ‘ice’ and ‘crystal meth’ ‘did accurately reflect the use of large translucent crystals of methamphetamine’. However the damp or wet form of methamphetamine commonly known as ‘base’ was given a variety of terms to describe it. ‘Speed’ was sometimes used as a synonym for powdered amphetamine sulphate and other times as a collective term for any form of methamphetamine (McKetin, McLaren & Kelly 2005, p.xiv).

of methamphetamine as speed, base, and crystal meth or ice. These terms reflect the different purities of the drug with speed being the least pure and ice the most refined.

Speed

Speed in the methamphetamine context refers to a powder form of the drug, usually of a lower purity and often cut with adulterants. It can also go by the street names of goey or go-ee, billy and whizz. Speed can also be adulterated with similar coloured off-white powders such as talc, paracetamol and in some rare cases strychnine (Connolly 2000).⁸⁰

As indicated in the previous section, speed as a form of methamphetamine can often be confused with amphetamine sulphate. Today what passes as speed, however, is more likely to be a form of methamphetamine, and to a lesser extent dexamphetamine (a drug sometimes used legitimately to treat Attention Deficit Hyperactivity Disorder (ADHD)). Methamphetamine can be in tablet form, although as a submission from Victoria Police to this Inquiry notes the tablet form has now almost entirely disappeared being virtually replaced by the crystalline form — ice.⁸¹

Base

Base is a form of methamphetamine that resembles an oily, gluggy, sticky or waxy powder or paste, often of a yellow or brownish shade. It can also be colloquially referred to as wax, 'point', pure or paste. Unlike the sophisticated chemistry knowledge needed to produce crystal methamphetamine (see next section), base can be and is produced in Australia by amateur chemists:

It is oily because the pseudoephedrine to methamphetamine conversion produces the base form of methamphetamine, which is oil. An oil is not highly marketable in illicit drug markets, because it cannot be easily injected or snorted. Therefore, manufacturers attempt to purify methamphetamine base (oil) into methamphetamine hydrochloride (crystal). To successfully complete this process requires considerable chemistry expertise, and few illicit manufacturers in Australia have such expertise. The result is an oily powder ...[with organic impurities]. These organic impurities, which would not be present if the conversion and purification were performed accurately, also prevent the substance from forming into the large translucent crystals typical of 'ice', so the appearance of these two forms of methamphetamine is quite different (Illicit Drug Reporting System (IDRS) 2002, p.3).

Base can be administered by swallowing, smoking, snorting and injecting, although its oily consistency makes dissolving for injecting difficult without the application of heat.

Ice or crystal meth

The most potent form of methamphetamine comes in crystalline form and is colloquially known as crystal meth, crystal, ice or more recently in Australia as shard. It may also be called other names such as crank or glass, particularly in the United States.⁸² Ice is a particularly strong high purity form of methamphetamine, which in the past 10 years has become more widely available and used on the streets of Melbourne and other Australian cities.

According to a submission from Victoria Police, the crystalline form of the drug now comprises 86 percent of all methamphetamine seizures in Australia.⁸³ Its composition is coarse, clear or translucent, a usually white or off-white crystal form of the drug. Sometimes

80 See below for discussion of the purity (or otherwise) of methamphetamine.

81 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013. This is almost a complete reversal from the early 2000s in which according to Victoria Police only 1 percent of the total methamphetamine seizures could be attributed to 'crystal meth'.

82 'Shabu' is a Japanese word that is used to refer to ice in the Philippines, where the use of ice has a long history. See NDARC 2003, Fact Sheet. For an account of the 'crank' trade and 'crank' use in the United States, see Kirn 1998.

83 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

a less pure crystallised form of the drug with a yellow to brownish hue may also be presented as ice. Crystalline methamphetamine is the form of methamphetamine most commonly smoked as it vaporises easily when heated. It also recrystallises when cool, allowing users to save unused ice:

This property of methamphetamine allows smokers to titrate their dose, inhaling small amounts of the drug at regular intervals to reinstate their high. It is also a convenient property for social users of the drug who wish to share their methamphetamine among friends (McKetin et al. 2013b, p.693).⁸⁴

Crystal methamphetamine is the form of methamphetamine which is the major focus of this Inquiry.

The chemical and street terms for the drugs, their relative purity and mode of administration are presented in Table 3.1 below.

Table 3.1: Forms of methamphetamine available on the illicit drug market in Australia

Street name (s)	Appearance	Active drug (s)	Average purity* (%)	Typical dose	Typical route of administration
Ice/crystal, shabu, skates, tina, shard	Clear to white or off-white crystalline	Methamphetamine	32	Point (0.1g)	Smoke, inject
Base, pure, p, paste, Wax	White or beige damp oily powder	Methamphetamine	25	Point (0.1-0.1g)	Swallow, inject
Speed	White or beige powder	Methamphetamine	13	Half or full gram	Snort, swallow, inject
Ecstasy pills	Tablet with various logos and colours	Methamphetamine (ketamine, MDMA)	8 (by pill weight)	1 to 2 pills	Swallow

Source: Adapted from McKetin et al. 2012a, p.11.

Price

The latest annual Illicit Drug Data Report produced by the Australian Crime Commission (ACC)⁸⁵ noted that the price for a gram of amphetamine remained stable in 2012-13 ranging between \$150 and \$800 compared with \$150 to \$400 in 2010-2011 (ACC 2014a).

Non-crystallised methamphetamine

The price range for non-crystallised forms of methamphetamine also remained stable at the national level ranging from \$700 to \$900 per gram (ACC 2014a). The only states to report the price for a kilogram of non-crystallised methamphetamine were New South Wales and Victoria. In New South Wales the price ranged from \$70,000 to \$110,000 per kilogram. In Victoria the price ranged from \$100,000 to \$120,000.

Crystal methamphetamine

Nationally, the price per gram of crystal methamphetamine or 'ice' increased from between \$300 to \$2000 in 2011-12 to between \$400 and \$1600 in 2012-13 (ACC 2014a). The Northern Territory reported the highest price for a gram in 2012-13 ranging between \$1200 and \$1600 per gram.

⁸⁴ See also discussion in Chapter 9 in the context of patterns and culture of methamphetamine use.

⁸⁵ The publication date of April 2014 covers the reporting period of 2012-13.

In New South Wales and Victoria the price of a kilogram of crystal methamphetamine has remained relatively steady over the last four years. The prices in both states ranged between \$200,000 and \$320,000 per kilo in 2012-13 compared to \$200,000 and \$330,000 in 2011-12. The price per kilogram has fluctuated in other states over that period (ACC 2014).

Victoria Police supplied figures on the price of methamphetamine, noting that due to the high Australian dollar the drug was profitable for drug traffickers but also strongly in demand by users.⁸⁶ According to the Victoria Police submission the current price for different quantities of street level methamphetamine are:

- 0.1 gram [a point] = \$30–\$40
- 1 gram = \$150–\$400
- 28.35 grams [1 ounce] = \$3500–\$5000
- 1 kilogram = \$80,000.⁸⁷

Such figures differ significantly from the ACC estimates noted above. It may be that this is due to the Victoria Police having access to more up-to-date data. Certainly the figures quoted above are consistent with the prices mentioned in submissions and oral evidence to the inquiry by both police witnesses and alcohol and drug, youth and health workers as outlined below.

Differing views on price

Contradictory evidence has been received by the Inquiry as to an approximate street price for methamphetamine. Some evidence suggests that it is a cheap drug, at least in comparison to other illicit drugs and even alcohol.⁸⁸ Other evidence has suggested that it is in fact quite expensive.

Crystal methamphetamine is considered to be expensive

A number of witnesses noted the prohibitively expensive cost of ice and the commensurate profits made by dealers, particularly those in the higher echelons of the supply chain. For example, Superintendent Daryl Clifton of Victoria Police (Bendigo) told the Committee:

If you look at the history of this drug, it would be fair to say that it is fairly profitable in Australia; it demands a good price. Therefore it is not a large stretch to consider why organised crime would be involved in it — because of the money that is available in it. If you look at overseas comparisons, the cost of methamphetamine or ice, as it is more commonly known, is quite high compared to other countries.⁸⁹

Similarly, Ms Belinda McNair from the Salvation Army in Geelong told the Committee:

The price of amphetamines is increasing, particularly over the last five years or more. Traditionally, heroin was probably the most expensive illicit drug on the market, and now ice is. What people would pay for a point of heroin, which is about \$50, they are paying about \$80 to \$100 for ice. The ramifications of that on the broader community, with it becoming more expensive, obviously people start to commit more crime to support their habits and that would be a concern that it is probably a result of increasing demand. If people can get that kind of dollar for it they will try and get it. It would appear to be slightly cheaper in regional areas than in the CBD, but we are only talking about a \$20

86 Methamphetamine production entails low production costs relative to the size of the product produced and the wholesale price, ease of manufacture compared to plant based drugs, and ease of access to precursor products such as pseudoephedrine (cold and flu) tablets which are relatively cheap compared to the huge mark-ups on the final product (Cherney, O'Reilly & Grabosky 2005, p.7). See also discussion in Chapter 15.

For a more detailed, if technical and complex, account of the pricing and profitability of synthetic drugs including methamphetamine see Chapter 4 (*Prices and Profits*) of Ritter, Bright and Gong 2012.

87 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

88 See discussion later in this chapter.

89 Superintendent Daryl Clifton, Victoria Police, Public Hearing, Bendigo, 25 October 2013.

difference, but it has skyrocketed. A gram of ice on the street is about \$650. A gram of heroin on the street is about \$500. That has only changed in the last few years.⁹⁰

Mr Zach Mason, Youth Worker with Junction Support Services in Wodonga advised that:

What is being reported back is it is not cheap, it is more expensive than speed, it is much more expensive than marijuana. It might be cheaper to produce but that is on a different scale to what we are seeing. We are seeing users coming that have lost everything because they are paying \$1,000 for such a small amount.⁹¹

Mr Bill Wilson from Gateway Community Health made similar observations:

Prices have skyrocketed in terms of the amount you would need to spend on a gram of ice. I would imagine \$100 a point, and multiply that by 10 is \$1,000. That is a lot of money. People are spending a significant amount of money on this drug. Its availability in this regional area is massive to be quite honest.⁹²

Yet crystal methamphetamine is considered to be cheap

Conversely however, drugs researcher Dr Rebecca McKetin has called methamphetamine 'a good working class drug that is not too expensive'.⁹³ Similarly, Mr Dave Rice, Ambulance Manager from Bairnsdale told the Committee that local young people are reporting to him that methamphetamine is much cheaper than alcohol:

So if [these young people] are going to a nightclub for the night they can buy ice fairly cheaply and there are a number of ways to use it, compared to buying drinks for the night which cost \$8 to \$10 each, and they said that is the biggest factor — that they can walk around with a bottle of water or two and have a fairly cheap evening.⁹⁴

AOD nurse Ms Debbie Stoneman added that methamphetamine had the added (dubious) advantage of under-age kids not needing identification to get into a nightclub or bottle shop to purchase it.⁹⁵

Mr Clive Alsop, Magistrate for the Latrobe Valley, also believes that methamphetamine is not as expensive as it is made out to be and can be cheaper than cannabis:

There are places, particularly in East Gippsland, where ice is being sold at half the cost of cannabis, which of course makes it directly attractive to young children. In one particular area there are kids of 12 who are starting to use ice because it is easier to get than ganja.⁹⁶

Finally, representatives from the Aboriginal community have also told the Inquiry that methamphetamine is an accessible and affordable drug for their young people in particular:

We think ice is accessible, it is affordable and this makes it a very attractive drug of choice for a young Aboriginal population that has experienced high levels of socioeconomic disadvantage, including high levels of unemployment, mental health issues, disability, homelessness and lower levels of educational attainment.⁹⁷

90 Ms Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013.

91 Mr Zach Mason, Youth Worker, Junction Support Services, Wodonga, Public Hearing, 24 February 2014.

92 Mr Bill Wilson, Youth Outreach, Alcohol, Tobacco and Other Drugs Team, Gateway Community Health, Wodonga, Public Hearing, 24 February 2014.

93 And therefore affordable for 'tradies'. See Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014 and also the discussion in Chapter 14.

94 Mr Dave Rice, Manager Sale Advanced Life Support Unit and Bairnsdale and Sale Single Responder MICA Units, Ambulance Victoria, Traralgon, Public Hearing, 28 January 2014.

A similar observation was made by a senior police officer in the Gippsland region who added that not only was methamphetamine a cheaper night out than alcohol, it had the added benefit of not putting on weight. See Detective Senior Sergeant Chris Pegg, Divisional Crime Adviser, Division 6, Eastern Region, Victoria Police, Traralgon, 28 January 2014.

95 Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Traralgon, Public Hearing, 28 January 2014.

96 Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates Court. Similar comments as to its inexpensive price in the Gippsland area were made by Superintendent Jock Menzel, Divisional Commander, Division 5, Eastern Region, Victoria Police, Traralgon, Public Hearing, 28 January 2014.

97 Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Melbourne, Public Hearing, 17 February 2014.

Certainly there may be fluctuations in price depending on factors such as geographic location⁹⁸, purity⁹⁹ and quality of the substance and the relationship of the user to the dealer.¹⁰⁰ However cheap is a relative term that needs to be put in the context of the user's lifestyle; what is relatively cheap for a 'tradie' on a good wage who uses occasionally may be prohibitively expensive for a dependent user in receipt of Centrelink benefits. Many drug users will spend more on drugs in a week than they legally earn or receive in benefits during the same period with little to cover their living expenses once their drug purchases are taken into account (McKetin, Kelly & McLaren 2006).¹⁰¹

Purity

As with most drugs the purity of methamphetamine will vary according to its form and composition. The powder form of methamphetamine (speed) has typically had a purity of 10 percent whereas the damp and oily form known as base can reach purity levels of 20 percent (Cruickshank & Dyer 2009). Crystalline forms of the drug, that is, ice, have a much higher level of purity unless diluted with cutting agents. Whilst some witnesses have stated that imported methamphetamine is generally more pure than locally manufactured product,¹⁰² others such as Superintendent Paul Pottage of the Victoria Police, Geelong, have commented that seizures from clandestine laboratories in the Geelong area are finding some of the purest forms of methamphetamine ever yet seen by their forensic analysts, up to 80 percent in some cases. There is also evidence that manufacturers in the region are 'washing' dirty methamphetamine thereby increasing its purity.¹⁰³

However, Topp, Degenhardt et al. state that gauging a real sense of the purity of methamphetamine is difficult for a number of reasons:

[i]ncluding the type and quality of the chemicals used in the production process, the expertise of the manufacturers, and whether the drug was manufactured or imported. A major limitation of purity data is that not all illicit drugs seized by Australia's law enforcement agencies are analysed for purity. In some instances seized drugs will only be analysed in a contested court matter (2002, p.342).¹⁰⁴

98 According to one expert witness who spoke to the Committee, in the United Kingdom ice is seen as a drug of affluence. The main reason in fact that it has not permeated the British scene in a big way is that it is prohibitively expensive compared to cocaine (\$A470 to \$A81 per gram respectively).

'Methamphetamine has not impacted on the British scene as it has in the US and I gather also in Australia. Methamphetamine has been limited so far largely to a very small group of the gay community in London and also in Manchester. This is not in the mainstream at the moment. There are various reasons presented for that. The main one is price. It is fantastically expensive. It has not really penetrated into, if you like, the working class communities or indeed into the underclass. This is a drug which is associated with affluence...'

Professor Richard Hobbs, Mannheim Centre for Criminology, London School of Economics and Political Science (via video conference), Canberra, 12 February 2014.

99 Watered down or less pure/refined versions of methamphetamine are selling much more cheaply according to many witnesses to the Inquiry. See for example, Mr Darren Holyroyd, Chair, Geelong Nightlife Association, Public Hearing, Geelong, 28 October 2013.

100 Although even in the same location there may be some varying views as to the price and affordability of methamphetamine. For example whereas some police in Wodonga may have believed it to be relatively cheap, AOD workers in the region have reported it to be prohibitively expensive.

101 See Chapter 7 for an example of the costs of methamphetamine use to an average unemployed client of a regional welfare agency.

102 See for example, comments of Mr John Rogerson, Chief Executive Officer, Australian Drug Foundation, Public Hearing, Melbourne, 14 October 2013.

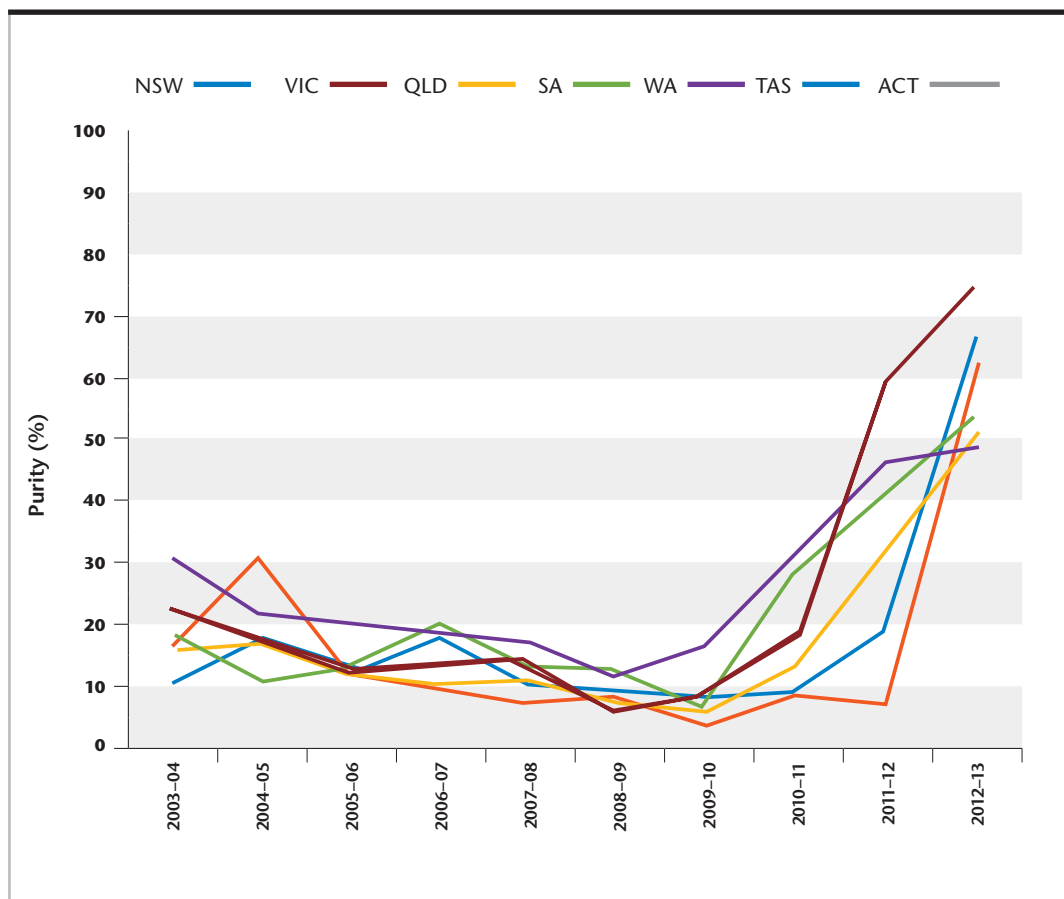
103 See Superintendent Paul Pottage, Division Commander, Division 1 (Geelong) Western Region, Victoria Police, Public Hearing, Geelong, 28 October 2013.

104 Although Topp et al. made these observations over 10 years ago, there is no reason to believe the same considerations and caveats are inapplicable today.

Australian states and territories have different practices for the amount of drugs they may send for purity analysis. For example in Tasmania, the police will not send drug exhibits for purity analysis unless requested by an investigator. In other states there may be a minimum amount of drug above which a sample can be sent for analysis. In New South Wales for example, exhibits are sent to the NSW Drugs Laboratory for purity testing when the amount is above the trafficable level (3 grams for methamphetamine). Western Australia and South Australia will generally not send drug samples of less than 2 grams for purity analysis. In Victoria, drug purity is analysed for all drug samples seized by Victoria Police in a relevant quarter. For further discussion of purity analysis practices across Australia, see ACC 2014a.

Even the purest forms of methamphetamine are not of *absolute* purity. The latest Australian Crime Commission *Illicit Drug Data Report* showed that over the decade since 2003-04 the median purity of analysed methamphetamine samples has ranged from 4.4 percent to 76 percent. In 2012-13 every state and territory reported an increase in the median purity figures for methamphetamine (see Figure 3.3). Victoria reported the highest annual median purity of 76.1 percent during the reporting period which was the highest median purity reported for the last decade (ACC 2014).

Figure 3.3: Annual median purity of methamphetamine samples, 2003–04 to 2012–13



Source: Australian Crime Commission 2014a, *Illicit Drug Data Report 2012-2013*, p.33.

Figures reported on a quarterly basis for the last year showed that during the reporting period the median purity of analysed methamphetamine samples ranged from 6.2 percent in Tasmania to 78.8 percent in Victoria (ACC 2014).

Victoria Police figures on the average purities for methamphetamine provided to this Inquiry can be seen in Table 3.2.

Table 3.2: Average purity of methamphetamine samples 2008-2013

Year	Average Purity (percentages)		
	Crystal	Powder	Tablet
2008	30%	13%	2.5%
2009	31%	10%	2.9%
2010	47%	12%	3.0%
2011	53%	14%	3.0%
2012	63%	30%	5.2%
2013 (to June)	63%	43%	2.2%

Source: Victoria Police.¹⁰⁵

Victoria Police also provided the Committee with data on the average purity of different forms of methamphetamine including crystal methamphetamine, as tested by the Forensic Services Department during 2012 and 2013.

Table 3.3 shows the percentage of average purity of different forms of methamphetamine based on the quantity in grams for different geographical regions in Victoria. The purity of crystal methamphetamine between 2012 and 2013 across all regions has increased, while average purity levels for powder methamphetamine have decreased during the same period across Victoria.

Table 3.3: Change in percentage of average purity of methamphetamine by location and year

Year	Purity (%)	Crystal		Powder		Tablet		Other	
		Nth	S/E/W	Nth	S/E/W	Nth	S/E/W	Nth	S/E/W
		Reg	Reg	Reg	Reg	Reg	Reg	Reg	Reg
2012	<20	73	11	3067	3756	170	597	234	18
	21-40	7	31	31	202	0.4	0	0	0
	41-60	10	73	144	443	0	0	0	16
	61-80	254	249	1052	734	0	0	0	0
	>80	550	504	6535	4723	0	0	0	0
2013	<20	71	329	396	898	26	15	0.2	325.2
	21-40	25	15.4	190	153	0	0.3	15	0
	41-60	195	288	1025	16	0	0	0	0
	61-80	580	1233	203	191	0	0	0	0
	>80	1048	1646	221	79	0	0	0	0

Note: Data provided in grams.

Source: Victoria Police Forensic Services Department.

Drug users who responded to the latest survey of the the *Ecstasy and Related Drug Reporting System* (EDRS) also gave their views as to the purity of methamphetamine available.

105 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

Participants were asked about their perceptions of purity currently and also whether this had changed over the last six months. Ice was most commonly perceived to be of 'high' purity, both nationally and in Victoria (Sindicich & Burns 2014) (see Table 3.4).

Table 3.4: Participant reports of current methamphetamine purity, 2013

(%)	National		NSW	ACT	VIC	TAS	SA	WA	NT	QLD
Current purity Speed	2012	2013								
	N=205	N=128	n=5 [^]	n=37	n=20	n=23	n=13	n=7 [^]	n=11	n=12
Low	18	20	0	38	30	9	15	14	0	8
Medium	35	36	20	32	30	44	39	71	27	33
High	35	37	80	16	35	39	46	14	73	50
Fluctuates	13	7	0	14	5	9	0	0	0	8
Current purity Base	2012	2013								
	N=62	N=16	n=2 [^]	n=1 [^]	n=4 [^]	n=2 [^]	n=6 [^]	n=0	n=0	n=1 [^]
Low	8	0	0	0	0	0	0	-	-	0
Medium	40	25	0	0	50	0	33	-	-	0
High	47	69	100	100	50	100	67	-	-	0
Fluctuates	5	6	0	0	0	0	0	-	-	100
Current purity	2012	2013								
Ice/Crystal	N=135	N=103	n=6[^]	n=4[^]	n=31	n=6[^]	n=24	n=18	n=6[^]	n=8[^]
Low	4	7	0	25	3	0	4	11	17	13
Medium	22	32	50	75	29	33	25	33	50	13
High	62	46 i	17	0	52	50	63	33	33	50
Fluctuates	13	16	33	0	16	17	8	22	0	25

Source: Sindicich & Burns 2014, p.70.

The largest proportion of ice users reported that purity of the drug remained 'stable' in the six months preceding interview, both nationally and in Victoria (Sindicich & Burns 2014) (see Table 3.5)

Table 3.5: Participant reports of methamphetamine purity change, 2013

(%)	National		NSW	ACT	VIC	TAS	SA	WA	NT	QLD
Current purity Speed	2012	2013								
	N=181	N=107	n=5[^]	n=37	n=20	n=23	n=13	n=7[^]	n=11	n=12
Increasing	12	12	0	23	15	0	9	14	0	8
Stable	51	52	100	40	60	47	55	29	86	58
Decreasing	12	17	0	17	25	12	0	43	14	17
Fluctuating	25	19	0	20	0	41	36	14	0	17
Base	2012	2013								
	N=56	N=13	n=1[^]	n=1[^]	n=3[^]	n=2[^]	n=5[^]	n=0	n=0	n=1[^]
Increasing	13	8	0	0	0	50	0	-	-	0
Stable	50	77	100	100	100	50	80	-	-	0
Decreasing	5	8	0	0	0	0	20	-	-	0
Fluctuating	32	8	0	0	0	0	0	-	-	100
Ice/Crystal	2012	2013								
	N=125	N=92	n=6[^]	n=3[^]	n=30	n=5[^]	n=22	n=16	n=3[^]	n=7[^]
Increasing	10	16	17	0	17	0	14	25	0	29
Stable	56	44	67	67	37	80	46	31	67	29
Decreasing	10	16	0	33	20	0	14	19	0	29
Fluctuating	24	24	17	0	27	20	27	25	33	14

Source: Sindicich & Burns 2014, p.70.

These findings reflect those presented by Victoria Police to the Committee following forensic analysis of samples tested by the Forensic Services Department referred to above (see Table 3.3). See also the discussion in Chapter 5 for further presentation of purity data.

Harms associated with the purity of the substance

Professor Dietze of the Burnet Institute noted that a substantial increase in the purity of methamphetamine over the last five years has been the driver of some of the harms experienced by methamphetamine users. It is the purity of the drug rather than an 'explosion of new people using the drugs' that may in part explain the increase in numbers reflected in data such as ambulance attendance call-outs.¹⁰⁶

Similar comments were made by Mr Simon Ruth from the Victorian AIDS Council:

In 2010–11 there was about 19 percent purity in methamphetamine that was on the market. A year later it was up to 60 percent. Again, as a naive user you are suddenly using three times more drug than you were previously, or if you have just come into the market at that point, you are much less used to how the drug should be affecting you and so you are suddenly experiencing a lot more of the drug in your system, and with much greater purity you start to experience much greater harms...so you have suddenly got a lot more men, generally, but women as well who do not realise that if they take this amount today that they took 12 months ago, they are probably going to be awake for the next four days and then they are going to have all the deleterious effects of being awake for four days when they are going to become intensely paranoid.

106 Professor Paul Dietze, Head, Alcohol and Other Drug Research, Centre for Research Excellence in Injecting Drug Use, Burnet Institute, Public Hearing, Melbourne, 30 September 2013.

See also discussion in Chapter 6 as to how the purity of the drug may result in harmful medical and psychological consequences.

The story of the man who has become incredibly paranoid because he has not slept for four days and is running down the street smashing car windows or attacking people can become more common: you are much more likely to experience those sorts of things and you are much more likely to experience overdoses and ambulance call-outs and deaths related to it when the drug is much more pure. Much more experienced users probably would have used the more pure drug once and realised what was going on and they would moderate their use, but again the naive group of users are much more likely to have those harms associated with it.¹⁰⁷

The combination of high purity of methamphetamine, compared to traditional amphetamine powder, in association with the smoking and injecting modes of administration can mean a greater risk of harmful medical consequences including dependence.¹⁰⁸ The high purity of the drug and its associated potency is one of the reasons that benzodiazepines may be needed to assist in the ‘come down’ period. This in itself can result in a different set of physical and psychological consequences.¹⁰⁹

Adulterating methamphetamine

It is not uncommon for all forms of methamphetamine to be adulterated with a range of benign and/or dangerous impurities or adulterants. McKetin et al. note that typically only 25 to 50mg of methamphetamine is needed to produce a ‘robust effect’. Adulteration is needed to control the dose strength although it is also a way in which dealers can increase their profit margins (2013b, p.692). McKetin et al. add, however, that stories with regard to the addition of contaminants such as battery acid are not always well founded:

Contrary to popular belief, most of the adulterants used to prepare methamphetamine for sale on the illicit drug market are relatively innocuous (eg sucrose). Harmful constituents usually occur because of incorrect manufacturing procedures or contamination with reagents used in the manufacturing process which can include heavy metals and carcinogens (2013b, p.692).

Nonetheless, there have been occasions when noxious and dangerous substances such as battery acid and brake fluid have been used in the manufacturing process (See Figure 3.4)

Even amounts of the drug that appear crystallised in form may not necessarily be the compound colloquially referred to as crystal meth or ice. In other words a lower grade form of methamphetamine may still be produced in crystal form that does not have the refined qualities of crystal methamphetamine.

Certainly many qualitative studies note that the majority of methamphetamine users prefer the more pure forms of the drug for the more intense and longer lasting ‘rush’ or high they give:

Several methamphetamine users justified their preference for purer forms of methamphetamine particularly ice because they did not contain as much cutting agent as powder, and therefore viewed them as ‘cleaner’ forms of the drug. This view was particularly common for ‘ice’ which was perceived as being uncut and ‘professionally’ produced (McKetin, Kelly & McLaren 2006, p.70).¹¹⁰

107 Mr Simon Ruth, Director of Services, Victorian AIDS Council, Public Hearing, Melbourne, 14 October 2013.

See also comments of drug educator Paul Dillon. Mr Dillon notes that with methamphetamine particularly ‘ice’ you are seeing a purity level that you simply don’t see with any other type of illicit substance. Mr Paul Dillon, Director and Founder, Drug and Alcohol Research and Training Australia, Melbourne, 3 February 2014.

108 Dr Rebecca McKetin, told the Inquiry that traditional speed was not easily smoked because it was full of sugar and other cutting agents that would not evaporate. Ice on the other hand when heated vaporises and is easily inhaled with an immediate, stronger and reinforcing effect. Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014. See also discussion below on mode of administration.

109 See comments of Mr Angelo Pricolo, Chair, Strategic Harm Minimisation in Pharmacy (SHarP) Advisory Group, Pharmacy Guild of Australia — Victoria, Melbourne, Public Hearing, 3 February 2014 and the discussion in Chapter 6 of this Report.

110 See also the comments in evidence of Superintendent Paul Naylor of Victoria Police (Mildura Region). Methamphetamine being seized in Mildura is of a much higher grade of purity than has hitherto been seen. Superintendent Paul Naylor, Superintendent, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013.

For observations on similar levels of purity in the Goulburn Valley and South Western regions, see respectively comments of Superintendent Michael Sayer, Eastern Region, Victoria Police, Shepparton, 25 February 2014 and Superintendent Don Downes, Western Region, Division 2, Victoria Police, Warrnambool, 3 March 2014.

McKetin, Kelly and McLaren's study noted that whilst pure crystalline methamphetamine was white with a median purity of 80 percent, the majority of methamphetamine seizures that were of a crystalline appearance were not high purity crystal methamphetamine but a lower purity crystalline substance of brownish or yellow hue with a median purity of 19 percent. 'This lower purity crystalline methamphetamine could reflect either 'base' methamphetamine that had a crystalline appearance or ice that had been cut with crystalline adulterants' (2006, p.xiv).¹¹¹ Such observations accord with evidence given to the Committee by other witnesses. For example, Dr Belinda Lloyd of Turning Point Alcohol and Drug Centre told the Committee that quite often they see clients who report they have been using crystal methamphetamine when in fact it is a less pure drug that has been made to look like the crystalline form.¹¹² Other evidence has been given to the Inquiry that on occasion methamphetamine is sometimes mixed with other drugs and then sold purporting to be MDMA or ecstasy.¹¹³ Witnesses have also told the Committee that some drug users were buying what they thought was crystal methamphetamine but was merely speed with additives or adulterants that make it 'burn' but which nonetheless could result in harmful consequences.¹¹⁴

Access and availability

Methamphetamine including crystal methamphetamine is readily available and easy to access. Certainly the research literature suggests that this has been the case in the past two to three years. For example, the Ecstasy and Related Drug Reporting System (EDRS) entails surveys with regular ecstasy users (REU), surveys with key experts who have contact with REUs due to the nature of their work, and an analysis of existing national and state-based data sources that contain information on ecstasy and related drugs, including methamphetamine and crystal methamphetamine. It provides data on the availability of drugs such as crystal methamphetamine on current markets.

Fifteen percent of the national EDRS sample commented on the availability of crystal methamphetamine. The majority of participants considered it 'easy' or 'very easy' to obtain (88%). In Victoria, 78 percent indicated that crystal methamphetamine was 'very easy' to obtain. Over half of the national respondents reported that availability had remained 'stable' over the preceding six months, with 59% reporting stability in Victoria (Sindicich & Burns 2014, p. 73) (see Table 3.6).

111 This practice of cutting lower purity methamphetamine with crystalline substances is characteristic of the smokeable drug *shabu* predominant in the Philippines (McKetin, Kelly & McLaren 2006, p.24).

112 Dr Belinda Lloyd, Strategic Lead, Population Health Research, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

113 Australian Nursing & Midwifery Federation (ANFM Vic Branch), Submission, 21 October 2013.

114 See for example: Ms Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013; Ms Donna Ribton-Turner, Director, Clinical Services, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013; Mr Angelo Pricolo, Chair, Strategic Harm Minimisation in Pharmacy (SHaP) Advisory Group, Pharmacy Guild of Australia–Victoria, Melbourne, 3 February 2014.

Table 3.6: Availability of crystalline methamphetamine (ice/crystal), 2013

Availability	National		NSW	ACT	VIC	TAS	SA	WA	NT	QLD
	2012	2013								
(among those who commented)	N=136	N=105	n=7[^]	n=4[^]	n=32	n=5[^]	n=25	n=18	n=6[^]	n=8[^]
Very easy	48	56	57	50	78	40	40	61	50	25
Easy	42	32	29	0	22	0	44	39	33	63
Difficult	10	11	14	50	0	60	16	0	17	0
Very difficult	1	1	0	0	0	0	0	0	0	13
Availability changes	2012	2013	NSW	ACT	VIC	TAS	SA	WA	NT	QLD
(among those who commented)	N=130	N=100	n=6[^]	n=5[^]	n=32	n=6[^]	n=23	n=18	n=2[^]	n=8[^]
More difficult	9	12	0	40	13	17	13	0	50	13
Stable	69	63	83	40	59	50	70	67	50	63
Easier	20	21	17	20	28	17	13	28	0	13
Fluctuates	3	4	0	0	0	17	4	6	0	13

Source: Sindicich & Burns 2014, p.73.

As with the other forms of methamphetamine, friends and known dealers were the most common sources of crystal methamphetamine in the EDRS survey. It was most commonly obtained and used in private locations, including at friends' homes, dealers' homes and at participants' own homes. The results from Victorian participants were comparable with those from most other states and territories (Sindicich & Burns 2014) (see Table 3.7).

Table 3.7: Last source, purchase location and use location of crystalline methamphetamine (ice/crystal), 2013

Obtained from (%) (among those who commented)	National		NSW	ACT	VIC	TAS	SA	WA	NT	QLD
	2012 N=139	2013 N=111	n=7^	n=8^	n=32	n=7^	n=25	n=19	n=7^	n=8^
Friends	45	51	14	33	53	71	52	58	57	50
Known dealers	30	33	71	33	41	0	28	26	14	50
Acquaintances	7	4	0	0	3	0	0	11	14	0
Unknown dealers	4	5	0	33	3	14	4	0	14	0
Street dealers	1	<1	0	0	0	14	0	0	0	0
Workmates	<1	<1	0	0	0	0	4	0	0	0
Haven't obtained	9	5	14	0	0	0	12	5	0	0
Locations obtained (among those who commented)	National		NSW	ACT	VIC	TAS	SA	WA	NT	QLD
	2012 N=139	2013 N=111	n=7^	n=8^	n=32	n=7^	n=25	n=19	n=7^	n=8^
Friend's home	36	35	14	50	16	43	40	53	57	38
Dealer's home	21	22	43	17	19	14	24	16	14	38
Own home	15	14	0	17	22	29	8	5	14	13
Agreed public location	11	16	29	17	34	0	4	5	14	13
Nightclub	2	3	0	0	3	0	4	5	0	0
Private parties	2	2	0	0	0	0	4	5	0	0
Raves/doofs	0	<1	0	0	0	0	0	0	0	0
Other	5	4	0	0	6	0	4	5	0	0
Used but not obtained	9	5	14	0	0	0	12	5	0	0
Last use venue (among those who commented)	National		NSW	ACT	VIC	TAS	SA	WA	NT	QLD
	2012 N=139	2013 N=111	n=7^	n=8^	n=32	n=7^	n=25	n=19	n=7^	n=8^
Home	26	27	14	17	50	29	20	16	14	25
Friend's home	36	32	14	33	28	29	28	37	57	38
Nightclub	11	14	29	33	0	0	32	11	0	13
Private party	3	5	0	0	3	0	4	11	14	0
Raves/doofs	0	4	0	0	6	29	0	0	0	0
Public place	4	4	14	0	0	14	0	5	14	0
Live music event	2	3	0	0	6	0	0	0	0	13
Public place	4	2	0	0	3	0	0	0	0	13
Other	4	5	0	17	3	0	0	0	0	0
Used but not obtained	8	6	14	0	3	0	13	11	0	0

Source: Sindicich & Burns 2014, p.76.

Witness views on access and availability

Several witnesses who gave evidence to the Committee also commented about the ease with which methamphetamine can be sourced. In particular, police across the state have reported how common the drug is, whether sourced on the streets, in nightclubs or the local pub.¹¹⁵ And unlike other drugs such as heroin, because of the local manufacture of methamphetamine, users who live in rural areas do not necessarily ‘have to get on a train and go to Melbourne, it is freely available here’.¹¹⁶

Witnesses from Aboriginal organisations expressed concerns as to just how available methamphetamine is in their local communities and how easily young people in particular can access it. For example Di Griffin of the Albury-Wodonga Aboriginal Health Service told the Committee that young Aboriginal people were bypassing cannabis as their first drug of choice because of the greater availability of methamphetamine:¹¹⁷

It is easy to get a hold of, possibly even more easy than cannabis is now. I do not know for sure but I ask my clients, ‘Do you have any trouble getting it?’ They do not have any trouble getting it at all.¹¹⁸

Similarly, Herb Goonen of Rumbalara Aboriginal Co-operative in Shepparton noted that for young Aboriginal people methamphetamine was generally easier to access than alcohol:

It is actually not easy for a 16-year-old or a 15-year-old to get alcohol — not impossible, but it is not easy. Drug dealers do not ask for ID. They will sell straight to the kids if the kids have the money. We are seeing 15-year-old kids and 16-year-old kids who are easily using ice.¹¹⁹

The observation that methamphetamine is easier to access than cannabis was also made by many non-Aboriginal AOD, health and community workers in metropolitan Melbourne¹²⁰ and particularly those working in rural and regional Victoria.¹²¹ Peter Wearne’s comments are representative:

We have seen a 50 percent increase in the number of young people coming through our service who are claiming methamphetamine as part of their drug-using profile. That is only in 12 months. In some cases we are seeing methamphetamine challenging alcohol or cannabis as being the more dominant of the drug presentations, so there is no doubt that this has been on the increase and there is no doubt that for some reason — ... I would say; ease of manufacturing — it is actually very available like other drugs have not been.¹²²

Some witnesses who work in the AOD field believe that it is the drug’s relative affordability that makes it so available.¹²³ Certainly, as indicated earlier in this chapter in some locations

115 See for example, Superintendent Andrew Allen, Divisional Commander, Ballarat Division, Western Region, Victoria Police, Public Hearing, Ballarat, 18 November 2013; Superintendent Paul Naylor, Superintendent, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013.

116 Superintendent Jock Menzel, Divisional Commander, Division 5, Eastern Region, Victoria Police, Traralgon, Public Hearing, 28 January 2014.

117 For other accounts of the ease with which young Aboriginal people can access methamphetamine in the Ballarat region, see Ms Karen Heap, Chief Executive Officer, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013.

Similar observations were made by Mr Matt Burke OAM, Chief Executive Officer, Mungabareena Aboriginal Corporation, Wodonga, Public Hearing, 24 February 2014.

118 Ms Di Griffin, Aboriginal Drugs and Alcohol Counsellor, Albury-Wodonga Aboriginal Health Service, Wodonga, Public Hearing, 24 February 2014.

119 Mr Herb Goonen, Drug and Alcohol Worker, Rumbalara Aboriginal Cooperative, Shepparton, Public Hearing, 25 February 2014.

120 See for example, in the context of the Dandenong area, comments of Mr John Insana, General Manager, Community Correctional Services, South-east Metropolitan Region, Corrections Victoria, Melbourne, Public Hearing, 17 February 2014.

121 See also for example: Mr Bill Wilson, Youth Outreach, Alcohol, Tobacco and Other Drugs Team, Gateway Community Health, Wodonga, Public Hearing, 24 February 2014; Ms Fiona Harley, Deputy Executive Director, Mallee Family Care, Public Hearing, Mildura, 5 December 2013.

122 Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Traralgon, Public Hearing, 28 January 2014.

123 As this chapter has discussed, however, witnesses have made different and varying observations as to just how affordable methamphetamine is.

crystal methamphetamine would appear to be cheaper than alcohol.¹²⁴ That in some circumstances crystal methamphetamine can be manufactured at home from ‘recipes’ on the internet including from YouTube also adds to its ready availability.¹²⁵ Some people may experience enormous pressures to take the drug even in circumstances where they may prefer not to:

The other thing is its availability through marketing. Putting the young professionals and the tradespeople aside, the way this drug is marketed among the dealers and the using population is quite insidious. If you have not scored, they have your contact number, they know where you live and they will be on your doorstep. Even if people want to make a break or not use, it is really difficult for them to not use when they have someone dangling it in their face. The other thing we see — and we have seen this with other drugs in the markets within Bendigo or in the rural and regional areas — is that this particular dealing network gives credit; if people cannot pay, they give credit.¹²⁶

For a detailed discussion on topics related to availability and access of methamphetamine including drug markets, supply chains and routes and local manufacture of the drug, see Chapter 15 of this Report. For further discussion of data with regard to accessing methamphetamine see Chapter 5.

Route of administration

Methamphetamine can be swallowed or snorted, smoked and injected.¹²⁷ It can also be added to drinks and swallowed or dabbed from the fingers to the mouth. It is not unknown for methamphetamine to also be inserted into the anus or vagina (shafting).¹²⁸ The crystalline forms of methamphetamine can be smoked in customised glass pipes, although when such apparatus is not available users have been known to smoke it from makeshift receptacles including broken light bulbs.¹²⁹ The route of administration may also affect the pharmacokinetics of methamphetamine absorption with intravenous injection and smoking being more ‘efficient’ ways of reaching rapid peak subjective and physiological effects (the high or the rush) (Carson et al. 2012). It is clear that routes of administration involve different risks and therefore require tailored responses.¹³⁰

Harms associated with different routes of administration

The mode used to administer methamphetamine can result not only in different intensities in experiencing the drug’s effects; it may also result in different levels of harmful effects. Evidence to the Committee from alcohol and drug agencies suggest that there are two main

124 See for example comments of Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014; Mr Darren Holyroyd, Chair, Geelong Nightlife Association, Public Hearing, Geelong, 28 October 2013; and Ms Fiona Harley, Deputy Executive Director, Mallee Family Care, Public Hearing, Mildura, 5 December 2013.

125 Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Traralgon, Public Hearing, 28 January 2014.

126 Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013.

127 See Table 3.1 above.

128 Sometimes expressively known as the ‘booty bump’ in the United States. See Semple, Grant and Patterson 2008.

129 Some witnesses to the Inquiry have argued the banning of smoke bongs or pipes in Victoria is short-sighted as it may lead to either more dangerous ways of smoking the drug or alternatively greater use of injecting methamphetamine. See for example, Mr Simon Ruth, Director of Services, Victorian AIDS Council, Public Hearing, Melbourne, 14 October 2013. The merits or otherwise of this argument are discussed in Chapter 26 pertaining to harm reduction interventions.

See also Morgan and Beck (1997) for an outline of the relatively prevalent practice of smoking methamphetamine in light bulbs among Latino populations in San Diego, California. In the United States, route of administration follows different regional patterns, for example intravenous use in San Francisco, intra nasal use in other parts of California and smoking in Hawaii (Morgan & Beck 1997).

130 See Ms Lyn Morgain, Chief Executive Officer, Western Regional Health Centre, Submission, 22 October 2013; and Mr Daniel Eltringham, Drug and Alcohol Care Coordinator, Emergency Department, Bendigo Health, Public Hearing, Bendigo, 25 October 2013.

cohorts of methamphetamine users — an older more established cohort that has experience of injecting drug use, particularly opioid injection, and are heavy poly-drug users, and a younger and newer cohort that smokes the drug. This is also borne out in the research literature.¹³¹ Oral ingestion of methamphetamine is not preferred by either group because of the propensity of the drug to be dissipated in the gut.¹³²

The injecting and smoking of methamphetamine are generally viewed as more harmful routes of administration than oral use with injecting marginally more dangerous because of the risk of disease transmission.¹³³ Dr David Jacka, a specialist in addiction medicine, told the Committee that despite possible problems with both forms of administration, injecting was still the more problematic route in terms of associated dangers:

I think injecting is much more likely to produce an intoxication, a binge, where people end up in an emergency department. It is something they are less in control of than if they are smoking, and I am really surprised to discover in Australia how many people are injecting methamphetamine compared to smoking it. Although smoking is still probably the largest way of using it, I have now seen people in the emergency departments in hospitals who have not only got infections but have died from their infections from injecting amphetamines. So it is a real problem in our community that not only are they using it but they are injecting it. The techniques for injecting it are really bad. It is a dirty drug, and they are getting heart infections, spinal infections and the like, and dying as a consequence. So there is a problem with injecting, but that is another area again. That is the method of use rather than the amount of use.

Here I think there is a culture of injecting that comes from the culture of injecting opiates; that has influenced the methamphetamine. But also I think there are these other drugs that are used with methamphetamine. You have got oxycodone and MS Contin that are used in conjunction with the methamphetamine to come down — probably the benzodiazepines: alprazolam, diazepam, oxazepam. All of those drugs are used to calm people down after a binge. A lot of those opiates people are injecting.¹³⁴

An American study by Dornier et al. conducted a survey of 427 methamphetamine users in California, 13 percent of whom were injecting users. Injecting methamphetamine users were found to be more at risk of developing serious health and social problems, including HIV and other blood-borne diseases. Interestingly, methamphetamine users themselves definitely had distinct views about differences between injecting and non-injecting users:

When the participants were asked if they injected methamphetamine many of the non-injectors responded adamantly in the negative. There seemed to be a stereotype present within the drug-using population that injectors were ‘more dependent’ or ‘more severe’ addicts than other users (Dornier et al. 2000, p.231).¹³⁵

Methamphetamine injectors and smokers are also ‘significantly more likely’ to become dependent on the drug than those who administer it orally or through other means (McKetin, Kelly & McLaren 2006). Academic commentators have looked with concern at

131 See for example, McKetin et al. 2013b.

132 See for example, Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013

Superintendent Paul Naylor, Superintendent, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013.

133 For earlier accounts of differences between injecting and non-injecting amphetamine users, see Moore 1992, particularly at p.49. See also Dornier et al. 2000; Hall & Hando 1994 and Drugs and Crime Prevention Committee 2004.

134 Dr David Jacka, Addiction Medicine Specialist, Monash Health, South East Alcohol and Drug Service, Melbourne, Public Hearing, 3 February 2014.

135 Dornier et al. (2000) note that paying attention to the difference between injecting and non-injecting users of amphetamines and methamphetamine may have important implications for strategy development:

‘Overall...there are characteristics of injecting users that make them uniquely different from users of other routes. Knowing about these differences can provide useful information for clinicians treating injection users. Possible topics to include or emphasise in an injector’s treatment plan are HIV concerns, legal issues, and a greater focus on depression, suicide and hallucinations’ (Dornier et al. 2000, p.232).

the trend towards smoking methamphetamine particularly by young people 'as it provides a very addictive means of taking methamphetamine that is also accessible to non-injecting "party" drug users' (McKetin, Kelly & McLaren 2006, p.83).¹³⁶ Similarly, Aboriginal AOD workers and community members have expressed their concerns at the ease with which a person may move from smoking to injecting methamphetamine.¹³⁷

Routes of administration as part of the patterns and rituals of drug use

The route of administration and the general rituals and culture of methamphetamine use will clearly be dependent on the situation and setting.¹³⁸ Those who use methamphetamine experimentally or only occasionally are less likely to inject than heavy, dependent or dysfunctional users (see Carson et al. 2012). Such differences may also apply to those who use them for 'functional' purposes such as truck driving, exam performance, weight loss or sports competition where oral administration may be more likely (Teter et al 2006; Carson et al 2012). Conversely, dependent and some recreational users may be more likely to smoke and/or inject methamphetamine as the purpose is the 'high' in itself rather than any extraneous purpose (Darke et al. 2008; McKetin, Kelly & McLaren 2006).

As well as the physical act of administration the context is all-important in terms of the consumption of methamphetamine, as with all drug use. Discussing methamphetamine use in Sydney, Mundy states:

Methods of administration appear to be dependent on 'community norms'. For instance residents in the Sydney beach suburb of Manly who use this drug seem to prefer smoking it, whereas Kings Cross users are more likely to inject (Mundy 2001, p.2).¹³⁹

Poly-drug use

The experience of almost all the service providers and agency workers in Victoria with whom the Committee has met has been that users of methamphetamine rarely use those substances exclusively. 'Poly-drug' use (using several different drugs at the same time or alternately) is a common practice amongst people who use drugs including alcohol. The many and complex issues relating to poly-drug use are discussed in Chapter 10 of this Report.

136 See the discussion on the preference for smoking methamphetamine by young people in recreational contexts in the discussion of the patterns and culture of methamphetamine use in Chapter 9.

Some witnesses to the Inquiry gave evidence that notwithstanding the apparent dangers of smoking methamphetamine many young people still believed it to be much safer than injecting. See for example, Superintendent Andrew Allen, Divisional Commander, Ballarat Division, Western Region, Victoria Police, Public Hearing, Ballarat, 18 November 2013.

137 See Ms Di Griffin, Aboriginal Drugs and Alcohol Counsellor, Albury–Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014.

138 For a discussion of the patterns and culture of methamphetamine use including Zinberg's (1984) classic concept of the importance of drug, set and setting, i.e. the context of drug use, see Chapter 9.

139 For further discussion of the routes of administration as part of the patterns and culture of methamphetamine use, see Chapter 9.

Conclusion

Whilst there are clearly concerns being expressed in the community about the prevalence and dangers of methamphetamine use it is not a new drug, even if the crystallised form of the drug is more common today than it was ten or even five years ago. As Topp stated, as early as 2001, in the context of 'crystal meth':

It is important to acknowledge that methamphetamine drugs are not new drugs; some people who have used drugs for decades will say that such drugs have been available, on and off, for years. The change appears not to be the appearance of the drugs themselves, but rather, the recent rapid increase in their availability and use across the country (Topp 2001, p.3).

It is also equally true that for many working in the field it is difficult to keep up with new trends and changes in drug use and that some aspects of crystal methamphetamine use seem particularly insidious. Whilst Topp's comments that methamphetamine is not a new drug are acknowledged, some things have clearly changed since 2001. In 2014 the increasing purity of the drug and the seeming ease with which it is accessed are clearly cause for concern. It is therefore important to be aware of the nature of methamphetamine and the potential for harm associated with its use.

4. International Perspectives

Introduction

During its Inquiry, the Committee has been made aware of the global nature of the methamphetamine market and its impact on both Australia and Victoria. Methamphetamine, and its precursor chemicals are brought into Australia from a range of overseas countries by individuals who appreciate the high level of profits to be made in Australia where prices tend to be higher than in other drug markets. This chapter presents evidence collected by both the United Nations Office on Drugs and Crime (UNODC) and the Australian Crime Commission on trends in methamphetamine markets internationally in recent years that help to explain why the market for this drug appears to be burgeoning locally. In addition, the Committee heard from a number of overseas experts who explained the nature and trends in drug markets in Asia, Europe and the United States. This information has assisted the Committee in understanding the international factors that have led to the current methamphetamine problem that currently exists in Australia and Victoria.

A global problem

The United Nations Office on Drugs and Crime (UNODC) *World Drug Report* for 2014 states that the global market for amphetamine-type stimulants (ATS) is expanding across most regions. In 2011, it is estimated that 33.8 million people had used ATS in the preceding year (UNODC 2013c). Increased levels of use have been reported in some of Asia's developed economies, particularly China, Indonesia, Malaysia and Thailand (UNODC 2013b). UNODC also identified Africa as an emerging market, based on increases in diversion of precursors and seizures of methamphetamine in the continent, particularly in West Africa (UNODC 2013c). In 2012, the UNODC (2014b) reported:

For the second year, ATS seizures reached an all-time high of 144 tons, up 15 per cent from 2011, due in large part to increases in methamphetamine seizures. Over the past five years, methamphetamine seizures have almost quadrupled, from 24 tons in 2008 to 114 tons in 2012. Of the total of 144 tons of ATS seized globally in 2012, approximately half were seized in North America alone and approximately a quarter in East and South-East Asia. Large quantities of amphetamine seizures continue to be reported in the Middle East, in particular by Jordan, Saudi Arabia and the Syrian Arab Republic (UNODC 2014b, p. 46).

In 2012, methamphetamine accounted for the majority of ATS seizures (80 per cent), approximately 114 tons of the total 144 tons of ATS seized worldwide. The UNODC (2014b) notes that 'seizures of methamphetamine have been surging in East and South-East Asia and Oceania. Between 2011 and 2012, approximately 70 per cent (12 of 17 countries) of the reporting countries in the region noted an increase in seizures of methamphetamine' (UNODC 2014b, p. 48). Consistent with these data, in 2012 the World Customs Organisation reported an increase in border detections of ATS in North America, Western Europe and the Middle East, with large quantities also detected in the Asia-Pacific region (Australian Crime Commission (ACC) 2014a).

Supporting seizure data, recent advances in forensic chemistry make it possible for law enforcement agencies to identify chemical signatures in methamphetamine batches that can

be used to trace the source of production. This information can be extremely valuable to international law enforcement efforts. Ms Judith Lind from the ACC told the Committee that:

Production methods are certainly diversifying, that is partly because of the strong controls now on the diversion of pseudoephedrine and ephedrine. We have recently commenced ... some new forensic testing of samples that are seized within Australia. Drugs have always been sampled forensically when seized at the border, but this is a relatively recent project. I think they are up to about 1300 samples, and part of the testing has revealed what is known as the Mexican synthesis signature for methylamphetamine. We cannot say it categorically, although in terms of the direct importation from Mexico to Australia, there is pretty good evidence that we are getting Mexican-produced methylamphetamine into Australia.¹⁴⁰

Ms Lind's submission is consistent with UNODC (2013c) reports of the influence of Mexican drug trafficking organisations in the synthetic drug market and their increased manufacturing activity. Myanmar continues to manufacture significant quantities of ATS, primarily in the form of methamphetamine tablets (UNODC 2013a). Methamphetamine seizures in Indonesia, Malaysia and Thailand, as well as seizures from Europe and the Middle East are reported to have originated in the Islamic Republic of Iran (UNODC 2014a).

Asia and Oceania

The UNODC report on transnational and organised crime in East Asia and the Pacific identified 'the use of crystal methamphetamine in Oceania and the Greater Mekong Sub-region as the highest in the world, and in parts of China, methamphetamine has begun to displace heroin as the most problematic drug of abuse' (UNODC 2013b, p. vii).

East and South-East Asia's crystal methamphetamine market is rapidly expanding, with seizures increased to 8.8 tons in 2011, the highest level during the past five years, indicating that the substance is an imminent threat (UNODC 2013c, p.xi). Mr Jeremy Douglas, Regional Representative for the UNODC, told the Committee:

Typically 2008 and 2009 were primarily China, because for six, seven or eight years China has been seizing a lot of crystal methamphetamine. Since 2009–10 there has been a change in the market in Southeast Asia. In Thailand and Cambodia-Laos there has been crystal meth coming into the market. Again, that crystal meth often comes from Myanmar, or Burma, and it comes from China. Increasingly it is coming from countries such as India which have manufactured precursors. Now at the airport the Thais are arresting quite a lot of Indians coming in with high-purity crystal methamphetamine, so there is obviously manufacture in India. The same is happening for Pakistan; people are flying in from Pakistan. Both countries have very active pharmaceutical markets, with a lot of companies.¹⁴¹

Indicative of the demand for methamphetamine and the extent of law enforcement activities in the East and South-East Asia, Oceania and the Pacific region, ATS seizures have risen from 13 tons in 2008 to 40 tons in 2012 (of which 12 tons in 2008 and 36 tons in 2012 were methamphetamine) (UNODC 2014a). According to the UNODC, record level seizures have been reported in a number of countries including Myanmar, Indonesia, Thailand, Cambodia, Japan, Brunei Darussalam and Hong Kong (UNODC 2013c). Strong economic conditions in a number of countries in Asia may have increased the market for illicit drugs, through an improved standard of living leading to greater expendable income. Aiding increased manufacture, in some countries in Asia conditions are conducive to illicit drug manufacture and distribution. Such conditions may include political instability, corruption, inadequate law enforcement governance and infrastructure, ineffective border control strategies and

140 Ms Judith Lind, Executive Director, Australian Crime Commission, Public Hearing, Canberra, 10 February 2014.

141 Mr Jeremy Douglas, Regional Representative for South-East Asia and the Pacific, United Nations Office on Drugs and Crime, Meeting, Canberra, 12 February 2014.

easy access to precursor chemicals. A lack of control strategies and regulation for precursors and pharmaceutical drugs in some Asian countries increases access to precursor chemicals such as ephedrine and pseudoephedrine (UNODC 2014a). There is a growing need for greater cooperation between various law enforcement and regulatory agencies in the Asia Pacific region, to strengthen border control regulations and security mechanisms.

In evidence to the Inquiry, Ms Judith Lind described the nature of the global methamphetamine traffickers:

We know that drug trafficking syndicates from Africa and Iran and others with links to China and Hong Kong are trafficking methylamphetamine into and through Southeast Asia, and Indian drug trafficking networks are smuggling precursor chemicals to drug manufacturing locations in the region. Both India and China have large and growing legitimate chemical industries. Those countries are also being used by organised crime groups to divert chemicals from the legitimate industries for use in the production of methylamphetamine and for trafficking into global markets. The rate of seizures and use in both Asia and Southeast Asia are also more pronounced, with some recent reporting showing that Thailand in particular has had fairly rapid increases in the use of the drug within that country.¹⁴²

Increases in the supply of and demand for methamphetamine in Asia may have an impact on the methamphetamine market in Australia. Increases in the production of methamphetamine in the region may increase opportunities for importation to Australia, or for drugs manufactured in Australia to be exported to Asia. In conversation with the Committee, Mr Jeremy Douglas described the nature of trafficking of synthetic drugs within the Asia–Pacific region:

We have received indications from the New Zealand police and the Australian Federal Police about activity in the Pacific, primarily in relation to it being a transshipment point, because there is not a lot of money in the Pacific or demand, if you will, for synthetic drugs. But as I said, we were told of a case from last week that was meant for Australia, which involved Nigerians travelling from East Asia to Fiji to Australia. It is a bit of a convoluted route but often traffickers do things in odd ways to try to avoid detection.¹⁴³

During the period 2008–2011, an average of around 150 clandestine ATS laboratories were dismantled each year in the East Asia, South-East Asia, Oceania and the Pacific region. The greatest proportion of these (47%) has been in New Zealand, followed by Australia (24%) and Thailand (18%) (UNODC 2014a). Laboratories have also been discovered in several other countries in the region, including Indonesia, Malaysia, the Philippines, Cambodia, Hong Kong (China), India, Japan, the Republic of Korea, Myanmar and Sri Lanka (UNODC 2014a).

Europe

Prevalence of use

As discussed in Chapter 3, in Europe, methamphetamine availability and use appears to be on a lesser scale than that observed in other parts of the world, including Australia. Evidence provided to the Committee during the hearings by key experts from Europe demonstrated that methamphetamine use is not, at this time, considered a significant problem in many European countries.¹⁴⁴ However, the comparatively low cost, ease of production and shorter

142 Ms Judith Lind, Executive Director, Australian Crime Commission, Public Hearing, Canberra, 10 February 2014.

143 Mr Jeremy Douglas, Regional Representative for South–East Asia and the Pacific, United Nations Office on Drugs and Crime, Meeting, Canberra, 12 February 2014.

144 Ms Anna Sergi, Researcher, University of Essex (via teleconference), Public Hearing, Canberra, 10 February 2014; Mr William Tupman, University Fellow, Terrorism and Organised Crime Consultant, University of Exeter (via teleconference), Public Hearing, Canberra, 11 February 2014.

distribution chain between producers and sellers for methamphetamine than for cocaine or heroin, may lead to increased availability and use in the future.¹⁴⁵

In Europe, the overall prevalence estimates for amphetamine and ecstasy use have remained relatively stable (EMCDDA 2012). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) report noted:

The number of offences related to amphetamines reported in the European Union has increased by an estimated 24% over 2005-2010, although it appears to have stabilised in the last two years. In contrast, the number of ecstasy-related offences fell by an estimated two thirds over the same period (a 71% decrease) (EMCDDA 2012, p.36).

According to the European Drug Report, methamphetamine use is an emerging issue in some parts of Europe, including Germany, Greece, Cyprus, Latvia and Turkey (EMCDDA 2014).

Of concern, the EMCDDA has noted sporadic reports of methamphetamine smoking and the availability of crystal methamphetamine, a highly pure form of the drug. Methamphetamine smoking has historically been extremely rare in Europe, but evidence from elsewhere suggests strong association with negative consequences (EMCDDA 2012, p.16).

Availability of methamphetamine

The recent European Drug Report proposed that it was the distribution route of methamphetamine from the Middle East to South-East Asia, via Europe, that was increasing availability and use of methamphetamine in Europe:

As well as domestic production in central and northern Europe, this drug is also produced in the Middle East and sometimes imported into European Union for re-export to South-East Asian countries. Increasingly, however, some of this production is contributing to availability within Europe. New reports of the emergence of the smoking of methamphetamine in Greece and Turkey are particularly worrying, given the potential health risks associated with the use of the drug in this way (EMCDDA 2014, p.14).

Supporting the European Drug Report (2014) explanation, Turkish authorities have observed that Turkey serves as a transit point for methamphetamine smuggled from the Islamic Republic of Iran to East and South-East Asian countries (UNODC 2014a). The latest European Union (EU) *Serious and Organised Crime Threat Assessment* released in 2013 also stated that the EU has been recognised as a transit and destination region for methamphetamine produced in Africa, Asia and Latin America (European Police Office 2013).

There is also evidence of domestic manufacture and distribution of methamphetamine within Europe. A 2012 European Drug Report released by the EMCDDA has identified two main areas of methamphetamine production in Europe:

First, in the Baltic States, production is centred around Lithuania for export to Norway, Sweden and the United Kingdom. In this region, BMK (benzyl methyl ketone) is used as a principal precursor. In the second area, focused around Czech Republic and neighbouring countries Slovakia and Germany, production is mainly based on ephedrine and pseudoephedrine and takes place in small-scale so-called kitchen laboratories. Here the output is destined primarily for distribution within the country. (EMCDDA 2012, p.24)

The latest EU *Serious and Organised Crime Threat Assessment* released in 2013 highlighted recent developments regarding precursor chemicals:

145 Professor Ernesto Savona, Executive Director, Joint Research Centre on Transnational Crime of the Università Cattolica del Sacro Cuore of Milan and the University of Trento (Transcrime), Meeting (via video conference), Canberra, 10 February 2014.

A shift to the use of non-controlled pre-precursors, a start substance for the synthesis of precursors, to overcome the reduction in the supply of traditional precursors since 2011 appears to have increased the availability of both amphetamine and MDMA.

China remains the main source of precursors and pre-precursors. However, India and Thailand are also sources for the substances used in the conversion process, albeit to a lesser extent (European Police Office 2013, p.23).

There are a number of independent organised crime groups operating within Europe, some of which are known to have connections to the illicit drug trade. The European Drug Report (2014) provides an indication of the cross-border nature of methamphetamine trade within Europe:

In the last two years, there have been signs of increased involvement of Vietnamese organised crime groups in Czech methamphetamine markets and scaling-up of production. In 2011, there were 350 reports of dismantled methamphetamine production sites in Europe, most of these, however, were small-scale sites reported by the Czech Republic [338 reports of small scale sites in the Czech Republic] (EMCDDA 2014, p.24).

The extent of European-based transnational organised crime activities within the global illicit drug trade is difficult to assess. The Committee heard evidence that middle-level suppliers in Europe are suspected of having ties with Australian organised crime groups. Ms Anna Sergi, from the University of Essex, described the nature of Italian-operated methamphetamine trafficking channels between Europe and Australia:

As for local branches of Italian organised crime groups involved, as we said, not in the production but generally in receiving the shipment of methamphetamine — or amphetamines in this case; we are still talking mainly about amphetamines — to Australia, mainly Melbourne, for Italians these are old questions. The branches of the 'Ndrangheta', which is the Calabrian Mafia, are identified and known to Italian authorities and have been known for more than 50 years. They have names of families, and they believe that there are at least from 7 to 15 active clans in Australia at the moment.¹⁴⁶

However, some experts state that the extent of involvement of European organised crime groups in trafficking and distribution of methamphetamine into Australia is minimal or non-existent. Professor Savona explained some of the reasons for suspecting the limited involvement of European organised crime groups:

It is quite clear for me that this is not a major organised crime issue. It is just a business. People from West Africa send this material to Australia; people intercept and buy. I repeat: the cost is so small but the earnings are so big that from one box of 50 pills, you are earning thousands of Australian dollars, and it is very easy to put it in your pocket and nobody will be controlling you at all, which means that shipping boxes of these things is really easy to do. They give it to people in a plane, for example, bringing it from one airport to another, and people just go out from the plane, sell all these things in the local market once they are introduced, and this is the biggest. In terms of what I know, major organised crime is not involved in this kind of shipping, at least for a measured component of organised crime, but who knows? Organised crime is doing money with everything else — such as cigarettes, pills and any business they can find — so it could be that they are involved sometimes. From what I know at the moment, it is not.¹⁴⁷

United Kingdom

Demand for methamphetamine in the United Kingdom (UK) also appears to be low (EMCDDA 2014). In the UK, the incidence of methamphetamine usage has only been

¹⁴⁶ Ms Anna Sergi, Researcher, University of Essex, Meeting (via video conference), Canberra, 10 February 2014.

¹⁴⁷ Professor Ernesto Savona, Executive Director, Joint Research Centre on Transnational Crime of the Università Cattolica del Sacro Cuore of Milan and the University of Trento (Transcrime), Meeting (via video conference), Canberra, 10 February 2014.

identified within certain population groups such as lesbian and gay communities. Mr Tupman observed:

Methamphetamine is not a big problem in the UK. I think that needs to be said to start with. We have some media scares, but it is primarily a sex drug for the wealthy and the gay community. It is not around in general use. I have some figures for you. There were 17 000 users of methamphetamine in the 2012–13 period. That compares with 27 000 heroin users, 47 000 users of crack cocaine, 120 000 users of ketamine and 2 million users of cannabis. Those are Home Office official figures. We have in the UK other stimulants which users tend to take. Mephedrone has 174 000 users; ordinary amphetamines, 211 000 users; ecstasy, 410 000; and 627 000 users of cocaine in powder form.¹⁴⁸

The reasons why the demand for the drug is low within the general population in the UK is primarily due to the high cost of methamphetamine in comparison with other drugs, such as cocaine, as well as a perception, especially among young people, of methamphetamine as a socially unacceptable drug.¹⁴⁹ Furthermore, in the UK there is greater availability of heroin, cocaine and cannabis compared to methamphetamine.

The Committee heard evidence that methamphetamine in the UK has primarily been imported from or through the Netherlands. Mr Tupman described the nature of networks developed between local and international drug traffickers in the UK:

For the UK, gangs in Liverpool certainly seem to do most of their work with the Netherlands. They import from bigger dealers based in Rotterdam and Amsterdam. Those guys tend to have the connection with the Columbian cartels, for example. They have imported or been in association with people importing cannabis from Afghanistan and from Morocco, and from Lebanon to a lesser degree. It tends to end up in Amsterdam. Connections tend to be made there, and then sometimes the Dutch bring it over themselves, sometimes there are all sorts of weird and wonderful games played by city gangs to bring it into the UK.¹⁵⁰

It appears that the relative ease with which amphetamine can be manufactured, transported and distributed has shifted the methamphetamine market away from organised crime groups who may be involved in the production, supply and distribution of other illicit drugs (Mills, Skodbo & Blyth 2013). Professor Hobbs advised the Committee:

I am suggesting really that the crossover between legitimate and illegitimate is easier to make now than it was in the previous generation. In the time that I have been studying this area and writing about it, in the last 25 years, I have seen the fading out of the old underworld and a new free market come in whereby sharp, savvy entrepreneurs can basically make money any way they can.¹⁵¹

Consistent with this, there are indications of methamphetamine becoming increasingly popular in the UK as a result of a growing night-time economy that facilitates and provides opportunities for illicit trade.¹⁵² Experts from the UK advised the Committee that some businesses operating in the night-time economy have been associated with the promotion and supply of illicit drugs. Professor Hobbs also indicated that:

One of the interesting things about meth's current popularity with a small group of the gay community is that there are elements there of what we saw with ecstasy in the late 1980s and early 1990s. Ecstasy became very popular as a dance drug amongst the gay community, and from the gay community it

148 Mr William Tupman, University Fellow, Terrorism and Organised Crime Consultant, University of Exeter, Meeting (via video conference), Canberra, 11 February 2014.

149 Mr William Tupman, University Fellow, Terrorism and Organised Crime Consultant, University of Exeter, Meeting (via video conference), Canberra, 11 February 2014.

150 Mr William Tupman, University Fellow, Terrorism and Organised Crime Consultant, University of Exeter, Meeting (via video conference), Canberra, 11 February 2014.

151 Professor Richard Hobbs, Mannheim Centre for Criminology, London School of Economics and Political Science, Meeting (via video conference), Canberra, 12 February 2014.

152 Professor Richard Hobbs, Mannheim Centre for Criminology, London School of Economics and Political Science, Meeting (via video conference), Canberra, 12 February 2014.

kind of spread outwards. I do not want to suggest that that is a probability with methamphetamine, because the price at the moment is so outrageous I cannot imagine it happening, but it is interesting that since the dance scene and the night-time economy has blossomed in the UK, quite often the gay community are at the forefront of new drugs and new opportunities to use drugs.¹⁵³

North America and Mexico

According to the 2013 UN World Drug Report, 61 percent of global methamphetamine seizures are from countries in North America, including the United States, Canada and Mexico (UNODC 2013c). ATS seizures in the region increased from 12 tons in 2007 to nearly 60 tons in 2012. Methamphetamine constitutes more than 90 percent of ATS seized (UNODC 2014a). While methamphetamine laboratories were reported in all global regions, the greatest number continue to be located in the United States, where the number of laboratories detected has increased from 2,754 in 2010 to 11,116 in 2011 (UNODC 2013c).

In the United States there has been an increase in the quantity of methamphetamine seized, as shown in official statistics from the US Drug Enforcement Administration (DEA) presented in Table 4.1 Growth in the number of laboratories and seizures in the United States is indicative of growth in the market. However, this growth has not been supported by an increase in number of users, which has remained relatively stable since 2010 (UNODC 2014a). This suggests that the increased production of methamphetamine is in support of exportation. Alternatively, it may suggest that whilst the number of users is remaining fairly constant, methamphetamine is being consumed in greater quantities.

Table 4.1: DEA domestic drug seizures of methamphetamine (kgs), 1986 to 2012

Calendar Year	Methamphetamine (kgs)
2012	3,898
2011	2,481
2010	2,187
2009	2,012
2008	1,519
2007	1,112
2006	1,804
2005	2,162
2004	1,659
2003	1,681
2002	1,352
2001	1,634
2000	1,771

Source: DEA, System to Retrieve Information from Drug Evidence (STRIDE).¹⁵⁴

153 Professor Richard Hobbs, Mannheim Centre for Criminology, London School of Economics and Political Science, Meeting (via video conference), Canberra, 12 February 2014.

154 United States Drug Law Enforcement Administration website, Statistics and Fact, viewed 21 May 2014. <http://www.justice.gov/dea/resource-center/statistics.shtml>

Results from the *National Survey on Drug Use and Health* (NSDUH) showed that methamphetamine use in the United States decreased from 0.5 percent in 2009 to 0.4 percent in 2010, since which time it has remained relatively stable (UNODC 2014a). Methamphetamine is one of the least widely used illicit drugs in the United States. Results from the 2012 NSDUH showed that over 12 million people (4.7% of the population) had tried methamphetamine at least once and approximately 1.2 million people used the drug in the previous year (National Institute of Drug Abuse 2013).

The Drug Abuse Warning Network (DAWN) measures the rate of hospital emergency department visits that involve illicit drugs. Rates are reported as the number of emergency department visits per 100,000 persons in the population of the United States. In 2010, there were 378.5 emergency department visits that related to illicit drugs (Substance Abuse and Mental Health Services Administration (SAMHSA) 2012); this figure rose to a rate of 402.0 in 2011 (SAMHSA 2012). Table 4.2 shows the rate of emergency department visits, per 100,000 persons in the United States population, which related to cocaine, marijuana, heroin and amphetamine/methamphetamine. There was an increase in emergency department presentations for all illicit drugs considered, with the exception of marijuana. Cocaine and heroin accounted for the highest proportion of presentations in both 2010 and 2011. However, the growth in presentation rate for amphetamine/methamphetamine appears consistent with that observed for cocaine and heroin across this period. The majority of emergency department visits for illicit drugs in both 2010 (58.8%) and 2011 (56.3%) involved poly-drug use, that is, involved multiple drugs.

Table 4.2: SAMHSA Rates of emergency department visits per 100,000 persons in the United States population related to cocaine, marijuana, heroin and amphetamines/methamphetamine

Drug type	Year	
	2010	2011
Cocaine	158	162
Marijuana	149	146
Heroin	73	83
Amphetamines/methamphetamine	45	51

Source: Adapted from SAMSHA 2013 and SAMSHA 2012.

Impact of methamphetamine use in the United States

A 2009 study by Nancy, Pacula and Beau estimated the economic cost of methamphetamine use in the United States, taking into account costs associated with the burden of addiction, premature death, drug treatment, aspects of lost productivity, crime and criminal justice costs, health care, production and environmental hazards, and child endangerment costs. The study reported that:

The economic cost of meth [methamphetamine] use in the United States reached \$23.4 billion in 2005. Given the uncertainty in estimating the costs of meth use, this study provides both a lower-bound estimate of \$16.2 billion and an upper-bound estimate of \$48.3 billion (Nancy, Pacula & Beau 2009, p. iii).

The study concluded that whilst methamphetamine use was associated with a number of unique harms, the primary cost drivers were similar to those for other illicit drugs.

Manufacture of methamphetamine in Mexico

The United States Drug Enforcement Agency's (DEA) *National Drug Threat Assessment* noted that methamphetamine availability is increasing because of sustained production in Mexico. The volume of Mexican production appears to be influencing the price and quality of methamphetamine in the United States market. The DEA reported that methamphetamine prices decreased more than 70 percent between the third quarter of 2007 and the second quarter of 2012, while during the same period the purity of seized methamphetamine increased by almost 130 percent (US DEA 2013, p.10).

Methamphetamine production appears to be a profitable enterprise for organised crime groups in Mexico, together with their involvement in other illicit drug trafficking. In relation to the total illicit drug market, a UNODC report on drug trafficking and other transnational organised crimes released in 2011 stated:

The US authorities estimated that the drug-related profits alone may have reached some US\$13.8 bn for the Mexican cartels in 2006. This seems to be in line with some estimates suggesting that up to \$25-\$30 billions' worth of illegal drugs come through Mexico into the United States each year (UNODC 2011, pp.65-67).

Mexican drug cartels use their drug trafficking networks to smuggle methamphetamine into the country for the purpose of making significant profits:

Cartels in Mexico purchase bulk ephedrine and pseudoephedrine from countries with less strict oversight of methamphetamine precursor chemicals, such as India, Germany and China, and despite efforts from both countries to prohibit import, production continues to increase (Vearrier et. al. 2012, p.45).

That influence of Mexican drug cartels extends beyond the United States as evidenced by the interception at Australian borders of methamphetamine found to show Mexican signatures of drug manufacture. Mr Shane Neilson from the ACC advised the Committee that methamphetamine produced in Mexico can be identified by use of the P2P manufacturing process:

The one to watch, even though it is small in number is P2P. That is where the more recent labs are going. That process used to exist about 15 years ago in Australia. It is coming back now. It is also a process that is popular in Mexico. We think Mexican groups in the future will play a more prominent role in the Australian amphetamine market.¹⁵⁵

It appears that relatively little of the large amount of methamphetamine produced in Mexico is used domestically. Similar levels of prevalence to those reported in the United States have been found in Mexico, where 0.12 percent of those aged between 12 and 65 had used methamphetamine, fewer than cocaine, cannabis or opioids (UNODC 2014a).

Australia

In Australia, the methamphetamine market comprises drugs and their precursor chemicals that have either been imported from overseas, or manufactured within Australia. The UNODC (2013c) has found that organised crime groups are involved in attempts to import large amounts of ATS and precursor chemicals into Australia. The scale of importation was indicated by Victoria Police in its submission to the Committee:

Through Victoria Police's involvement in the Joint Organised Crime Taskforce and the Trident Taskforce, they [Victoria Police] have identified vulnerabilities in Australia's borders and assisted with reducing the supply of these imported drugs and precursor chemicals. During the period July 2012 to October 2013, over 2,500 kg of precursor chemicals and approximately 550 kg of methamphetamine were seized through joint agency taskforce activities.¹⁵⁶

¹⁵⁵ Mr Shane Neilson, Head of Determination, Australian Crime Commission, Public Hearing, Canberra, 10 February 2014.

¹⁵⁶ Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

The ACC submission to the Committee also provided examples of recent interception of precursor chemicals:

In October 2013, 650 kilograms of pseudoephedrine concealed in vanilla powder shipped from India by air freight was seized during the closure of Operation Diamondback, a joint agency investigation. The estimated street value of this seizure was A\$100 million. During the 18 month investigation, a total of 10 individuals (members of a Canadian transnational crime group) were arrested and an estimated 1.0 tonnes of powder was seized.¹⁵⁷

Evidence suggests that international drug traffickers consider Australia to be an important methamphetamine market.¹⁵⁸ The Australian market is relatively small by international standards, but high levels of demand result in high prices and yield substantial profits for traffickers. A recent UNODC assessment of global synthetic drug trafficking routes, based on reports of methamphetamine seizures, identified West Africa as the most likely country of origin for imported methamphetamine in Australia. Methamphetamine is likely to be directly imported, or indirectly trafficked via Southern Africa and Western Europe (UNODC 2014a). Recognising the role of international organised crime syndicates in the Australian supply of methamphetamine, Australian law enforcement agencies have targeted this involvement. AFP Assistant Commissioner Jabbour told the Committee:

One more recent example would be an international organised crime syndicate spanning five countries that was allegedly involved in the importation and trafficking of ice into Australia. We worked closely in a task force arrangement with the Victorian Police, the New South Wales Police Force, the Australian Crime Commission and the Australian Customs and Border Protection Service.¹⁵⁹

Conclusion

The findings highlight the fact that criminal syndicates will exploit global vulnerabilities in the control and monitoring of precursor materials to support methamphetamine manufacture. The majority of methamphetamine production appears to be, in the main, driven to satisfy domestic markets. However, the apparent excess in production of methamphetamine in Mexico and identification of international trafficking routes suggest that international importation of methamphetamine is an economically viable enterprise. International evidence on organised crime group presence in the methamphetamine market is inconsistent, with a number of sources suggesting that the ease of methamphetamine manufacture allows non-organised criminal groups participation in the market, in an unpredicted way not observed for cocaine or heroin. Prevalence of use of methamphetamine in the United States and United Kingdom is low, in comparison to cocaine and heroin, whilst increases in the prevalence of use are being observed in the Asia and Oceania region. As indicated above, Australia has become a lucrative market for methamphetamine, largely owing to the high street prices that the drug commands.

Recommendation 20

The Committee recommends that the Australian Crime Commission (ACC) Board consider the establishment of a Special Operation in collaboration with the UNODC into the short and long-term implications for Australia of the substantial growth in the methamphetamine market within the South-East Asian region.

157 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

158 Mr Jeremy Douglas, Regional Representative for South-East Asia and the Pacific, United Nations Office on Drugs and Crime, Public Hearing, Canberra, 12 February 2014.

159 Assistant Commissioner Ramzi Jabbour, National Manager, Serious and Organised Crime, Australian Federal Police, Public Hearing, Canberra, 10 February 2014.

5. Prevalence and Extent of Harm

Introduction

Understanding the prevalence of illicit drug use is important for the development and implementation of effective policies and procedures by law enforcement, public health and community sector practitioners. Recently, concern has been expressed that the production and use of crystal methamphetamine has increased in Victoria with serious associated harm to users and communities. This chapter provides information from sources and datasets provided to the Committee on the prevalence and the extent of harm associated with methamphetamine in Victoria. The first section of the chapter assesses the prevalence of methamphetamine use in Victoria by reference to demographic factors such as rates of use, age, gender and location of methamphetamine users. It then compares methamphetamine use in Victoria to that in other states and territories, and nationally, before comparing methamphetamine prevalence and harms to other drugs, including alcohol and tobacco. The second section of the chapter assesses the harm caused by methamphetamine use by reference to health, coronial and treatment data. Given that the extent of methamphetamine use can also be determined by measuring the availability of drugs in the community, the chapter includes an analysis of the cost and purity of methamphetamine. The Committee's findings and conclusions are set out at the end of the chapter.

Sources of information

In Australia, the prevalence of drug use has been measured using surveys of the general population as well as within targeted groups. This chapter draws on a number of surveys including the National Drug Strategy Household Survey (NDSHS), the Australian Needle and Syringe Program Survey (ANSPS) and the Australian Secondary Students Alcohol and Drug Survey (ASSAD). Other sentinel group surveys such as the Ecstasy and Related Drug Reporting System (ERDRS), the Illicit Drug Reporting System (IDRS), and the Drug Use Monitoring Australia (DUMA) program also provide information on drug use within each jurisdiction, and are discussed throughout the chapter.

Additional data sources such as the National Prisoner Health Data Collection and the National Hospital Morbidity Database are presented in this chapter to highlight some of the key indicators of harm associated with methamphetamine use in the community. Health data is important in understanding the extent of harm associated with methamphetamine use in the community as health institutions are a primary point of contact with drug-affected people. The Committee was also provided with statistics prepared by the Victorian Injury Surveillance Unit (VISU) at the Monash Injury Research Institute (MIRI) on hospital-treated injury and poisoning in Victorian hospitals: the Victorian Emergency Minimum Dataset (VEMD) and the Victorian Admitted Episodes Dataset (VAED) as well as data on the frequency of deaths reported to the Coroners Court of Victoria where methamphetamine was detected during the period 1 January 2009 to 31 December 2013. The extent of methamphetamine use can also be gauged by reference to the availability of drugs in the community. Official law enforcement statistics on methamphetamine-related crime such as arrests can provide such information and are discussed in Chapter 8 on the use of methamphetamine and links to crime.

While prevalence and harm data can provide decision and policy-makers with information about the nature and size of methamphetamine use, and in turn help in the design of interventions

to help reduce its use and harm, they have a number of limitations. Firstly, there are notable differences in the way in which these surveys and monitoring programs are conducted especially with respect to data collection methodologies, the selection of the target population, the frequency of administration and the types of location at which they are conducted. Secondly, there are also substantial variations in the drug categories and levels of specificity adopted in categorisation, although all provide information on amphetamine type stimulants (ATS) and most do not provide information on specific ATS including methamphetamine.

Limitations with datasets

A number of the surveys used by the Committee have methodological limitations in terms of sample size, frequency and their ability to report findings for specific types of drugs (including ice), or for specific geographical areas (such as Victoria). Of particular note are the limitations in the national household survey. For example, in the NDSHS not all sectors of the population are equally represented and the degree of under-representation is likely to be greatest amongst those most likely to be using or to have had significant historical experience with illicit drugs. The homeless, those with no fixed address, those living in emergency accommodation or halfway houses, and those residing in hospitals, treatment centres and police or other custodial centres are just some of the populations unlikely to be adequately represented by the NDSHS methodology.¹⁶⁰ Further, there are also concerns that even if the NDSHS methodology captures sufficiently representative samples of the population, the self-report methodology may still understate the true extent of drug use. Notwithstanding the NDSHS's important contribution as Australia's only national population survey of drug use, there remain a number of key methodological limitations that must be considered when interpreting these results. Many young people, for example, commonly report completing the NDSHS questionnaire in the presence of a parent or guardian. This may have significant implications for their willingness to be open and honest about their licit or illicit drug use. In addition, the stigma associated with drug use, especially among older populations, may adversely influence the reliability of self-reported drug use data. This has implications not only for the most recent estimates, but also for any comparative analysis conducted between different populations over time.¹⁶¹

Variations between data collection methods employed by different organisations can also make direct comparisons difficult. While surveys such as the EDRS, IDRS and DUMA are conducted frequently, they only sample respondents from metropolitan areas in some jurisdictions which limits the ability of policy-makers to understand illicit drug use trends in rural and remote areas. While this chapter presents a large amount of data and analysis, the Committee wishes to stress that it is important to note the weaknesses and limitations of the data when seeking to understand the nature and extent of methamphetamine use in Victoria, and in Australia more generally.

Section One: Prevalence — Drug use in Victoria and Australia

National Drug Strategy Household Survey

The NDSHS is a Commonwealth-funded initiative managed by the Australian Institute of Health and Welfare (AIHW or Institute).¹⁶² It is the only population-based tool for estimating the prevalence of community-level licit and illicit drug use in Australia. Its findings provide a unique insight into the prevalence and nature of methamphetamine use not otherwise available at a population or community level.

160 Dr Rebecca McKetin, Fellow in Mental Health Research, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

161 Dr Rebecca McKetin, Fellow in Mental Health Research, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

162 The NDSHS is a triennial population survey, most recently administered in 2013, conducted across all Australian states and territories. Most results are based on the population aged 14 years or older, as this allows consistent comparison with earlier survey results. The NDSHS provides cross-sectional data on alcohol, tobacco and other drug use.

At the time of the tabling of this Report, only preliminary findings of the 2013 NDSHS survey were available, relating mainly to lifetime and most recent use of drugs, with some data on type of drug, and frequency of use for some demographic variables. Other information was prepared for the Committee and has been included with the permission of the Institute, excluding state and territory-level results for 2013 that were still being prepared for publication. For present purposes, findings of the 2013 survey will be presented where available, and in other cases, the findings of the 2010 survey will be used. Where possible, data is reported separately for Victoria, although on some occasions only national statistics were available. The Committee believes that it is important to consider prevalence both from national and Victorian perspectives.

Use

In Victoria in 2013, methamphetamine was the fourth most prevalent illicit drug type used in the previous twelve months — similar to cocaine, but less prevalent than cannabis (9.1%) or ecstasy (2.4%). Nationally, methamphetamine was the equal third most prevalent drug type used — the same as cocaine, but also less prevalent than cannabis (10.2%) or ecstasy (2.5%) (see Table 5.1 below).

Table 5.1: Prevalence of recent^(a) illicit drug use, by drug type, Victoria and Australia, people aged 14 years or older, 2013 (percentage)

Drug type	Victoria	National
Cannabis	9.1	10.2
Ecstasy	2.4	2.5
Cocaine	2.0	2.1
Meth/amphetamine ^(b)	1.9	2.1
Hallucinogens	1.3	1.3
Inhalants	0.9	0.8
Heroin	*0.1	0.1
Ketamine	*0.3	0.3
GHB	**<0.1	*<0.1
Synthetic Cannabinoids	1.0	1.2
New and Emerging Psychoactive Substances	*0.5	0.4
Injected drugs	*0.2	0.3
Any illicit ^(c) excluding pharmaceuticals	11.0	12.0

Notes:

(a) Used in the previous 12 months. For tobacco and alcohol, 'recent use' means daily, weekly and less than weekly smokers and drinkers.

(b) For non-medical purposes.

(c) Used at least 1 of 17 illicit in the previous 12 months in 2013.

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

Source: AIHW unpublished.

The NDSHS survey data for both 2010 and 2013 showed that 2.1% of those surveyed in Australia had used methamphetamine during the preceding 12 months (AIHW 2011, 2014). This was higher than the equivalent for Victoria in 2013 for which 1.9% of respondents had used the drug in the last 12 months — the lowest yet recorded both nationally and in Victoria (Table 5.2).

Table 5.2: Recent^(a) use of methamphetamine, persons aged 14 years or older, Victoria and Australia, 2001 to 2013

Year	Victoria	Australia
2001	2.4	3.4
2004	2.8	3.2
2007	2.3	2.3
2010	2.3	2.1
2013	1.9	2.1

Note:

(a) Used in the last 12 months.

The definition of meth/amphetamine has changed over time and was defined as:

a) Methamphetamine/Amphetamine (speed) in 2004

b) Meth/amphetamine in 2007

c) Non-medical of meth/amphetamine in 2010 and 2013.

Sources: AIHW (2011, 2014) and AIHW unpublished.

State and territory data was only available for the 2010 survey. A comparison between individual states and territories shows that in 2010 Victoria recorded the third highest prevalence estimate of recent methamphetamine use, exceeded only by Western Australia (3.4%) and South Australia (2.5%). More recent, unpublished, data from the 2013 survey shows similar trends, although Victoria's rating was reduced to the second lowest state at 1.9% in 2013 compared to 2.3% in 2010 (AIHW, unpublished data).

Location of users

The trend in Victoria over the nine years covered by the survey suggests that meth/amphetamine use has decreased in both categories covered in Table 5.3. A similar trend can be seen in the aggregated Australian data.

Table 5.3: Recent use^(a) of meth/amphetamines by remoteness area, 2004 to 2013

Location	Victoria				Australia			
	2004	2007	2010	2013	2004	2007	2010	2013
Major city	3.3	2.4	2.1	2.1	3.4	2.5	2.0#	2.1
Inner regional, outer regional, remote/very remote	1.6	2.0	2.8	*1.1#	2.2	1.8	2.1	1.8

Notes:

In Table 5.3, the remoteness categories 'Inner regional', 'Outer regional', 'Remote', and 'Very remote' were combined for data quality purposes.

(a) A recent user is a person who reported using meth/amphetamines in the last 12 months

Statistically significant change between 2010 and 2013

* Estimate should be interpreted with caution.

Sources: AIHW (2011, 2014) and AIHW unpublished.

In both 2004 and 2007 methamphetamine use was more prevalent in major cities than other areas (inner regional, outer regional, remote and very remote), both in Victoria and nationally. In Victoria, in 2010, this pattern was reversed with a higher rate seen outside major cities. By 2013, major cities in Victoria showed a higher prevalence in comparison to other areas, noting that this data needs to be treated with caution due to the small number of respondents. In spite of that caution, the largest reduction in the location of methamphetamine users appears to have been in the major cities, for both Victoria and Australia, over the period covered.

Age

Age at which methamphetamine was first used

Since 1995 the NDSHS has examined the average age of initiation of lifetime use of illicit substances including methamphetamine (see Table 5.4). The reported average age for Australian respondents has remained fairly constant, although in 2013 the average age was found to be 18.6, slightly higher than the age recorded in 1995. In 2013 the average age of initiation for cannabis and heroin was lower (16.7 and 16.9 years respectively), while cocaine, ketamine and GBH were all higher (19.2, 19.4 and 20.1 years respectively) (AIHW, unpublished data).

Table 5.4: Average age of initiation^(a) of lifetime methamphetamine^(b) use, people aged 14–24 years, 2001 to 2013 in Australia

Year	Average Age of initiation of use (years)
1995	18.3
1998	17.7
2001	17.6
2004	18.0
2007	18.1
2010	17.9
2013	18.6#

Notes:

Statistically significant change between 2010 and 2013.

(a) Age first tried/used.

(b) Included 'designer drugs' before 2004.

Source: Adapted from AIHW 2014, table 26.

Age of users

The NDSHS has also found differences in the prevalence of recent methamphetamine use according to age and gender. Table 5.5 shows survey results for recent methamphetamine use of persons 14 years or older by age category both for Victoria and Australia.

Table 5.5: Recent^(a) use of meth/amphetamine, persons 14 years or older, by age category Victoria and Australia, 2004 to 2013

Age group	Victoria				Australia			
	2004	2007	2010	2013	2004	2007	2010	2013
14-19	2.8	1.3	*3.1	**1.7	4.4	1.6	1.6	2.0
20-29	9.7	7.9	6.4	5.6	10.7	7.3	5.9	5.7
30-39	4.1	4.2	3.2	*2.8	4.1	3.9	3.4	3.1
40+	0.2	0.2	*0.4	*0.4	0.4	0.4	0.5	0.6
14+ ^b	2.8	2.3	2.3	1.9	3.2	2.3	2.1	2.1

Notes:

^(a) Used in the previous 12 months

^(b) Average percentage of use over all surveyed age groups

* Estimate has a relative standard error of 25% to 50% and should be used with caution

** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

Source: AIHW unpublished.

In 2013, in both Victoria and nationally, recent methamphetamine use was highest among those aged between 20 and 29 years, a consistent pattern since 2004, although percentages have been declining in this age group both nationally and in Victoria since 2004. As previously noted, the prevalence of recent use in 2013 was marginally lower in Victoria than was estimated for the national average. This difference, however, was also consistent by age category. Importantly, in the 20–29 age group there was a reduction from 9.7 in 2004 to 5.6 percent in 2013 in Victoria, with decreases also cited in the 30–39 group.

Gender

In terms of gender, as shown in Table 5.6, recent use by males was considerably higher than for females, both nationally and in Victoria in 2010 and 2013. Comparatively, in 2010 the prevalence of recent methamphetamine use in Victoria was higher for males in all age groups except for those aged between 14 and 19 years. For this younger cohort of Victorians, a near equal proportion of males and females reported the use of methamphetamine in the past 12 months (3.1% and 3.0% respectively).

Table 5.6: Recent^(a) use of methamphetamine, people aged 14 years or older,^(b) by gender, Victoria and Australia, 2010 (percentage)

Gender	Victoria		Australia	
	2010	2013	2010	2013
Males	2.9	2.5	2.5	2.7
Females	1.7	1.3	1.7	1.5
Persons	2.3	1.9	2.1	2.1

Notes:

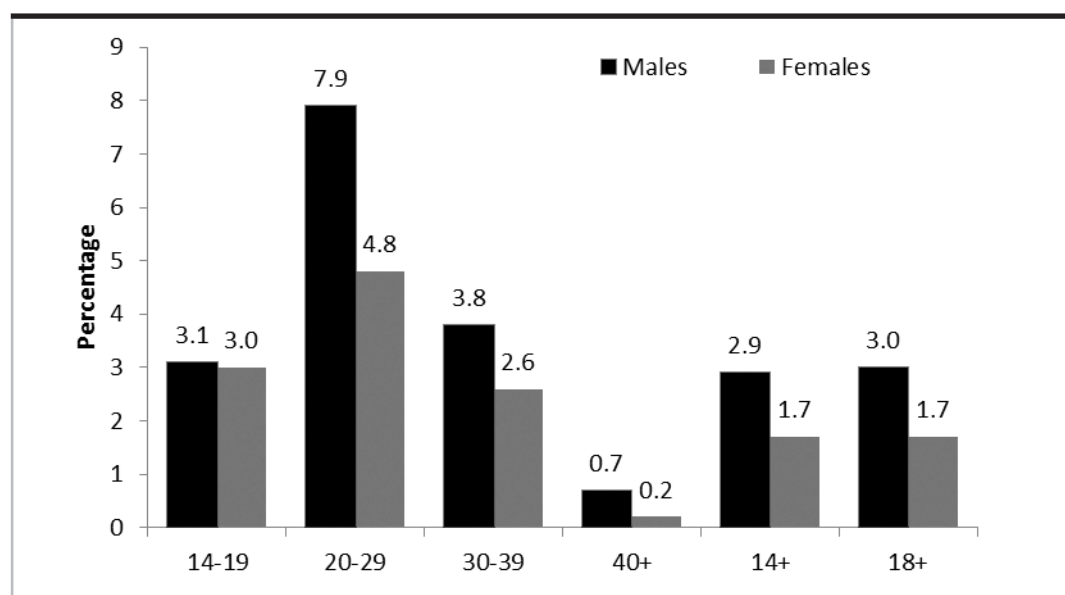
(a) Used in the previous 12 months.

(b) 14 years and older for 2013 in Victoria and nationally

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

Sources: AIHW (2011, 2014); and AIHW unpublished.

Interestingly when analysing both the gender and age of users, it appears clear that the 20–29 age group for both males and females is the highest category for using meth/amphetamines. For females the next highest age using population is the 14–19 years of age whereas for males, the 30–39 category is the second highest.

Figure 5.1: Recent use of meth/amphetamines¹⁶³ by gender and age, Victoria, 2010

Source: Adapted from National Drug Strategy Household Survey data 2010 (AIHW 2011)

The form of methamphetamine used

In addition to estimating the recent use of methamphetamine generally, the NDSHS also seeks information on the main forms of methamphetamine used in the past 12 months. In Victoria, the available data indicates a shift from the use of powder to the crystal form of the drug. While the data is problematic, there also appears to be an increase in the use of methamphetamine in the crystal form of the drug during the same period nationally between 2007 and 2013 (see Table 5.7 below).

Table 5.7: Main form of meth/amphetamines used, population prevalence, Victoria and Australia, 2007 to 2013 (percentage)

Form of methamphetamine	Victoria			Australia		
	2007	2010	2013	2007	2010	2013
Powder	74.3	71.9	47.2#	51.2	50.6	28.5#
Crystal, ice	*17.5	*10.1	43.9#	26.7	21.7	50.4#
Other (include liquid, base, and prescription)	*8.1	*18.0	*8.9	17	19.5	21.1

Notes:

Base is recent methamphetamine users

Statistically significant changes between 2010 and 2013

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

Source: AIHW unpublished.

In 2010, over two-thirds (71.9%) of methamphetamine users in Victoria had used the powdered form of methamphetamine as the main form of the drug used. Crystal methamphetamine or ice was the main form used by one in ten (10.1%) recent methamphetamine users in Victoria, while other forms of including liquid and base were used by 18 percent of users in that year.

163 Note that a reference to meth/amphetamine in a figure, table or graph in this chapter refers to stimulants in aggregate, meaning the data being represented includes amphetamine and methamphetamine.

In 2013, however, there had been a significant change to the trend, with the use of powder decreasing from 71.9% in 2010 to 47.2% in 2013. Conversely, crystal increased from 10.1% to 43.9%. Use of other forms of methamphetamine in 2013 almost reverted to the rate seen in 2007.

These trends were also present in the national sample with crystal/ice becoming much more prevalent as the main form of the drug used than powder in 2013. Between 2010 and 2013, nationally, there has been a large increase in crystal/ice as the form of the drug ever used (20.7% increase) as well as in the main form of the drug used (28.7% increase).¹⁶⁴ Correspondingly, large decreases occurred for powder methamphetamine. Other forms of the drug have, however, continued to increase from 17.0% in 2007 to 21.1% in 2013. The Committee notes that the national trend replicates that in Victoria, with an increase in the use of crystal or ice.

Frequency of methamphetamine use

The frequency of methamphetamine use across Australia including ice and powder has been reported in the national surveys conducted for the last three surveys. Recent use of all forms of methamphetamine was relatively stable between 2007 and 2013 with an average 44.1% of respondents reporting use once or twice a year.

In 2013, approximately one-quarter (25.3%) of recent crystal/ice methamphetamine users reported using the drug at least once a week, compared with 12.4% in 2010, although the 2010 data came from a small number of respondents making the finding less reliable. Much smaller proportions of recent powder methamphetamine users reported usage at least once a week (2.9% and 2.2% in 2010 and 2013 respectively).¹⁶⁵

Comparisons with other licit and illicit substances

During its Inquiry, the Committee received information not only on the prevalence and harms associated with methamphetamine use, but also on the impact that alcohol has on the community in Victoria. The health impact of alcohol has been found to be higher than that of methamphetamine in a number of ways. For example, Ambulance Victoria, during a Committee hearing, argued that a higher number of attendances relate to alcohol use as opposed to crystal methamphetamine use. Associate Professor Tony Walker, General Manager, Regional Services, Ambulance Victoria, in speaking with the Committee, noted that:

‘...we attend approximately 650 to 700 cases per annum for crystal methamphetamine. I think it is an important issue but fades in significance around the numbers of cases of alcohol we attend’.¹⁶⁶

Clearly, there are important differences between licit drugs such as alcohol, and illicit drugs such as ice, and the Committee is aware of the need to exercise caution when making comparisons between these two categories of substance, particularly owing to the fact that alcohol is extensively used in the community in a lawful way, other than in respect of certain age-related circumstances and in connection with driving. A detailed analysis of alcohol-related harm is also beyond the scope of the Terms of Reference of the current inquiry.

The results of the NDSHS for 2013 show the much higher national usage of alcohol and tobacco than illicit drugs (see Table 5.8). Comparable data for 2013 at state and territory level are not yet published.

¹⁶⁴ Refer to Table 5a in Appendix 8.

¹⁶⁵ Refer to Table 5b in Appendix 8.

¹⁶⁶ Associate Professor Tony Walker, General Manager, Regional Services, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013.

Table 5.8: Summary tobacco, alcohol and recent^(a) illicit drug use, people aged 14 years or older, Australia, 1993 to 2013 (percentage)

Drug type	1993	1995	1998	2001	2004	2007	2010	2013
Daily smoker	25.0	23.8	21.8	19.4	17.5	16.6	15.1	12.8#
Daily drinker	8.5	8.8	8.5	8.3	8.9	8.1	7.2	6.5#
Lifetime risky drinking ^(b)	n.a.	n.a.	n.a.	20.5	20.8	20.7	20.5	18.2#
Single occasion risky drinking ^(c)	n.a.	n.a.	n.a.	29.2	29.5	29.2	29.0	26.4#
Illicit drugs^(d)								
Cannabis	12.7	13.1	17.9	12.9	11.3	9.1	10.3	10.2
Ecstasy ^(e)	1.2	0.9	2.4	2.9	3.4	3.5	3.0	2.5#
Meth/amphetamines ^(f)	2.0	2.1	3.7	3.4	3.2	2.3	2.1	2.1
Cocaine	0.5	1.0	1.4	1.3	1.0	1.6	2.1	2.1
Hallucinogens	1.3	1.9	3.0	1.1	0.7	0.6	1.4	1.3
Inhalants	0.6	0.4	0.9	0.4	0.4	0.4	0.6	0.8
Heroin	0.2	0.4	0.8	0.2	0.2	0.2	0.2	0.1#
Ketamine	n.a.	n.a.	n.a.	n.a.	0.3	0.2	0.2	0.3
GHB	n.a.	n.a.	n.a.	n.a.	0.1	0.1	0.1	*<0.1#
Synthetic Cannabinoids	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	1.2
New and Emerging Psychoactive Substances	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	0.4
Injected drugs	0.5	0.5	0.8	0.6	0.4	0.5	0.4	0.3#
<i>Any illicit^(g) excluding pharmaceuticals</i>	<i>13.7</i>	<i>14.2</i>	<i>19.0</i>	<i>14.2</i>	<i>12.6</i>	<i>10.9</i>	<i>12.0</i>	<i>12.0</i>
Misuse of pharmaceuticals								
Pain-killers/analgesics ^(h)	1.7	3.4	5.2	3.1	3.1	2.5	3.0	3.3
Tranquillisers ⁽ⁱ⁾	0.9	0.7	3.0	1.1	1.0	1.4	1.5	1.6
Steroids ^(j)	0.3	0.2	0.2	0.2	—	—	0.1	*0.1
Methadone ^(h) or Buprenorphine ⁽ⁱ⁾	n.a.	n.a.	0.2	0.1	0.1	0.1	0.2	0.2
Other opiates/opioids ^(j)	n.a.	n.a.	n.a.	0.3	0.2	0.2	0.4	0.4
<i>Misuse of pharmaceuticals^(k)</i>	<i>n.a.</i>	<i>4.1</i>	<i>6.3</i>	<i>3.9</i>	<i>3.8</i>	<i>3.7</i>	<i>4.2</i>	<i>4.7#</i>
Illicit use of any drug^(k)	14.0	16.7	22.0	16.7	15.3	13.4	14.7	15.0

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

Statistically significant change between 2010 and 2013.

(a) Used in the previous 12 months.

(b) On average, had more than 2 standard drinks per day.

(c) Had more than 4 standard drinks on one occasion at least once a month.

(d) Used in the previous 12 months.

(e) Included 'designer drugs' before 2004.

(f) For non-medical purposes.

(g) Illicit use of at least 1 of 12 drugs (excluding pharmaceuticals) in the previous 12 months in 2013; the number and type of drug used varied between 1993 and 2013.

(h) Non-maintenance.

(i) Did not include buprenorphine before 2007.

(j) Included barbiturates up until 2007; did not include methadone in 1993 and 1995; did not include other opiates from 1993 and 1998.

(k) Illicit use of at least 1 of 17 drugs in the previous 12 months in 2013; the number and type of drug used varied between 1993 and 2013.

Source: 2013 National Drug Strategy Household Survey Key Findings (released 17 July 2014).

The NDSHS for 2013 (AIHW 2014) found that 42.5% of respondents believed that excessive use of alcohol was the drug of most serious concern for the general community, a finding unchanged from the 2010 survey when it was 42.1% (see Table 5c in Appendix 8). Methamphetamine was the second highest illicit drug of serious concern according to respondents in the 2013 survey, an increase from 9.4% in 2010 to 16.1% in 2013. Respondents nominated alcohol, tobacco and heroin as the drugs that caused the most death (33.6%, 32% and 14.1% respectively), with methamphetamine identified as the fourth worst drug (8.7%) in 2013. In the same year, more people thought that methamphetamine caused the most drug-related deaths as compared to the 2010 survey (an increase from 4.7% in 2010 to 8.7% in 2013), but this was still lower than heroin (15.9% in 2010 to 14.1% in 2013) (AIHW 2014, n.p).

Drug use and young people: School surveys

In Australia, prevalence of drug use within a sub-section of the general population, that is young people considered most vulnerable, can be estimated by findings from self-reported surveys. Recognising that young people are unlikely to be adequately represented in national population-level surveys, alternative data collection programs provide an opportunity to shed

new light and offer better estimates of illicit drug use, including methamphetamine use, by young people (White & Bariola 2012). They are conducted nationally and in the different states and territories on secondary school students and in Victoria on young adolescents.

Australian Secondary Students Alcohol and Drug Survey 2011

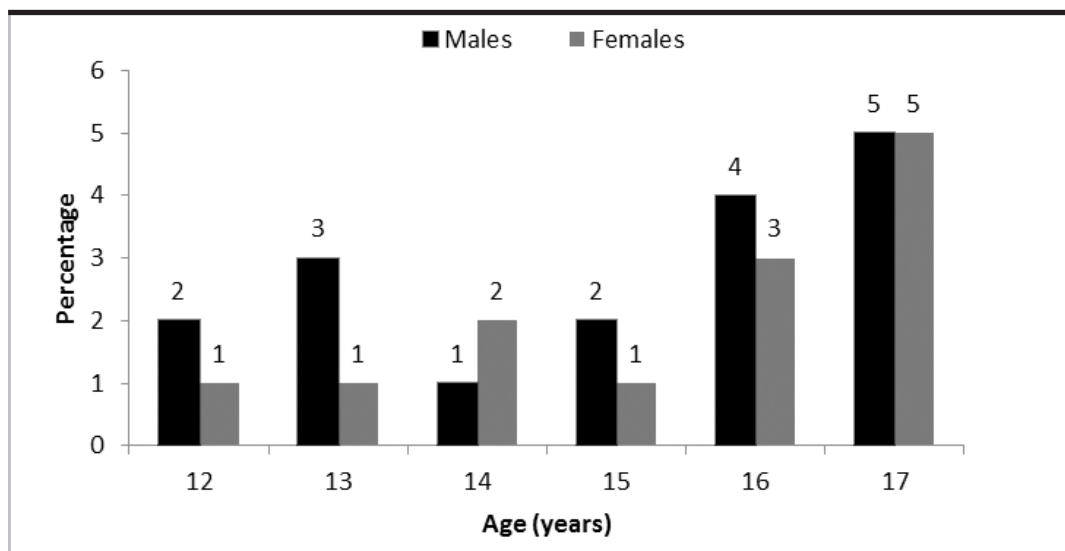
The Australian Secondary Students Alcohol and Drug (ASSAD) survey was developed with a specific focus on the licit and illicit drug use experiences of secondary school students aged between 12 and 17 years. ASSAD is coordinated by the Centre for Behavioural Research in Cancer, Cancer Council Victoria, and is implemented in all Australian states and territories (White & Bariola 2012, p. 142). This section is drawn from the Victorian survey findings from the 2011 ASSAD.¹⁶⁷

The Victorian component of the 2011 ASSAD survey found that approximately five percent of 17-year-old male and female secondary school students had previously used amphetamine for non-medical purposes at least once in their lifetime as indicated in Figure 5.2. Prevalence was generally lower at younger ages with, for example, amphetamine (which includes methamphetamine) having been used by:

- ◆ 4% of 16-year-old males and 3% of 16-year-old females;
- ◆ 2% of 15-year-old males and 1% of 15-year-old females; and
- ◆ 2% of 12-year-old males and 1% of 12-year-old females.

Overall, the lifetime prevalence of amphetamine use was estimated to be 3% of those aged 12-17 (combining male and female students); however, with the exception of those aged 14 years, male students in Victoria were more likely than their female counterparts to have tried the drug. This compares with 14% for cannabis, 3% for hallucinogens, 2% for ecstasy, and 1% for each of opiates, cocaine, GHB and ketamine.

Figure 5.2: Percentage of students who have ever used amphetamines (for non-medical reasons) in their lifetime, by age and sex, 2011



Source: Victorian Secondary Students Alcohol and Drug (ASSAD) Survey 2011, p.142

167 The most recent of ASSAD’s triennial surveys was conducted in 2011, culminating in a series of national and jurisdictional-specific reports published in 2012. Focusing in particular on the lifetime prevalence and recent use of illicit drugs, the survey included a total of 4,797 students in Years 7 to 12 from Victoria, which represents a participation rate of 76% of the total number of students selected for the survey (i.e. 80 students from 45 lower secondary schools and 100 students from 27 upper secondary schools). A random sampling method was used based on a stratified two stage sample design and the survey was administered between June and December 2011 (Bariola & White 2012b).

Comparatively, the lifetime prevalence of amphetamine use in Victoria is consistent with the national average and there are few substantive differences in terms of gender or age. Nationally,¹⁶⁸ for example, three percent of secondary students aged between 12 and 17 had tried amphetamines at least once; the highest prevalence being among those aged 17.¹⁶⁹

Trends in the past-month concerning prevalence of amphetamine use among secondary school students in Victoria and nationally are set out in Table 5.9. Between 2005 and 2008, there was a notable decline (from 2.8% to 1.3%) in amphetamine use among the national sample of male students aged between 12 and 15 years. There was also a less significant decrease observed among them between 2008 and 2011 (1.3% to 1.0%). Among female students in Victoria and nationally between the ages of 12 to 15 years, the pattern of recent amphetamine use remained fairly stable between 2005 and 2008, however a minor decline was observed in 2011.

Table 5.9: Percentage of students using amphetamines in the past month in 2005, 2008 and 2011, Australia (sample) and Victoria (sub-sample)

Gender	12 to 15 years			16 to 17 years		
	2005 (%)	2008 (%)	2011 (%)	2005 (%)	2008 (%)	2011 (%)
National						
Males	2.8*	1.3	1	3.4	2.8	2.3
Females	1.6*	1.1*	0.5	2.1	2	1.3
Total	2.2*	1.2*	0.7	2.8*	2.4	1.8
Victoria						
Males	2**	1	1	3	2	2
Females	1	1**	0	2	1	1
Total	2***	1	1	3**	2	1

Notes:

* Significantly different from 2011 $p < 0.01$

** Differences statistically significant compared to 2011 at $p < .05$

*** Differences statistically significant compared to 2011 at $p < .01$

Source: Adapted from the Victorian and national ASSAD surveys 2011.

Secondary school students between the ages of 16 and 17 years reported a higher percentage of use in the past month nationally and in Victoria between 2008 and 2011. However, in national trend terms, a notable decline was seen between 2005 and 2011 in amphetamine use among males (3.4% to 2.3%) whereas those from Victoria reported a decline of from three percent to two percent during that period. A decline in amphetamine use in the past month reported in 2005, 2008 and 2011 among female students was also observed nationally (2.1% in 2005 and 1.3% in 2011) and in Victoria (2% in 2005 and 1% in 2011).

Overall, a relatively substantial decrease in past-month amphetamine use was witnessed in 12 to 15 year old students from the national sample between 2005 and 2011 (2.2% to 0.7%), compared with a decrease from 2% to 1% during that period in the Victorian sub-sample.

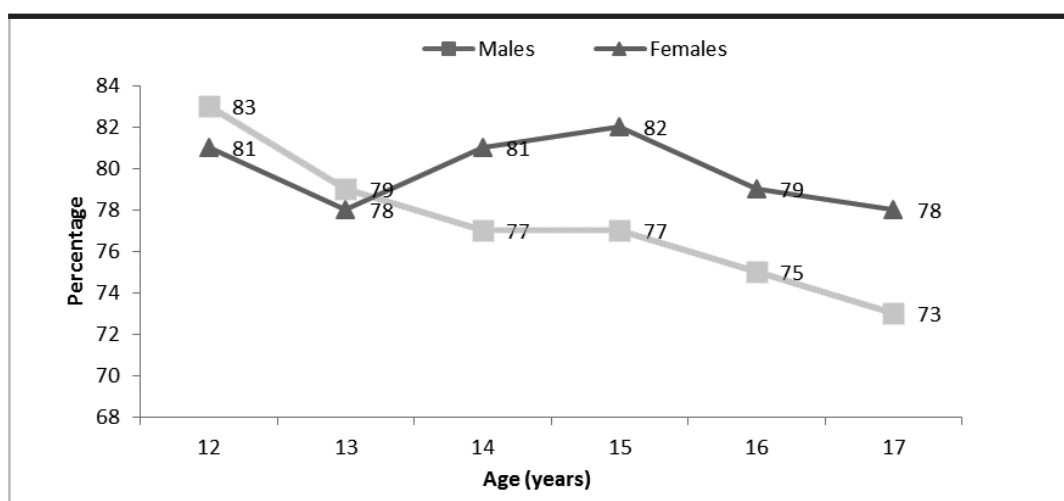
168 Just under 25,000 secondary students aged between 12 and 17 years participated in the national survey, in which they were asked about their lifetime and current use of tobacco, alcohol, analgesics, tranquilisers and illicit substances and related behaviour (Bariola & White 2012a, p.1).

169 Refer to Table 5d *Lifetime prevalence of amphetamine use, by age and sex, in Victoria and nationally, 2011* in Appendix 8.

In addition to past-month use findings, the Victorian ASSAD found that 2% of students had used amphetamine in the preceding 12 months (Bariola & White 2012b). Among the national sample, 1% of 12-year-olds had ever (at any time in their life) used amphetamine, increasing to 6% of 17-year-old students.

The 2011 Victorian ASSAD survey also presented findings on the perceptions of secondary school students about the dangers of occasional use of amphetamines (Bariola & White 2012b). As shown in Figure 5.3 below, there was a negative correlation between age and perceived dangers among males, with 83% of 12-year-old male students and 73% of 17-year-old female students perceiving that occasional amphetamine use was very dangerous. The relationship between age and perceived dangers was less clear among female students, although there was a decrease in perceived danger each year from 15 to 17 years old. Overall, over three-quarters (78%) of students aged 12 to 17 years indicated they believed occasional amphetamine use to be very dangerous (Bariola & White 2012b, p.144).

Figure 5.3: Percentage of students who believe it is very dangerous to use amphetamines occasionally, by age and sex, 2011



Source: Victorian ASSAD survey 2011, p. 144

Overall, the findings based on the Victorian and national ASSAD surveys showed that only a small proportion of secondary school students have ever used amphetamine, with most (97%) reporting they had never used amphetamine. Older students, aged 16 to 17 years, were more likely to have used amphetamines, both recently and ever, than younger students. The questions used in the ASSAD do not allow for more specific information on the type of amphetamine used. It is also important to note that this survey was conducted at least three years before the time of writing this Report and therefore cannot assess the current prevalence of amphetamine use in young people. Further, given this data relates to amphetamines generally, and not methamphetamine specifically, it is difficult to assess changes in trends for methamphetamine.

Targeted sentinel surveys: Drug users, police detainees and prisoners

In addition to such large-scale population based surveys, prevalence of drug use, including methamphetamine, can be determined from other smaller-scale surveys conducted with sentinel drug user groups. These represent injecting drug users, regular ecstasy users, general illicit drug users, and include users within prisoner and police detainee populations. These surveys, even though they comprise a relatively small sample size, offer a wider range of information on the prevalence of drug use and some help illustrate drug market characteristics. Furthermore, they offer specific information on methamphetamine and

some on crystal methamphetamine or 'ice', which is of interest to this Inquiry. The surveys include the following:

- ◆ Australian Needle and Syringe Program Survey (ANSPS);
- ◆ Ecstasy and Related Drug Reporting System (EDRS);
- ◆ Illicit Drug Reporting System (IDRS);
- ◆ Drug Use Monitoring Australia (DUMA) program provides information on the prevalence of drug use and perceptions among police detainees; and
- ◆ The National Prisoner Health Data Collection.

Injecting drug users

Unlike the NDSHS and ASSAD, the ANSPS identifies methamphetamine use among one of the key sentinel drug user population groups — injecting drug users. The ANSPS report provides a unique opportunity to assess the nature and prevalence of methamphetamine use among injecting drugs users who attend NSPs across Australia (Iversen & Maher 2013). The findings can demonstrate levels of methamphetamine use within the injecting drug user population relative to other drugs such as heroin. It can also provide information on characteristics of users, such as preferences for injecting methamphetamine as compared to smoking the drug, especially in the crystalline form.¹⁷⁰

The ANSP survey found that between 2008 and 2012 around one-third of respondents had most recently injected heroin, while just over-one quarter had reported methamphetamine as the last drug injected during that period (Iversen and Maher 2013). Nationally, when asked what drug they had last injected, the second highest proportion of respondents (approximately 25%) identified methamphetamine, with heroin the most frequently cited. Of particular significance was the finding that 'in 2012 methamphetamine was the most commonly-reported drug last injected in Queensland (26%) and Western Australia (32%) and the second most prevalent drug last injected in all other jurisdictions' (Iversen & Maher 2013, p.2). In Victoria, methamphetamine was the most commonly reported drug last injected in 2012 (18% of respondents). Heroin was the most commonly last-injected in drug in Victoria (65%), the Australian Capital Territory (38%) and New South Wales (30%).

Further information on more recent injecting drug user behaviour among respondents nationally and in Victoria is presented in Tables 5.10 and 5.11. Nationally, the percentage of recent injecting methamphetamine users remained stable between 2008 and 2012 at an average of 26%. In comparison, the findings from Victoria revealed lower proportions of injecting methamphetamine users (average of 16%) even though the number of users increased during that time (55% in 2008 to 82% in 2012).

170 The ANSP surveys are conducted annually at more than 50 NSP services over a one to two week period in October and are administered in all states and territories. Between 2,000 and 2,500 NSP attendees are recruited to complete the survey. 'Over the period of 2008 and 2012, the median age of survey respondents increased from 36 years to 38 years and the median time since first injection increased from 15 to 17 years (Iversen & Maher 2013, p.i)'. Participants complete a brief self-administered questionnaire and provide a blood sample, which is used to provide estimates of HIV and hepatitis C antibody prevalence and monitor sexual and injecting behaviour among injecting drug users (Iversen & Maher 2013).

Table 5.10: Number and percentage of respondents by last drug injected in the month prior to survey and year of survey, National, 2008 to 2012

Injecting behaviour	2008	2009	2010	2011	2012
	N=2270	N=2697	N=2396	N=2395	N=2391
Cocaine	53 (2%)	66 (2%)	31 (15%)	23 (1%)	21 (1%)
Heroin	781 (34%)	917 (34%)	808 (34%)	802 (33%)	799 (33%)
Methadone	192 (8%)	232 (9%)	177 (7%)	173 (7%)	159 (7%)
Methamphetamine	645 (28%)	657 (24%)	628 (26%)	649 (27%)	621 (26%)
Performance/image-enhancing drugs	35 (2%)	43 (2%)	57 (2%)	109 (5%)	162 (7%)
Pharmaceutical opioids	345 (15%)	426 (16%)	382 (16%)	358 (15%)	341 (14%)
Suboxone®	–	35 (1%)	46 (2%)	43 (2%)	46 (2%)
Subutex® /Buprenorphine	104 (5%)	134 (5%)	100 (4%)	94 (4%)	84 (4%)
More than one	53 (2%)	86 (3%)	118 (5%)	106 (4%)	121 (5%)
Other drug	21 (1%)	34 (1%)	37 (2%)	33 (1%)	22 (1%)
Not reported	41 (2%)	67 (2%)	12 (<1%)	5 (<1%)	15 (1%)

Source: ANSP survey report 2008–2012, p.10.

Nationally, heroin was the only drug that consistently recorded a higher proportion of use amongst injecting users during the five years of reporting (averaging 33%). Pharmaceutical opioids were the third most frequent type of drugs being injected after heroin, followed by methamphetamine (with an average of 15% of the respondents reporting usage during that period). Similar findings were observed also in Victoria, even though a much higher proportion of injecting heroin users was found (an average of 61%), compared with injecting methamphetamine users (with an average of 16%).

Table 5.11: Number (percentage) of respondents by last drug injected in the month prior to survey and year of survey, Victoria, 2008 to 2012

Injecting behaviour	2008	2009	2010	2011	2012
	N=308	N=334	N=445	N=506	N=463
Cocaine	2 (1%)	0 (0%)	4 (1%)	2 (<1%)	0 (0%)
Heroin	180 (58%)	205 (61%)	265 (60%)	307 (61%)	299 (65%)
Methadone	8 (3%)	9 (3%)	13 (3%)	12 (2%)	7 (2%)
Methamphetamine	55 (18%)	45 (13%)	57 (13%)	91 (18%)	82 (18%)
Performance/image-enhancing drugs	3 (1%)	1 (<1%)	1 (<1%)	1 (<1%)	2 (<1%)
Pharmaceutical opioids	22 (7%)	21 (6%)	34 (8%)	26 (5%)	15 (3%)
Suboxone®	–	3 (1%)	13 (3%)	16 (3%)	10 (2%)
Subutex® /Buprenorphine	21 (7%)	26 (8%)	31 (7%)	20 (4%)	13 (3%)
More than one	6 (2%)	10 (3%)	23 (5%)	26 (5%)	32 (7%)
Other drug	2 (1%)	8 (2%)	4 (1%)	2 (<1%)	2 (<1%)
Not reported	9 (3%)	6 (2%)	0 (0%)	3 (<1%)	1 (<1%)

Source: ANSP survey report 2008–2012, p.112.

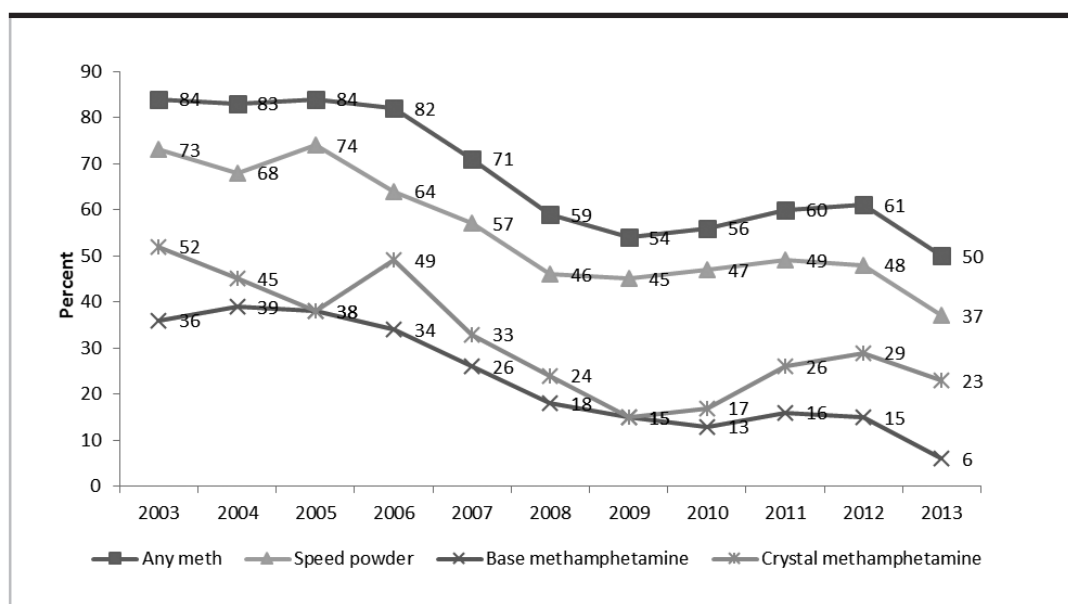
The findings from the ANSP survey support some of the evidence presented to the Committee during this Inquiry, which showed injecting methamphetamine users constitute a relatively small group in the community.¹⁷¹

3.4.2 Ecstasy and Related Drug Reporting System

The EDRS is managed by the National Drug and Alcohol Research Centre (NDARC) at the University of New South Wales. The surveys are conducted annually in each state and territory, and the findings not only provide a snapshot of the ecstasy and related drugs (ERD) market in Australia (including drug market characteristics such as price, purity and availability), but also provide an evidence base for policy decisions and directions for further investigation of issues related to ecstasy and related drug use (Sindicich & Burns 2014).¹⁷²

The most recent national and Victorian surveys available for reporting were conducted in 2013. The EDRS national findings include patterns of methamphetamine (and its specific forms) use by regular psychostimulant users (RPU) between 2003 and 2013, as described in Figure 5.4. Use of methamphetamine in any form was higher between 2003 and 2006 (around 83%) followed by a decline during the period of 2007 and 2009 (to 54% in 2009). Since 2010, an increase of around 5 percent is evident with 61% of REU in 2012 reporting recent use compared to 56 percent two years earlier. However, between 2012 and 2013 a marked decline of 11% in recent use was observed for any form of methamphetamine (Sindicich & Burns 2014).

Figure 5.4: Recent methamphetamine use by form of drug used among national EDRS participants, 2003 to 2013



Source: Ecstasy and Related Drug Reporting System interviews in 2013 reporting recent use, p.18.

The largest proportion of methamphetamine use was in the form of speed powder during that period. The pattern of use of speed powder essentially mirrored overall methamphetamine use. The national use of crystal methamphetamine (ice) has followed a different and more

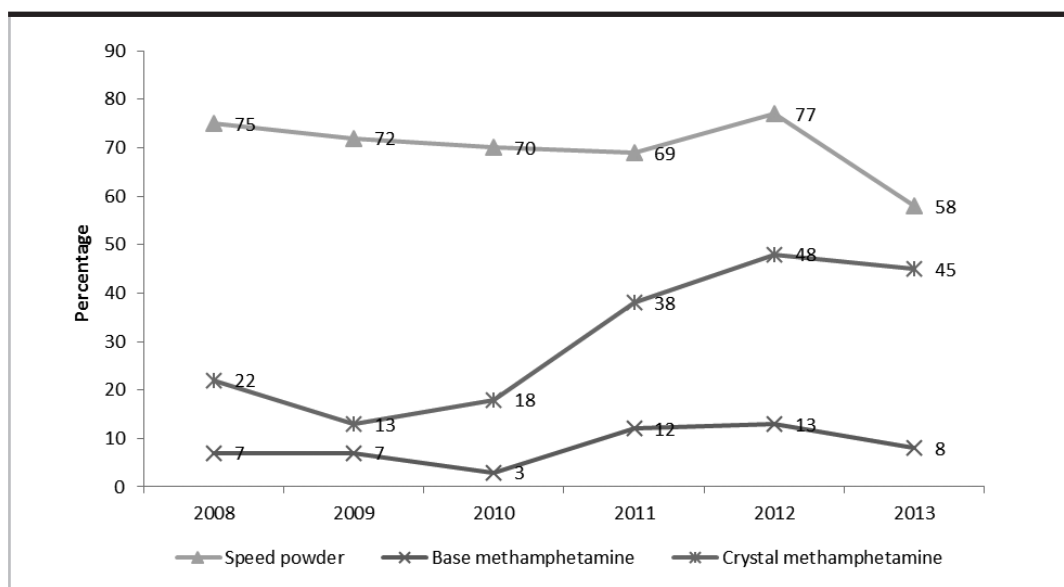
171 Rev Ric Holland, Chief Executive Officer, Melbourne City Mission, Submission, 1 November 2013.

172 The EDRS methodology incorporates surveys with regular ecstasy users (REU), surveys with key experts who have contact with REUs due to the nature of their work and an analysis of existing national and state-based data sources that contain information on ecstasy and related drugs (Sindicich & Burns 2014, p.xvii). For the 2013 survey, the sample was expanded to a broader group of regular psychostimulant users (RPU). The surveys are conducted using face-to-face interviews with current RPU, as well as telephone and face-to-face interviews with key experts.

variable pattern, from peaks of 52% in 2003 and 49% in 2006 to a low of 15% in 2009. Following consistent annual increases in ice use from 2010 to 2012 there was a decrease of six percentage points (from 29% to 23%) in 2013. Methamphetamine in base form has generally been less frequent than other forms. It is not clear from this evidence whether these changes reflect fluctuations in the availability of the different forms of methamphetamine, or are reflective of user preferences.

Analysis of the Victorian RPU sample indicates similar patterns of use to those seen in the national sample. In both national and the Victorian samples there has been a marked increase in the use of crystal methamphetamine in the 2010–2012 period, followed by a decline between 2012 and 2013. The scale of the increase is greater in Victoria (from 18% in 2010 to 45% in 2013) than nationally (17% to 23%). Nationally, the use of speed powder decreased from 2003 to 2008, and then remained largely stable until 2012. In 2013, there was a 19% decrease in the use of speed powder in Victoria and smaller decrease in the use of ice (Figure 5.5).

Figure 5.5: Recent methamphetamine use by form of drug among Victorian EDRS participants, 2008 to 2013



Source: Adapted from responses based on EDRS interviews, 2008–2013 in table 5 and 6 and p.13.

The national EDRS report indicated prevalence of methamphetamine use among REU/RPU in each Australian jurisdiction, as displayed in Table 5e in Appendix 8. National figures are shown for 2012 and 2013, while only 2013 figures are shown for the states and territories. There was no difference in the national pattern of methamphetamine use between 2012 and 2013.

In comparing Victorian RPU with those in other jurisdictions, the survey results¹⁷³ indicate that Victoria’s RPU were the second most likely jurisdictional group to have ever used methamphetamine (91%) after Tasmania (96%) and represented a larger sample of users (n=100) in comparison to Tasmania (n=76) (Sindicich & Burns 2014). The proportion who had ever used methamphetamine in Victoria was notably higher than in the one larger sample, NSW (59%). REU in Victoria were more likely to have used methamphetamine in the last six months (71%) than any other jurisdiction and were well above the national average (60% in 2012 & 49% in 2013). In particular, the proportion of REU in Victoria who had used methamphetamine in the last six months (71%) was about double that in

173 See Table 5e in Appendix 8.

NSW (36%). Consistent with the overall pattern of last-six-month use, REU in Victoria reported using methamphetamine on more days (median=8days) than those in all other jurisdictions. Victorian REU were much less likely to have ever injected methamphetamine (19%) than those in Western Australia (69%); injecting drug use in Victoria was slightly higher but similar to the proportions in the remaining jurisdictions.

The present Inquiry is specifically interested in the prevalence of crystal methamphetamine or ice use, and the EDRS also provides specific information on ice use in each jurisdiction (refer to Tables 5e and 5f in Appendix 8).

Between 2012 and 2013 there was a decrease in the proportion of REU nationally who had ever used ice (48% to 35%). Victorian REU were much more likely to have used ice (62%) than those from any other jurisdictions. Users from Tasmania (38%), South Australia (37%) and the Northern Territory (36%) also reported used of ice up to a lesser extent. The markedly higher proportion of REU/RPU in Victoria, compared with other jurisdictions, reporting lifetime ice use is of concern. As was the case for methamphetamine overall, Victorian REU/RPU were more likely than those in other jurisdictions to have used ice in the last six months (45%), with the difference most marked in respect to NSW (11%) and the Australian Capital Territory (14%). The median days of ice use by Victorian REU in the last six months were the highest recorded among all jurisdictions (10 days) followed by Western Australia (6 days).

Similarly, Victorian REU/RPU were much more likely to have binged on ice over a 48 hour period than those in any other jurisdiction, with the proportion in Victoria who had binged (55%) being considerably higher than the national average (40% and 32% in 2012 and 2013 respectively). Most Victorian REU/RPU who used ice had smoked the drug (93%) and they were more likely to have smoked ice than REU/RPU in any other jurisdiction except the Northern Territory (100%), the ACT (100%) and South Australia (96%).

More than one-quarter of Victorian REU/RPU reported snorting ice (36%) which was relatively higher than most other jurisdictions except Western Australia where 46% of the users stated using such method of drug administration. A slightly smaller proportion of Victorian REU (27%) had swallowed ice which is consistent with national average of 25% in 2013. Victorian REU/RPU reported the second higher number of users who injected ice (27%) after New South Wales (46%).

Patterns of crystal methamphetamine use in Victoria during the period from 2008 to 2013 are presented in Table 5g (refer to Appendix 8). While the proportion of Victorian REU/RPU who had ever used ice decreased from 2008 to 2009, it has increased each year since. Between 2010 and 2013, there was an increase of 17% (from 45% in 2010 to 62% in 2013) in the percentage of respondents reporting having ever used crystal methamphetamine. The proportion of those using in the last six months, as previously indicated, increased markedly in 2011 and 2012 compared with previous years, however a minor decrease was witnessed in 2013.

As noted above, the extent of individual ice use, as indicated by the median days of use, is greater among Victorian REU/RPU than those in other jurisdictions and this use in Victoria increased substantially in 2011, 2012 and 2013 compared with previous years.

Drug quality and cost

In addition to patterns of use, the Victorian EDRS 2013 report also described drug market characteristics including crystal methamphetamine purity, availability and price. Of the 32 participants who responded, 56% stated that the price of crystal methamphetamine had remained stable while 25% stated it had decreased. Generally, purity of crystal methamphetamine was reported as being high (50% of respondents) or medium (28% of respondents) (Papanastasiou, Dietze & Lloyd 2014). In relation to the availability of crystal methamphetamine, 78% of the RPU participants who responded stated that the drug was 'very easy' to obtain and 59% described that the availability has been stable during the preceding six months (Papanastasiou, Dietze & Lloyd 2014, p.32).

In comparison, the national EDRS report from 2013 reported that the median price of ice ranged from \$50 in New South Wales to \$100 in most other jurisdictions except the Northern Territory where it was \$150 (Sindicich & Burns 2014). The purity was perceived as high and most participants of the national sample reported that ice was 'easy' or 'very easy' to obtain. This was stable over the preceding six months.

Comparisons with other drugs

The EDRS survey for 2013 also presented data on alcohol use and harm compared with that of other drugs (Sindicich & Burns 2013). In 2013, it was found that the drugs most likely to have ever been used, as well as those used in the preceding six months, were alcohol, followed by cannabis and tobacco. Nationally, of all of the respondents who reported ever having used alcohol, 93% reported use in the preceding 6 months. In the case of ice, 35% reported ever having used the drug, and 23% in the preceding 6 months (Sindicich & Burns 2014, p.106). In terms of harm, 43% of national respondents had ever experienced a non-fatal drug overdose with 30% reported having ever overdosed on a stimulant drug, and 26% having done so in the preceding 12 months. Twenty-three percent of the national sample reported having ever overdosed on a depressant drug and 22% reported recent (last 12 months) overdose. Recent overdoses were most commonly attributed to alcohol (81%) (Sindicich & Burns 2014, p. 108).

These findings, and those presented elsewhere in this chapter, indicate that alcohol remains the drug of greatest concern to the community, with much higher levels of harm associated with its use than illicit drugs, including methamphetamine and ice. This is principally due to the much higher levels of use combined with risky patterns of alcohol consumption compared with illicit substances.

Illicit Drug Reporting System 2013

The IDRS uses a similar methodology to that of EDRS, however it provides additional information on the prevalence of methamphetamine use among injecting drug users who also use illicit drugs other than ecstasy.¹⁷⁴ While both EDRS and IDRS offer valuable insight into drug users' preferences and market trends each year, they are limited to both relatively small sample sizes and samples drawn only from urban areas. These limitations therefore preclude an understanding of methamphetamine use in rural and remote areas.

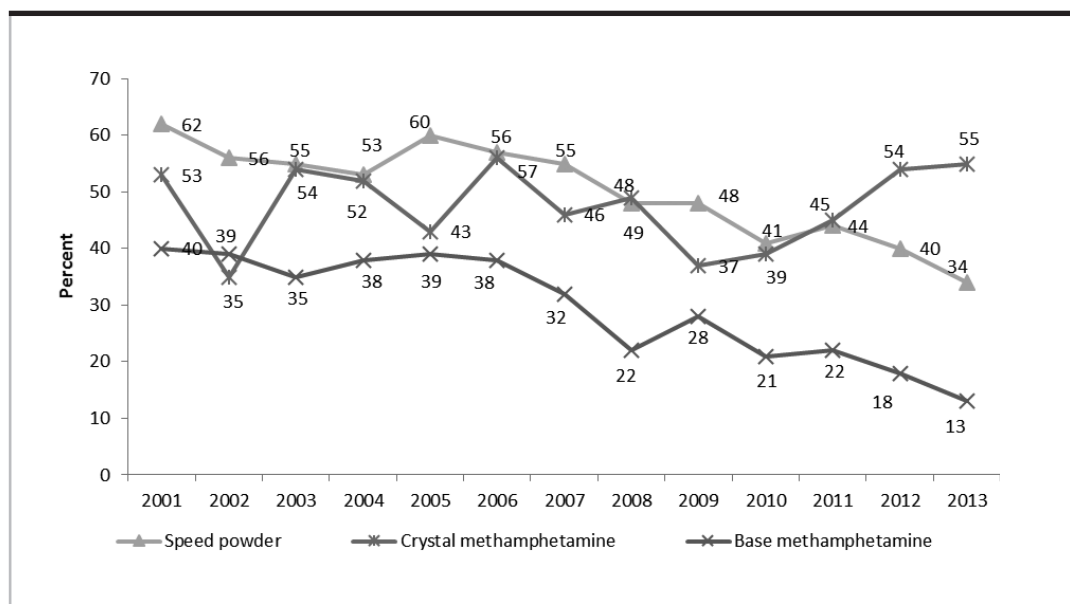
174 Both the IDRS and EDRS follow similar methodologies, although IDRS sampled injecting drug users who also use illicit drugs other than ecstasy whereas EDRS only sampled regular ecstasy users (and, in 2013, regular users of other psychostimulants). It aims to identify emerging trends in the local and national illicit drug markets based on survey results from those users, as well as key experts working in the field (Stafford & Burns 2014). The 2012 IDRS incorporates a quantitative survey of people who inject drugs, semi structured interviews with key informants. The survey comprises questions that sought to measure drug use habits; drug market characteristics on price, purity, availability and purchasing patterns; health and law enforcement-related trends associated with drug use; and special topics of interest (Stafford & Burns 2014). The national survey was comprised of 887 participants interviewed as part of the national survey with a mean age of 40 years (range 18-66 years) and 64% were male (Stafford & Burns 2014). The Victorian component of the survey was comprised of 150 people who inject drugs (PWID) interviewed in Victoria, and the mean age of the sample was 40 years and almost three-quarters of the sample were male (Cogger, Dietze & Lloyd 2014).

The most recent IDRS survey was conducted in 2013 nationally, including in Victoria. The results of the survey showed that the prevalence of ice use in Victoria remained the same in 2012 and 2013 after an increase from 2011. However, the median frequency of use doubled from six to 13 days in the past six months and smoking fell significantly to the same level as seen in 2011 (13%) (Cogger, Dietze & Lloyd 2014, p. xii).

Nationally, around two-thirds (66%) of the sample reported using one or more forms of methamphetamine recently, with a median of 24 days (Stafford & Burns 2014, p. xv). Patterns of ice use within the sample remained stable and such users were well represented, however speed and base use were found to have declined (Stafford & Burns 2014).

The 2013 IDRS report offers information on national trends in the recent use of different forms of methamphetamine for the period 2001 and 2013 (see Figure 5.6). The proportion of base methamphetamine use in recent years has been relatively low (an average of 18.5% between 2010 and 2013) in comparison to earlier years. The greatest proportion of methamphetamine use has been in speed powder form, even though a steady decline in powder use has been observed in recent years (from 41% in 2010 to 34% in 2013). Of particular importance are the fluctuations in the use of crystal methamphetamine between 2001 and 2012. Between 2009 and 2013, there has been an upward trend in the national proportion of crystal methamphetamine use (37% to 55%).

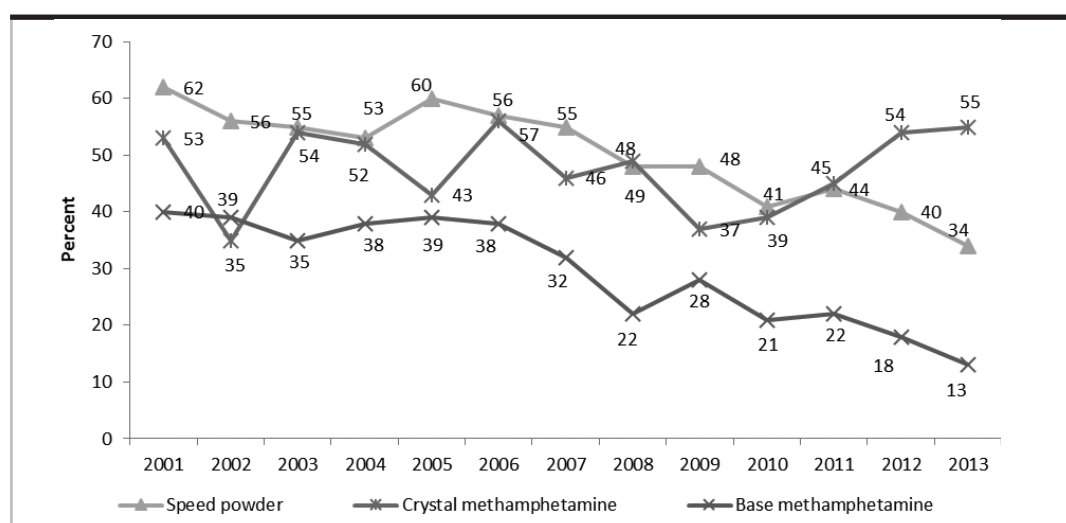
Figure 5.6: Proportion of participants reporting methamphetamine use in the past six months, National, 2001 to 2013



Source: IDRS participant interviews 2013, p.150.

The findings from the Victorian sub-sample (as described in Figure 5.7) revealed that speed powder was also the most common form of methamphetamine used between 2001 and 2011. It was then followed by a decline of 26% (49% in 2011 to 23% in 2013). However, in 2011 crystal methamphetamine exceeded speed powder as the most commonly used form of the drug and has remained the most commonly used form, despite a small decrease in 2013. The proportion of base methamphetamine use among the respondents was consistently lower than for other forms of the drug, and in comparison to the use of base in the national sample.

Figure 5.7: Proportion of participants reporting methamphetamine use in the past six months, Victoria, 2001 to 2013



Source: IDRS participant interviews 2013, p. 19.

The IDRS also captured patterns in the use of different forms of methamphetamine among respondents in 2013 (Tables 5.12 and 5.13). Nationally, the route of administration of all three forms of methamphetamine was most often by injection. In terms of use in the last six months, crystal methamphetamine was reported by 55% of the respondents as compared to 33% of respondents who had used speed powder.

Table 5.12: Patterns of methamphetamine use (any form), 2013, Australia

(%)	Speed powder	Base/point/wax	Ice/shabu/crystal	Any methamphetamine ^a
Ever used	84	39	78	93
Ever injected	78	36	74	90
Ever smoked	13	3	29	34
Ever snorted	27	6	5	29
Ever swallowed	24	6	6	29
Used in the last six months	33	13	55	66
Median days used in the last six months	10	6	12	24

Note:

Maximum number of days, i.e. daily use =180. See p. xiii for guide to days of use/injection.

^a Category includes speed powder, base, ice/crystal and amphetamine liquid (oxblood).

Source: Adapted from national IDRS participant interviews 2013, table A3, p.148.

Comparable data from Victoria show that similar proportions of respondents to those in the national sample had used methamphetamine overall, speed powder and ice, however Victorian respondents were less likely to have used base. The proportion of Victorians who had injected any form of methamphetamine (93%) was higher than in the national sample (90%), in sharp contrast to data from the EDRS. This is almost certainly due to the focus of the IDRS on injecting drug users, compared with the EDRS which involves a group that is relatively unlikely to inject. Victorians were somewhat more likely to have smoked ice (33%) than the national sample (29%), which is consistent with EDRS findings. The median number of days of methamphetamine use in the last six months among Victorian participants was lower (15 days) compared to that of the national sample (24 days). Median days used for ice was almost the same for the national (12 days) as for the Victorian sample (13 days).

Table 5.13: Patterns of methamphetamine use (any form), 2013, Victoria

(%)	Speed powder	Base/point/wax	Ice/shabu/crystal	Any methamphetamine
Ever used	88	16	81	93
Ever injected	85	15	80	93
Ever smoked	14	1	33	35
Ever snorted	34	1	2	35
Ever swallowed	25	1	3	27
Used [^] in the last six months	23	3	55	61
Median days used [^] in the last six months [*]	8	6	13	15

Note:

[^]Refers to any route of administration (injecting, smoking, swallowing and or/or snorting)

^{*}Among the participants who reported any use or injection in the preceding six months

Source: Adapted from Victorian IDRS participant interviews 2013, table 3, p. 11-12.

Data on crystal methamphetamine use in the different states and territories between 2003 and 2013 is presented in Table 5.14. Nationally, the highest recorded levels of crystal methamphetamine use were in 2006 (57%) followed by 2013 (55%). While the proportion of injecting drug users (IDUs) in the national sample using ice fell to its lowest level in 2009 (37%), there have been increases each year since. There have also been fluctuations in the proportion of Victorian IDUs using ice, but use has increased from 2009 and most markedly from 2011 to 2013 when over 50% of the participants consistently reported use. While crystal methamphetamine use among Victorian IDUs fell by four percentage points in 2013 compared with 2012, use in 2013 remained higher than in any other year since 2003. In contrast to the findings from the EDRS, the IDRS found the highest proportion of ice users in 2013 to be from NSW, followed by the ACT and Western Australia. Low levels of use were reported in the Northern Territory.

Table 5.14: Proportion of IDUs who reported use of ice/crystal methamphetamine in the preceding six months, 2003 to 2013

Year	National	NSW	ACT	VIC	TAS	SA	WA	NT	QLD
2003	54	38	65	50	69	48	80	34	60
2004	52	45	73	41	52	48	83	32	51
2005	43	38	62	29	50	46	68	21	36
2006	57	57	88	53	56	49	76	29	55
2007	46	50	80	43	38	41	56	29	39
2008	49	69	68	39	32	49	61	28	40
2009	37	46	57	32	26	30	43	15	46
2010	39	48	48	36	20	60	40	18	37
2011	45	53	57	53	26	44	46	28	50
2012	54	68	66	59	43	56	64	26	44
2013	55	74	61	55	45	57	59	30	50

Source: IDRS Injecting drug user interviews in 2013, p.21.

Drug quality and cost

As with the EDRS, the IDRS also captures drug market based information on price, purity and availability from survey participants, including those related to different forms of methamphetamine. Findings from the national IDRS showed that the majority of participants (72%) felt the price of crystal methamphetamine had remained stable over the preceding six months (Stafford & Burns 2014). Participants reported the purity of speed and base as medium (37% and 40% respectively), while ice was of high purity (44%). Participants in all jurisdictions suggested that each of the forms of methamphetamine was easy or very easy to obtain. While users purchased ice from a variety of sources, the most common purchases were through friends and dealers known to them (Stafford & Burns 2014), and this was reported to have been stable, although some jurisdictional variations were noted.

In comparison, the 2013 Victorian IDRS findings showed that a higher proportion of participants (79%) perceived that the price of crystal methamphetamine had remained stable in the previous six months (Cogger, Dietze & Lloyd 2014). In relation to purity levels, a similar proportion of participants (47%) described it as being high, whereas for speed, 32% of respondents reported that it was of medium purity. All forms of methamphetamine were generally considered to be available with 47% and 39% reporting that ice was easy and very easy to obtain, respectively. The most common sources of purchase of ice were from a dealer's home (27%) followed by public locations (25%) (Stafford & Burns 2014. p.65).

Drug use has also long been associated with individuals who come in contact with the criminal justice system. Therefore, for the purpose of understanding methamphetamine use within this population, the follow sections will present findings based on police detainees and prisoners in Australia.

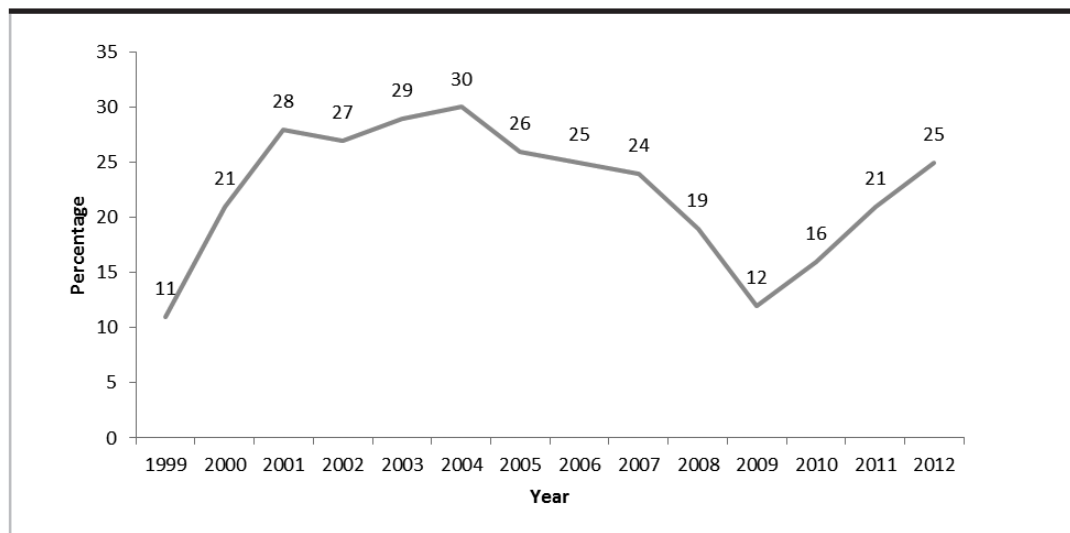
Drug Use Monitoring Australia

The Drug Use Monitoring Australia (DUMA) program provides information on the prevalence of drug use and perceptions among police detainees concerning different drug types, supply and usage within Australia. It is the only ongoing nationwide survey of police detainees conducted in Australia.¹⁷⁵ It is currently the only regularly conducted nationwide survey of detainees in Australia.

Figure 5.8 shows the proportion of detainees nationally who tested positive to methamphetamine between 1999, when the program was introduced, and 2012. The proportion of detainees who tested positive to methamphetamine showed an increase in use between 1999 until 2004 (11% to 30%). Then a steady decline was observed from 2005 (26%) until 2009 (12%). There has been a 13% increase (from 12% in 2009 to 25% in 2012) in the proportion of detainees who tested positive to methamphetamine, although proportions remain slightly lower than during the peak period from 2001 to 2005. On current trends, those peak levels will again be reached in 2012. The trends seen through DUMA mirror those seen through other data sources, particularly the decrease in use to 2009 and the sharp rise thereafter.

175 DUMA is based on a dual methodology which incorporates both self-reported information gained from police detainees through surveys and voluntary urinalysis of samples given by detainees. The questions in the survey on methamphetamine are on recent patterns of use, drug market habits and preferences, and availability of drugs in the local market. Since its inception in 1999, the number of sites at which the program operates has increased from four to nine. The DUMA program employs a sophisticated data collection methodology, details of which are explained by Sweeney & Payne (2012) who also describe the limitations of the research design including those that arise from the use of self-reported surveys.

Figure 5.8: National data on the proportion of detainees who tested positive to methamphetamine, National, 1999 to 2012



Note: Not all DUMA sites were operational during the period.

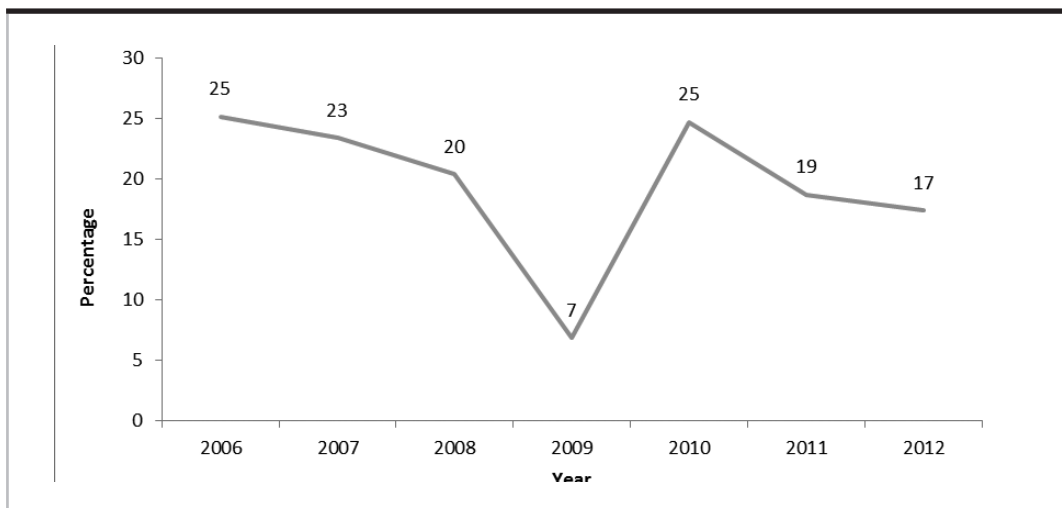
Source: AIC DUMA collection 1999–2012 (computer file).

The Australian Government, through funds collected under the *Proceeds of Crime Act 2002*, funded the Australian Institute of Criminology (AIC) to expand the DUMA Program from seven to nine sites in 2006 only, with the inclusion of one site in Victoria. Collection in Victoria was further extended by the AIC through core funds until 2012, after which the collection in Victoria was ended due to lack of funding. During the first quarter of 2006, DUMA was based at Sunshine Police Station, 14 kilometres west of Melbourne. However as a result of the low number of detainees processed at the station, DUMA was trialed at Footscray Police Station in the second quarter and continued there for the remaining quarters until 2012. Following a mid-year review in January 2013, the AIC Executive took a decision to temporarily suspend data collection through the DUMA program to allow an opportunity to review the program's relevance as a criminological and public health data collection system. Data collection was subsequently recommenced, using a rationalised number of collection sites. Among the sites where collection was ceased was Footscray, owing primarily to the high costs of administering that site compared with others, and the relatively low number of detainees available for inclusion in the program.

In Victoria between 2006 and 2012, some 929 detainees agreed to provide samples for urinalysis. The results revealed that 19.4% of detainees tested positive. Figure 5.9 shows that between 2006 and 2008, there was a decline in the proportion of detainees who tested positive for methamphetamine. However, in 2009 the proportion reduced to a low of 7% before increasing to 25% in 2010. In 2011 and 2012 the proportion testing positive for methamphetamine fell to 19% and then 17% respectively.

The data from all DUMA sites shows national use has followed a slightly different pattern to that seen in Victoria. After falling to a low of 12% in 2009, methamphetamine use among police detainees nationally increased, with 25% of detainees reporting use in 2012.

Figure 5.9: Detainees testing positive to methamphetamine, Victoria, 2006 to 2012



Source: AIC DUMA collection 1999-2012 (computer file).

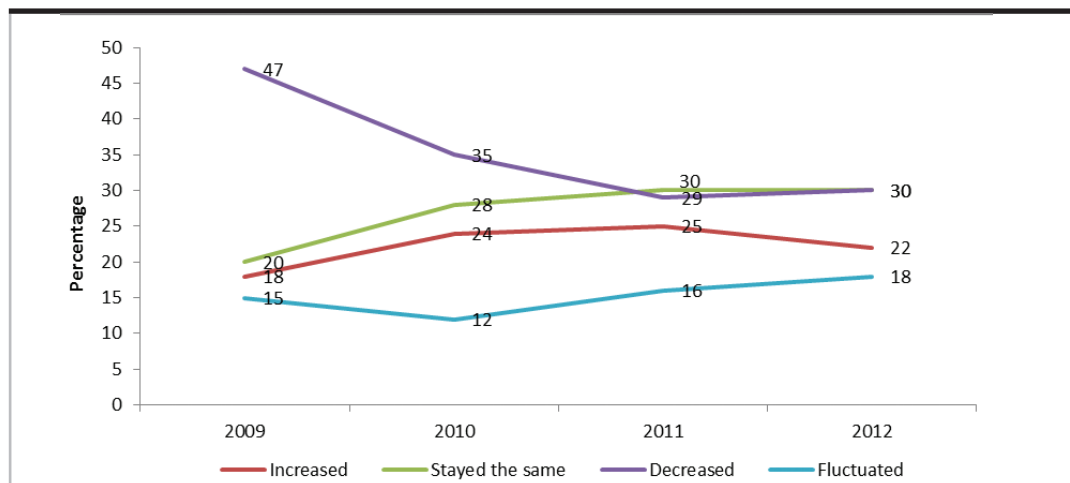
Drug quality and cost

In addition to findings based on urinalysis data, ‘DUMA interviews also collect a range of key drug use and drug market indicators in an effort to better understand the nature and context of local drug markets’ (Macgregor & Payne 2011, p.1).¹⁷⁶ Perceived changes in quality can influence the decisions of drug users sourcing their preferred choice of substances from different markets. Figure 5.10 shows trends in such perceptions between 2009 and 2012, based on responses from national detainees. It was found that a higher proportion of national detainees in 2009 (47%) believed there was a decrease in quality of methamphetamine as compared to 30% of them in 2012. A minor increase in quality was reported by detainees between 2009 (18%) and 2012 (22%).

The proportion of detainees who perceived that the quality of methamphetamine had fluctuated also remained stable. However, an increase of 10% was witnessed among detainees who believed that the quality remained the same between 2009 and 2012. The findings suggests that the market has been fairly stable when associating perception of quality especially considering that there has been less decrease in quality of methamphetamine in recent years.

¹⁷⁶ The DUMA survey has questions on quality, price and availability of methamphetamine, which provide an assessment of local drug market characteristics.

Figure 5.10: National trends on perceived change in quality of methamphetamine, 2009 to 2012

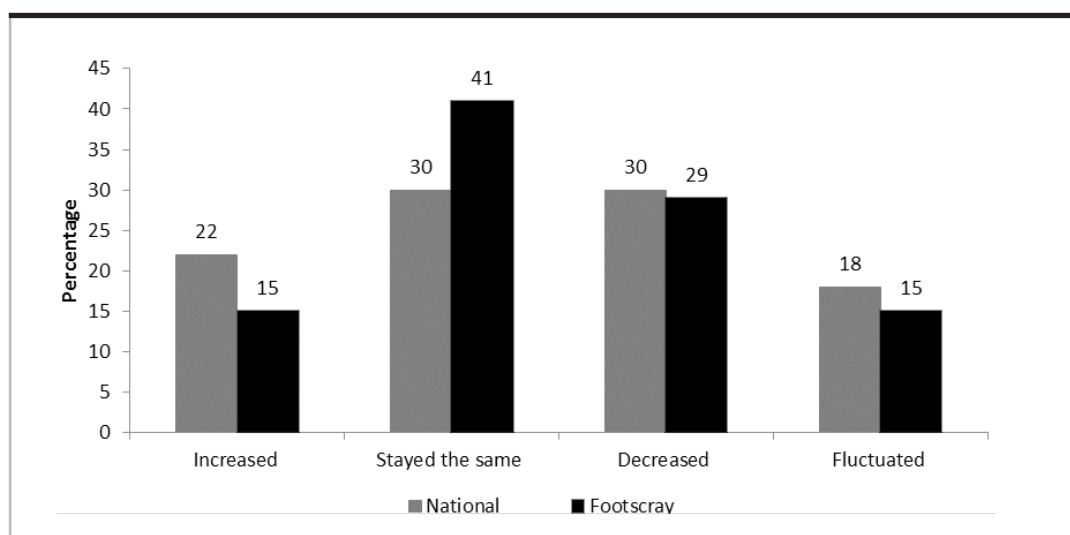


Note: While the DUMA questionnaire asks police detainees about 'methamphetamine', the information provided by detainees may also relate to other types of amphetamines.

Source: AIC DUMA collection 1999–2012 (computer file).

Figure 5.11 shows comparisons based on responses on perceived change in quality of methamphetamine between national detainees and those from Victoria for 2012. The detainees from Footscray reported a higher percentage of stability in quality in comparison to those from the national sample (41% to 30%). No changes were observed in the proportion of detainees from either sample who reported a decrease in quality. However, 22% of the national sample did report higher perceived quality compared with detainees from Victoria (15%).

Figure 5.11: Comparison between national and Footscray data on perceptions of detainees regarding change in quality of methamphetamine, 2012



Note: While the DUMA questionnaire asks police detainees about 'methamphetamine', the information provided by detainees may also relate to other types of amphetamines. The only DUMA site in Victoria was operational between 2009 and 2012.

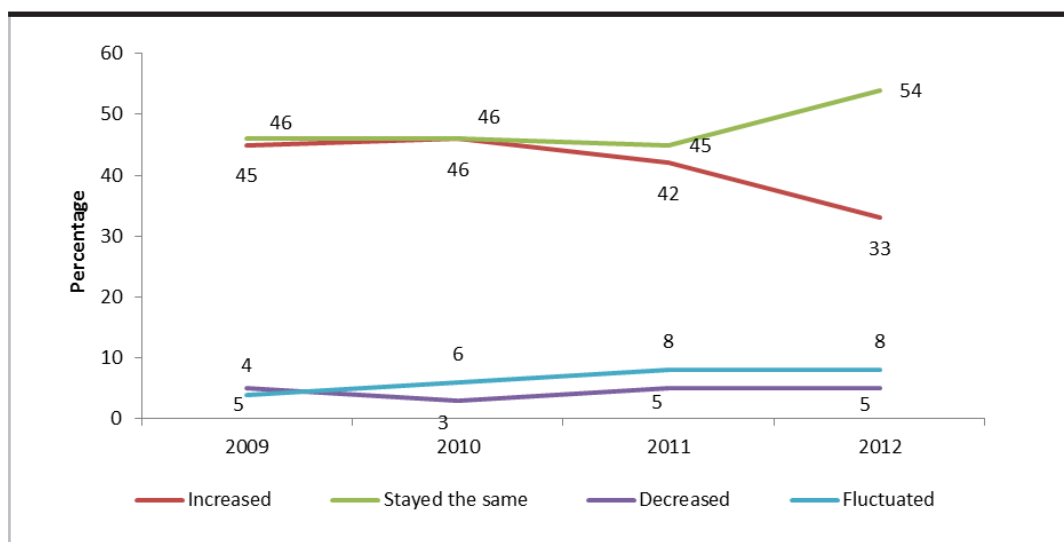
Source: AIC DUMA collection 1999–2012 (computer file).

Perceptions of price are another important indicator of the motivations of illicit drug users. Figure 5.12 shows the perceptions of detainees in regard to changes in the price of

methamphetamine between 2009 and 2012. It is apparent that the proportion of detainees who perceived that the price had fluctuated, or decreased, remained stable during the reporting period.

However, between 2010 and 2012, there was an increase in the proportion of detainees who believed that the price remained the same. This was mirrored by a reduction in the proportion of those who indicated that prices had increased. On that basis, there is a possibility of a stabilisation of the national methamphetamine market that will be important to watch in coming years given that price stability may be indicative of a market that is becoming more mature and established.

Figure 5.12: National trends on perceived change in price of methamphetamine, 2009 to 2012

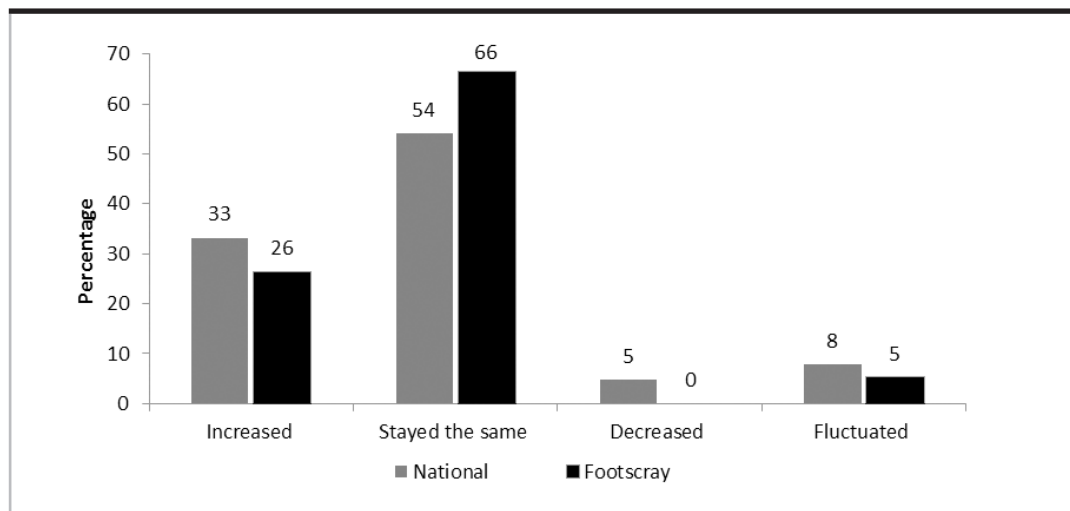


Note: While the DUMA questionnaire asks police detainees about ‘methamphetamine’, the information provided by detainees may also relate to other types of amphetamines.

Source: AIC DUMA collection 1999-2012 (computer file).

A comparison between the 2012 national and Victorian samples was conducted to assess perceptions of changes in price (Figure 5.13). A much higher percentage of detainees from Footscray (66%) reported that the price of methamphetamine stayed the same, compared with those from the national sample (54%). On the contrary, detainees nationally were more likely (33%) than those in Footscray (26%) to believe that the price of methamphetamine increased in 2012. Few detainees believed prices had decreased or fluctuated and there were no substantial differences between responses from national and Victorian detainees.

Figure 5.13: Comparison between national and Footscray data on perceptions of detainees regarding change in price of methamphetamine, 2012



Note: While the DUMA questionnaire asks police detainees about 'methamphetamine', the information provided by detainees may also relate to other types of amphetamines. The only DUMA site in Victoria was operational between 2009 and 2012. There was no response from Footscray on decrease in price.

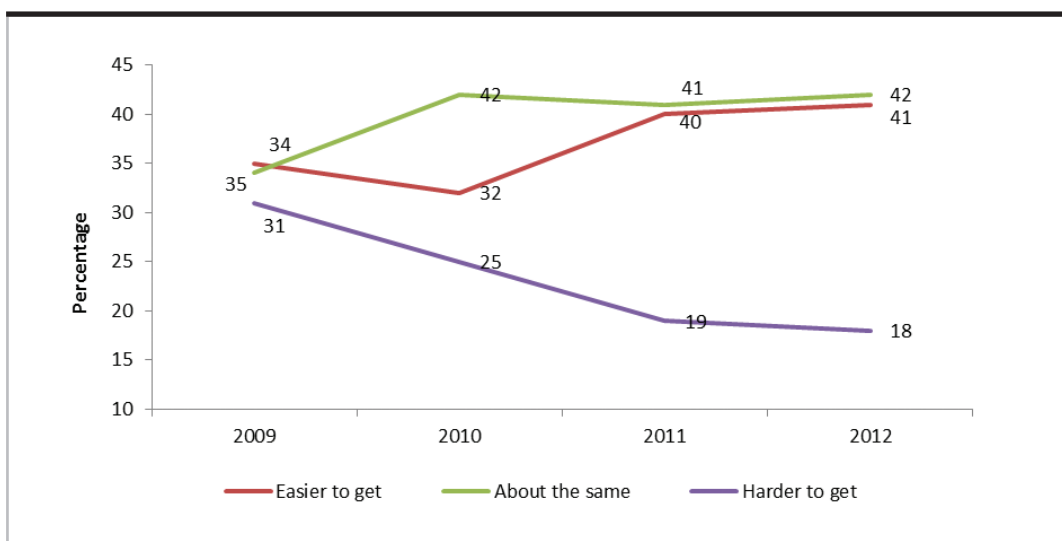
Source: AIC DUMA collection 1999–2012 (computer file).

Availability

In addition to quality and price, DUMA findings can help in assessing the number of people selling illicit drugs in the market. Drug markets can be categorised as open or closed. In open markets most drug users including new, recreational and dependent users can have relatively easy access to their drug(s) of choice, within the constraints of an illicit market operating in ways that seek to avoid police attention. Closed markets are less accessible to casual or unfamiliar users and are based upon trust within networks such as between families, friends and known dealers.

Figure 5.14 shows trends in the perceived changes in the availability of methamphetamine between 2009 and 2012, based on the national sample. There was a notable increase in the proportion of detainees who believed that methamphetamine had become easier to obtain between 2010 and 2011. This corresponded with a seven percentage point decrease between 2010 and 2012 (from 25% to 18%) in the number of detainees who believed methamphetamine had become harder to obtain. This suggests local differences in the availability of methamphetamine.

Figure 5.14: National trends on perceived change in the availability of methamphetamine, 2009 to 2012



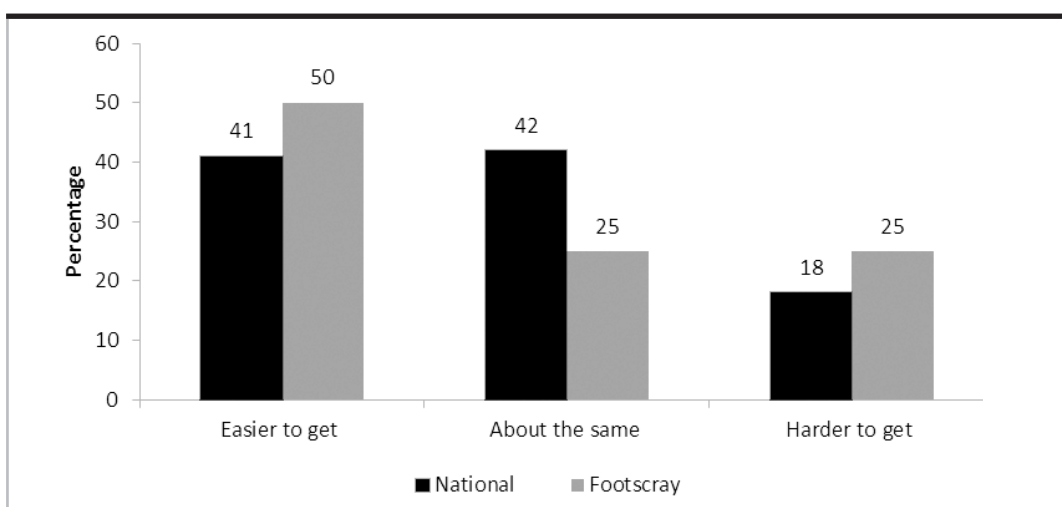
Note: While the DUMA questionnaire asks police detainees about ‘methamphetamine’, the information provided by detainees may also relate to other types of amphetamines.

Source: AIC DUMA collection 1999–2012 (computer file).

Figure 5.15 shows a comparison between detainees’ perceptions regarding availability of methamphetamine between the national and Victorian samples in 2012. It was found that more detainees from Footscray (50%) perceived that methamphetamine had become easier to obtain, compared with the national sample (41%).

Conversely, more national detainees (42%) as compared to those from Victoria (25%) believed the availability of methamphetamine to be the same. However 25% of national detainees stated that the drug was harder to find, compared with 18% of detainees from Footscray.

Figure 5.15: Comparison between national and Footscray data on the perceptions of detainees on availability of methamphetamine, 2012



Note: While the DUMA questionnaire asks police detainees about ‘methamphetamine’, the information provided by detainees may also relate to other types of amphetamines. The only DUMA site in Victoria, in Footscray, was operational between 2009 and 2012.

Source: AIC DUMA collection 1999–2012 (computer file).

The findings from the national DUMA data on trends in methamphetamine use revealed an increase between 1999 and 2004 in the number of detainees using methamphetamine, followed by a decline until 2009 when only 12% of detainees tested positive for methamphetamine. However, between 2010 and 2012 there was a substantial increase in the use of methamphetamine among detainees. Conversely, there was a decline in the proportion of Victorian detainees testing positive to methamphetamine from 2010 to 2012.

The self-reported responses from detainees representing the national and Victorian samples to 2012 provided some interesting findings on perceptions of quality, price and availability of methamphetamine. Victorian detainees were most likely to indicate that quality had remained the same, while those in the national sample were equally likely to indicate quality had remained the same or decreased. The price of methamphetamine was perceived to have been stable by the majority of detainees in both Victoria and nationally. In regard to the availability of methamphetamine, a significant proportion of the detainees in 2012 believed it was easier to get the drug than previously. Taken together, these findings suggest that the methamphetamine market is becoming more established, but with variations in the quality of material supplied in different jurisdictions.

National Prisoner Health Data Collection

The AIHW in its submission to the Inquiry provided information from the National Prisoner Health Data Collection (NPHDC). In 2013 AIHW also released a report on the health of Australia's prisoners (using 2012 data), which contained data on prisoners' use of alcohol, tobacco and illicit drugs in the 12 months before entry into prison. More specifically, the report included information on the prevalence of methamphetamine use among serving prisoners.¹⁷⁷ 'The indicators and data collection were developed by the AIHW with assistance and advice from the National Prison Health Information Committee (AIHW 2013a, p.2)'. For this section, national data is reported. While the total data includes Victoria, separate data has not been published for Victoria due to the small sample obtained.¹⁷⁸

In 2012, 37% of prison entrants across Australia had used methamphetamine during the 12-month period prior to their current imprisonment (AIHW 2013a). In comparison, cannabis was used by 50% of prison entrants nationally during that period and 17% of that sample had used analgesics/pain killers (AIHW 2013a). Slightly smaller proportions had used tranquilisers, heroin and ecstasy. Further demographic information on illicit drug use among the prison entrants in 2012 is presented in Table 5.15.

Males were more likely to use cannabis (51% compared to 45% of females) but females were more likely to have used a more diverse range of drugs, including methamphetamine, analgesics, tranquilisers, heroin and ecstasy. Young prisoners aged between 18 and 24 years were much more likely than prisoners aged 45 or over to have used cannabis, methamphetamine, heroin and ecstasy prior to prison. A higher proportion of prison entrants who used methamphetamine were non-Indigenous (45%) as compared to those of Indigenous background (21%).

177 Included are the data from 794 prison entrants, just over 4,000 prisoners who visited the clinic and about 9,000 prisoners who took medication (Australian Institute of Health and Welfare 2013a, p. ix).'

178 Mr David Kalisch, Director, Australian Institute of Health and Welfare, Submission, 23 January 2014.

Table 5.15: Prison entrants, illicit drug use in the 12 months preceding 2012 for selected drugs, by sex, age group and Indigenous status

Number of prisoners						
	Cannabis/ Marijuana	Methamphetamine	Analgesics/ pain killers	Tranquilisers/ sleeping pills	Heroin	Ecstasy
Sex						
Male	361	257	105	107	103	62
Female	36	35	30	24	16	11
Age groups (years)						
18-24	134	90	38	34	26	33
25-34	131	119	50	54	54	26
35-44	103	67	31	35	35	10
45+	23	14	14	8	4	3
Indigenous status						
Indigenous	161	57	45	29	20	17
Non-Indigenous	226	222	85	98	98	53
Total	397	292	135	131	119	73
Percentage of prisoners						
Sex						
Male	51	36	15	15	14	9
Female	45	44	38	30	20	14
Age groups (years)						
18-24	59	39	17	15	11	14
25-34	47	43	18	20	20	9
35-44	53	34	16	18	18	5
45+	27	16	16	9	5	4
Indigenous status						
Indigenous	59	21	16	11	7	6
Non-Indigenous	46	45	17	20	20	11
Total	50	37	17	16	15	9

Notes:

1. Excludes Western Australia, as they did not participate in the 2012 NPHDC.
2. Total includes 10 prison entrants of unknown age and 25 of unknown Indigenous status.

Source: Entrant form, 2012 National Prisoner Health Data Collection, AIHW (2013, p. 77).

Comparing the survey data for 2012 with the earlier survey in 2009, it appears that recent use of methamphetamine by prisoner entrants has increased by 7%, while recent use of cannabis and ecstasy has declined (see Table 5.16).

Table 5.16: Use of illicit drugs during the last 12 months, prison entrants (percentage)

Age group	Cannabis		Methamphetamine		Ecstasy	
	2009	2012	2009	2012	2009	2012
18-24	60	59	28	39	24	14
25-34	54	47	35	43	17	9
35-44	45	53	30	34	13	5
45+	30	27	19	16	9	4
All	52	50	30	37	18	9

Note:

Includes New South Wales, Victoria, Queensland, Western Australia, South Australia and the Australian Capital Territory in 2009; Excluding Western Australia in 2012.

Source AIHW 2010, p.107; AIHW 2013, p.77.

Section Two — The extent of methamphetamine-related harm

While the first section of this chapter assessed the prevalence of methamphetamine use in Victoria, this section assesses the impact of methamphetamine on Victorians by reference to health data. This data, which is composed of ambulance, hospital and treatment data provides both an indication of the nature of harms arising from the use of the drug and the extent of the problem in Victoria and nationally.

This chapter draws on the data provided by, or drawn from, Victorian ambulance data, hospital data from the Victorian Injury Surveillance Unit (VISU) at the Monash Injury Research Institute (MIRI)¹⁷⁹ and fatality data from the Coroners Court of Victoria (CCOV). In terms of the hospital data, the Committee has drawn on the Victorian Emergency Minimum Dataset (VEMD) and the Victorian Admitted Episodes Dataset (VAED) for methamphetamine-related injury and poisoning. The VEMD contains demographic, administrative and clinical data detailing presentations at Victorian public hospitals with 24-hour emergency departments.¹⁸⁰ Similarly, the VAED contains demographic, administrative and clinical data for all admitted patients from Victorian public and private acute hospitals including rehabilitation centres, extended care facilities and day procedure centres.¹⁸¹ In the context of the Coroners Court, the fatality data provides information on the extent of the detection of methamphetamine in deaths investigated in Victoria by coroners. The Committee is particularly grateful to these two organisations for providing current data not otherwise publicly available. In order to present this information in as complete a way as possible, the Committee has drawn heavily from these reports.¹⁸²

179 See Ms Angela Clapperton, Manager — Data Systems, Data Requests and Reports, Victorian Injury Surveillance Unit (VISU) and Research Fellow, Monash Injury Research Institute (MIRI), Submission, 6 August 2014.

180 Victorian Parliamentary Road Safety Committee, *Inquiry into Serious Injury*, May 2014, Parliament of Victoria, pg. 15.

181 Victorian Parliamentary Road Safety Committee, *Inquiry into Serious Injury*, May 2014, Parliament of Victoria, pg. 15.

182 The original reports are:

Ms Angela Clapperton, Manager — Data Systems, Data Requests and Reports, Victorian Injury Surveillance Unit (VISU) and Research Fellow, Monash Injury Research Institute (MIRI), Submission, 6 August 2014.

Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

The use of methamphetamine, particularly over an extended period, can cause a broad range of physical, psychological and social harms. Compared with amphetamine, methamphetamine produces a more intense experience through its interactions with the nervous system Australian Crime Commission (ACC) (2014a). In the short-term, all ATS can cause dehydration, sweating, headaches, sleep disorders, anxiety and paranoia (ACC 2014a; Pennay & Lee 2008). Used over the longer-term, physiological impacts include weight loss, dermatological problems, neurotoxicity, reduced immunity, elevated blood pressure, damage to teeth and gums, cardiovascular problems and kidney failure (ACC 2014a; Pennay & Lee 2008). Long-term use can lead to psychological, cognitive and neurological impacts including schizophrenia, depression, impaired memory and concentration and aggressive or violent behaviour (ACC 2014a; Pennay & Lee 2008). The use of methamphetamine alongside other drugs can increase methamphetamine toxicity while also compounding the harmful effects of the other substances, leading to heightened risks of respiratory failure, blood-borne diseases, alcohol poisoning and accidents (Pennay & Lee 2008).

Victorian methamphetamine-related ambulance attendances

This section is based on the 2013 Turning Point Alcohol and Drug Centre study on trends in alcohol and drug-related ambulance attendances in Victoria. Table 5.17 presents the data on the characteristics of crystal methamphetamine-related ambulance attendances within metropolitan Melbourne and regional Victoria. According to this data, there was an 88% increase in the number of attendances (per 1 million population) within metropolitan Melbourne between 2011-12 and 2012-13.

Over the same period there was an increase of 200% for regional Victoria, indicating a proportionately large increase in ambulance attendances. For both metropolitan Melbourne and regional Victoria the increase in attendances, measured by the mean number of attendances per day, was statistically significant.

Table 5.17: Characteristics of crystal methamphetamine-related Ambulance attendances, 2011-12 and 2012-13

	Metropolitan Melbourne			Regional Victoria		
	2011-12	2012-13	<i>p</i>	2011-12	2012-13	<i>p</i>
Number of attendances (per 1m population)	592 (144.1)	1112 (265.7)		77 (54.2)	231 (159.8)	
Mean per day (SD)	1.62 (1.45)	3.05 (1.92)	<0.001	0.21 (0.44)	0.63 (0.84)	<0.001
Daily range	0-7	0-10		0-2	0-4	
Alcohol involved	158 (27%)	243 (22%)	0.022	25 (32%)	63 (27%)	0.377
Age — Mean (SD)	28 (8.80)	28 (8.41)	0.136	26 (9.06)	28 (8.83)	0.136
Age — Mean (range)	26 (<1-53)	27 (12-70)		25 (<1-68)	26 (13-60)	
Male	386 (65%)	724 (65%)	0.975	46 (59%)	150 (65%)	0.313
Public space	256 (44%)	424 (39%)	0.028	18 (23%)	78 (34%)	0.062
Outdoor space	226 (40%)	405 (38%)	0.407	10 (56%)	54 (63%)	0.559
Police co-attendance	124 (21%)	306 (27%)	0.002	5 (6%)	51 (22%)	0.002
Transported to hospital	458 (78%)	858 (87%)	<0.001	65 (84%)	182 (90%)	0.136

Note: Except where indicated, all figures in the proportions are based on non-missing information.

Source: Lloyd, Matthews & Gao 2014, p.50.

As well as the number of ambulance attendances increasing, the seriousness of the incidents also appears to have increased. The proportion of attendances that resulted in a person being transported to hospital increased in both metropolitan Melbourne (by 9%) and in regional Victoria (by 6%). While only the increase in metropolitan Melbourne was statistically significant, the increase in regional Victoria approached significance.

Alcohol continued to be involved in ambulance attendances relating to crystal methamphetamine use, but the proportion of cases in which alcohol was involved decreased in both metropolitan Melbourne and regional Victoria. This suggests a change in the nature of crystal methamphetamine use, towards more an exclusive use of the drug or use of the drug in greater quantities and/or purity, although that trend needs to be treated cautiously given the data relates to a two-year period.

In terms of gender representation, the data indicates that there was no change in the representation of males in the period covered. Police co-attendance rates, however, have risen in both Melbourne (by 6%) and regionally (by 16%), the latter constituting a significant increase.

Victorian emergency department presentations and hospital admissions for methamphetamine-related injury and poisoning

As mentioned earlier, the Victorian Injury Surveillance Unit (VISU) at the Monash Injury Research Institute (MIRI) has access to two datasets that provide information on hospital-treated injury and poisoning in Victorian hospitals: the VEMD and the VAED. It is important to note that both of these datasets are subject to some limitations in relation to methamphetamine related cases¹⁸³. The tables in this section provide an overview of Victorian hospital emergency department presentations and admissions for methamphetamine-related injury and poisoning over the five year period between July 1, 2008 and June 30, 2013.

Trends in the frequency of hospital admissions and emergency department presentations (non-admissions) for methamphetamine-related injury and poisoning

Hospital admissions¹⁸⁴

Figure 5.16 shows the frequency of psychostimulant-related injury and poisoning which has generally increased over the period reaching its peak in 2011-12. However, the sharp decrease in 2012-13 should be interpreted with caution as it is likely to be a consequence of some recent changes in hospital policy which will reduce the numbers of injury cases being

183 VEMD data are often collected in the busy emergency department, so detailed data collection is not always achieved. Identification of cases for this analysis used the 'description of injury event' variable and this data item is known to be of variable quality (e.g., some hospitals collect good text descriptions while others simply collect descriptions such as 'unknown, unknown, unknown' for many of their records). Information regarding methamphetamine use is usually only recorded for the injured person, i.e., a patient recorded in the VEMD may have been injured as a result of a road crash where another person was using methamphetamine but this information would be very unlikely to appear in the VEMD. Hence these data are very likely to be an underestimate of the true number of cases. It is also possible that the involvement of methamphetamine may be more likely to be noted for some types of cases than others, which means that the pattern of injury reported here may not be necessarily representative. In the VAED the information regarding methamphetamine use is only available for the injured person, i.e., a patient recorded in the VAED may have been injured as a result of a road crash or assault etc. where another person was using methamphetamine but this information is not recorded in the VAED as all the details only pertain to the injured patient.

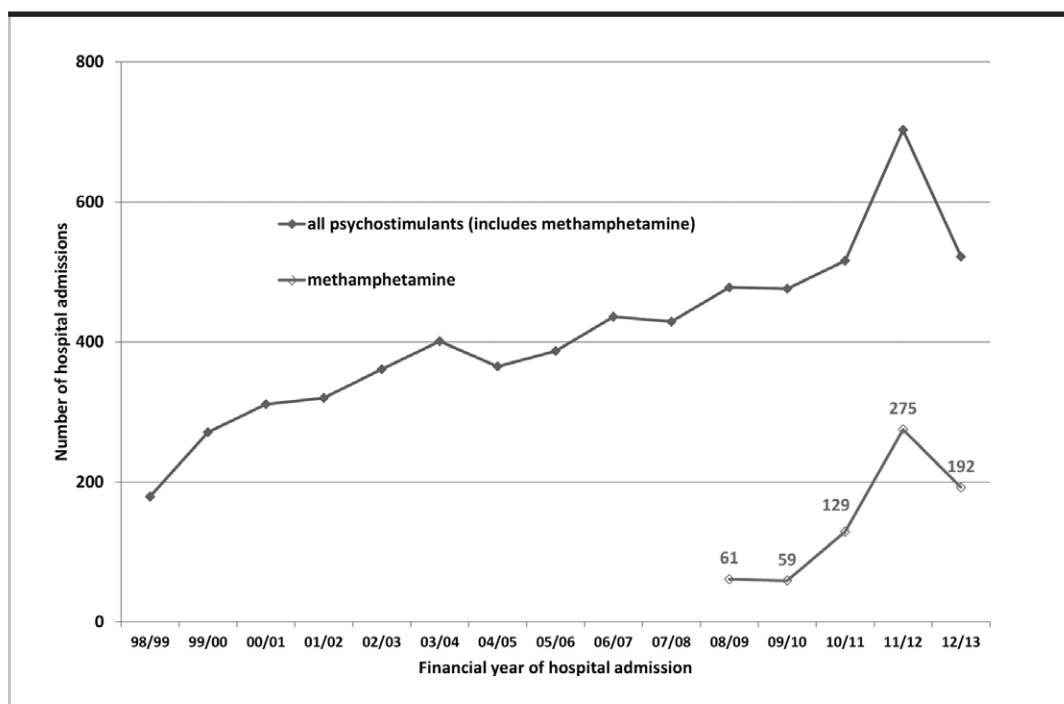
The term 'methamphetamine-related' in this instance refers to any hospital admission or ED presentation where it could be identified that the injured person had used methamphetamine. Case identification is reliant on good data being provided. Hence these data may be an underestimate of the true number of cases. It is also possible that the involvement of methamphetamine may be more likely to be noted for some types of cases than others, which means that the pattern of injury reported here may not be necessarily representative.

184 The introduction of Version 10 of the International Classification of Diseases-Australian Modification (ICD-10-AM), a major revision of the hospital admissions coding system, occurred in 1998. In the first 10 years of ICD-10 the codes T43.6 and F15 did not have sub-codes that allowed the identification of different types of psychostimulants. Specific sub-codes for different types of psychostimulants were introduced in 2008-09. Consequently, trends for all psychostimulants are shown for the whole 15-year period 1998-99 to 2012-13 and for methamphetamine for only the latest 5-years of the period. (See Figure 5.16 below.)

admitted to hospital. The trend in methamphetamine-related injury and poisoning hospital admissions followed the same pattern as all psychostimulant-related injury and poisoning.

In 2008-09 methamphetamine-related injury and poisoning accounted for 12.8% of all psychostimulant-related injury and poisoning cases (n=61/478), by 2011-12 this had increased to 39.1% of all psychostimulant-related injury and poisoning cases (n=275/703).

Figure 5.16: Frequency of hospital admissions for psychostimulant-related injury and poisoning by financial year, Victoria 1998-99 to 2012-13

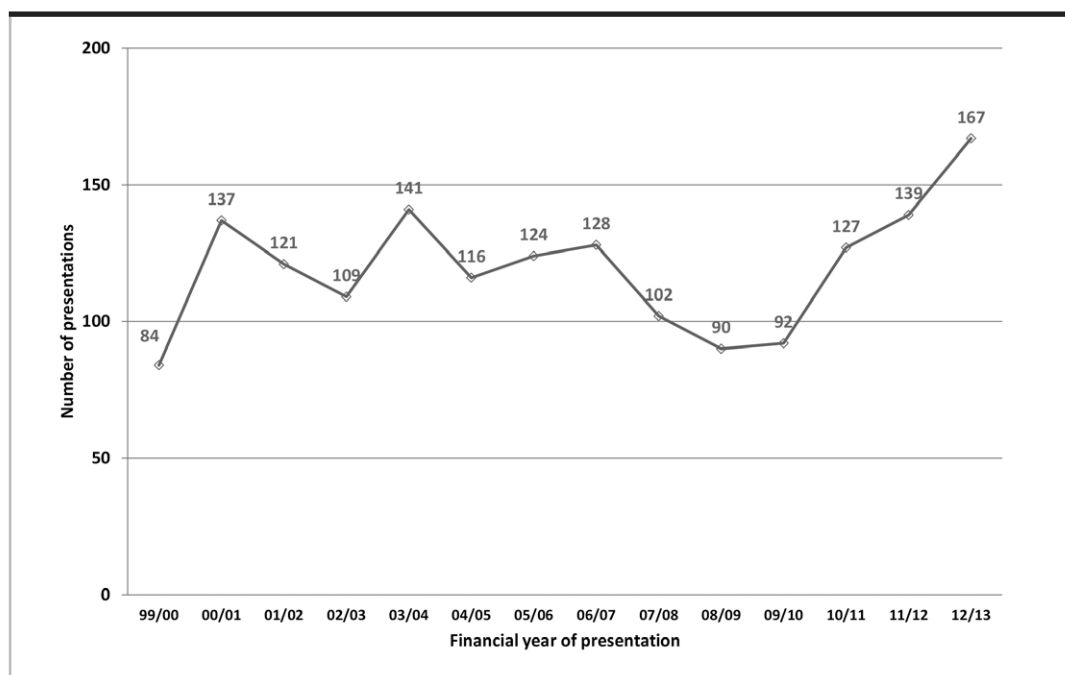


Source: Monash Injury Research Institute (MIRI) (2014).

Emergency department presentations (non-admissions)

Figure 5.17 shows the trend in frequency of methamphetamine-related injury and poisoning ED presentations (non-admissions) was quite volatile over the period 1999-00 to 2009-10 and then increased sharply over the period 2010-11 to 2012-13.

Figure 5.17: Frequency of ED presentations (non-admissions only) for methamphetamine-related injury and poisoning by financial year, Victoria 1999-2000 to 2012-13



Source: Monash Injury Research Institute (MIRI) (2014).

Hospital-treated methamphetamine-related injury and poisoning cases, July 2008–June 2013

Table 5.18 shows that males accounted for around two-thirds of hospital admissions and ED presentations for methamphetamine-related injury and poisoning over the 5-year period July 2008-June 2013 (n=856, 64.3%).

Table 5.18: Frequency of hospital admissions and ED presentations (non-admissions only) for methamphetamine-related injury and poisoning by sex, Victoria 2008-09 to 2012-13

Sex	Hospital admissions		ED presentations (non-admissions)		All hospital-treated	
	N	%	n	%	n	%
Male	455	63.5	401	65.2	856	64.3
Female	261	36.5	214	34.8	475	35.7
ALL	716	100.0	615	100.0	1331	100.0

Source: Monash Injury Research Institute (MIRI) (2014).

Table 5.18 shows that around half of all hospital admissions and ED presentations for methamphetamine-related injury and poisoning were among persons aged 20-29 years (n=696, 52.3%).

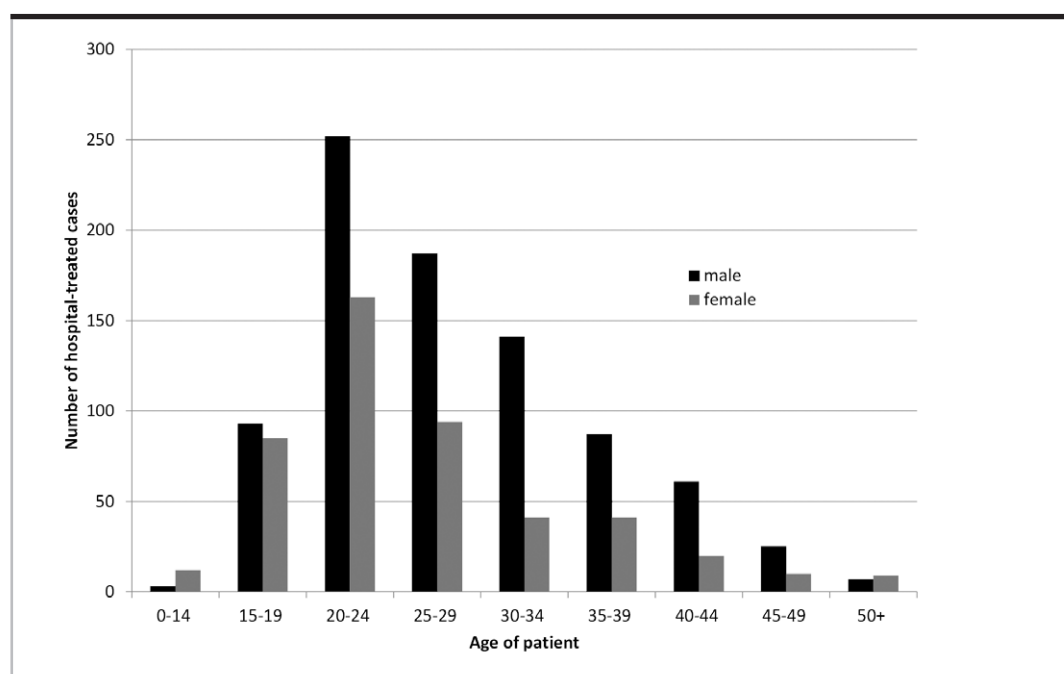
Table 5.18: Frequency of hospital admissions and ED presentations (non-admissions only) for methamphetamine-related injury and poisoning by age group, Victoria, 2008-09 to 2012-13

Age Groups	Hospital admissions		ED presentations (non-admissions)		All hospital-treated	
	N	%	n	%	n	%
0-14 years	7	1.0	8	1.3	15	1.1
15-19 years	83	11.6	95	15.4	178	13.4
20-24 years	217	30.3	198	32.2	415	31.2
25-29 years	142	19.8	139	22.6	281	21.1
30-34 years	110	15.4	72	11.7	182	13.7
35-39 years	77	10.8	51	8.3	128	9.6
40-44 years	44	6.1	37	6.0	81	6.1
45-49 years	23	3.2	12	2.0	35	2.6
50+ years	13	1.8	3	0.5	16	1.2
ALL	716	100.0	615	100.0	1331	100.0

Source: Monash Injury Research Institute (MIRI) (2014).

Figure 5.18 shows the peak age group among males and females for hospital-treated methamphetamine-related injury and poisoning was 20-24 years. Males outnumbered females in all age groups except the youngest (0-14 years) and oldest groups (50+ years).

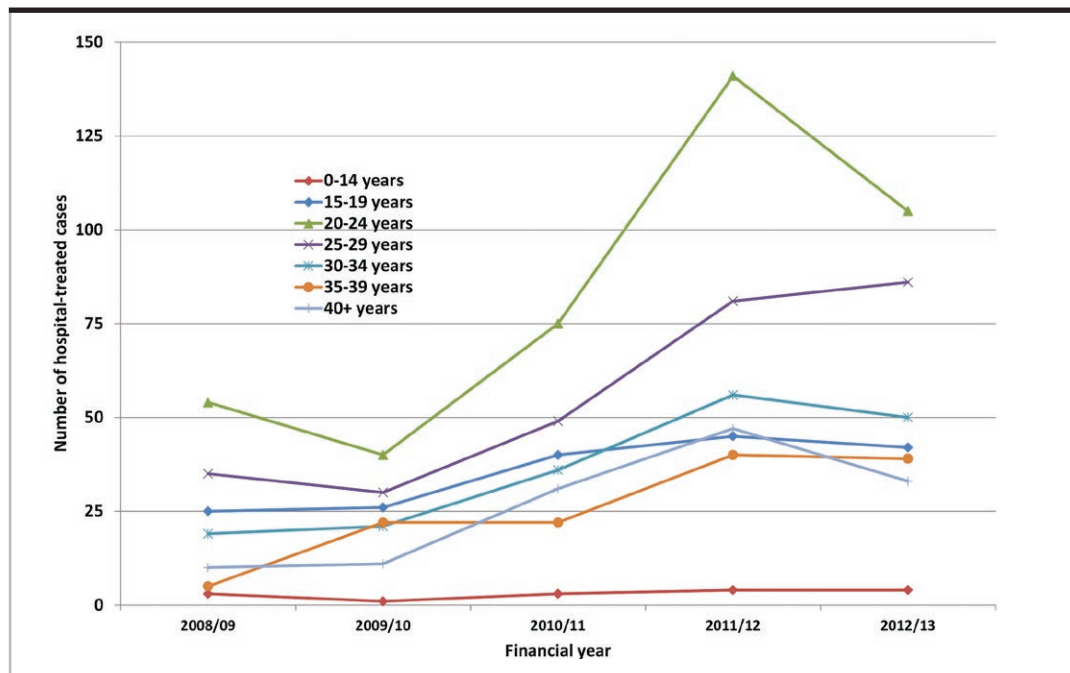
Figure 5.18: Frequency of hospital-treated methamphetamine-related injury and poisoning cases by age group and sex, Victoria, 2008-09 to 2012-13



Source: Monash Injury Research Institute (MIRI) (2014).

Figure 5.19 shows the trend in hospital-treated methamphetamine-related injury and poisoning over the last 5 years is fairly consistent across age groups although the greatest increase over the period 2010-11 to 2011-12 appears to have occurred among 20-24 year olds. The sharp decrease in 2012/13 should be interpreted with caution as it is likely to be a consequence of some recent changes in hospital policy which has reduced the numbers of injury cases being admitted to hospital (as noted earlier in this chapter).

Figure 5.19: Frequency of hospital-treated methamphetamine-related injury and poisoning cases by age group and year of hospital treatment, Victoria, 2008-09 to 2012-13



Source: Monash Injury Research Institute (MIRI) (2014).

Table 5.19 shows that around one-half of all methamphetamine-related hospital-treated unintentional injury and poisoning cases, intentional self-harm cases, and cases of other and undetermined intent, involved those aged 20-29 years. The pattern was slightly different for methamphetamine-related assault, maltreatment and neglect cases where around 40% of cases involved those aged 20-29 years (42%, n=24) with a further 37% involving those aged 30-39 years (n=21).

Table 5.19: Frequency of hospital-treated methamphetamine-related injury and poisoning cases by intent and age group, Victoria, 2008-09 to 2012-13

	unintentional		intentional self-harm		assault, maltreatment & neglect		other & undetermined intent		ALL	
	N	%	n	%	n	%	N	%	n	%
0-14 years	*	*	*	*	*	*	6	1.2	15	1.1
15-19 years	64	13.2	32	11.7	4	7.0	78	15.1	178	13.4
20-24 years	152	31.3	92	33.6	15	26.3	156	30.3	415	31.2
25-29 years	97	20.0	54	19.7	9	15.8	121	23.5	281	21.1
30-34 years	65	13.4	41	15.0	12	21.1	64	12.4	182	13.7
35-39 years	49	10.1	28	10.2	9	15.8	42	8.2	128	9.6
40-44 years	33	6.8	17	6.2	*	*	28	5.4	81	6.1
45-49 years	16	3.3	*	*	*	*	13	2.5	35	2.6
50+ years	*	*	*	*	0	0.0	7	1.4	16	1.2
ALL	485	100.0	274	100.0	57	100.0	515	100.0	1331	100.0

Source: Monash Injury Research Institute (MIRI) (2014).

Table 5.20 shows that the leading cause of methamphetamine-related hospital-treated unintentional cases, intentional self-harm cases, and cases of other and undetermined intent was poisoning (61.4%, 83.9% and 78.1% respectively). The pattern was slightly different for methamphetamine-related assault, maltreatment and neglect cases where 56% of cases were the result of hitting/striking/crushing by a person or a blunt object (56.1%, n=32) and a further 23% were cutting/piercing incidents (n=13).

Table 5.20: Frequency of hospital-treated methamphetamine-related injury and poisoning cases by intent and cause, Victoria, 2008-09 to 2012-13

	Unintentional		intentional self-harm		assault, maltreatment & neglect		other & undetermined intent		ALL	
	N	%	n	%	n	%	N	%	n	%
Poisoning	298	61.4	230	83.9	*	*	402	78.1	933	70.1
Transport	46	9.5	0	0.0	0	0.0	0	0.0	46	3.5
Fall	31	6.4	0	0.0	0	0.0	0	0.0	31	2.3
Hitting/ striking/ crushing by person or blunt object	7	1.4	*	*	32	56.1	*	*	44	3.3
Cutting/piercing	25	5.2	29	10.6	13	22.8	*	*	71	5.3
Other specified	51	10.5	12	4.4	6	10.5	47	9.1	116	8.7
Unspecified	27	5.6	*	*	*	*	58	11.3	90	6.8
ALL	485	100.0	274	100.0	57	100.0	515	100.0	1331	100.0

Source: Monash Injury Research Institute (MIRI) (2014).

It is important to note that these conclusions from the data in Table 5.20 need to be considered in light of the research, design and methodological constraints outlined earlier in this chapter. The data shows that the frequency of psychostimulant-related injury and poisoning has generally increased over the period 1998-99 to 2012-13 with a peak in 2011-12. The same trend was present for methamphetamine-related injury and poisoning hospital admissions since 2008-09. In the case of methamphetamine-related injury and poisoning ED presentations (non-admissions), there was a sharp increase sharply over the period since 2009-10. Males accounted for around two-thirds of hospital admissions and ED presentations for methamphetamine-related injury and poisoning over the 5-year period July 2008 to June 2013.

The leading cause of methamphetamine-related hospital-treated unintentional cases, intentional self-harm cases and cases of other and undetermined intent was poisoning (61.4%, 83.9% and 78.1% respectively). The pattern was slightly different for methamphetamine-related assault, maltreatment and neglect cases where 56% of cases were the result of hitting/striking/crushing by a person or a blunt object (56.1%, n=32) and a further 23% were cutting/piercing incidents.

Treatment data: Use of specialist treatment services

The Alcohol and Drug Information System (ADIS)

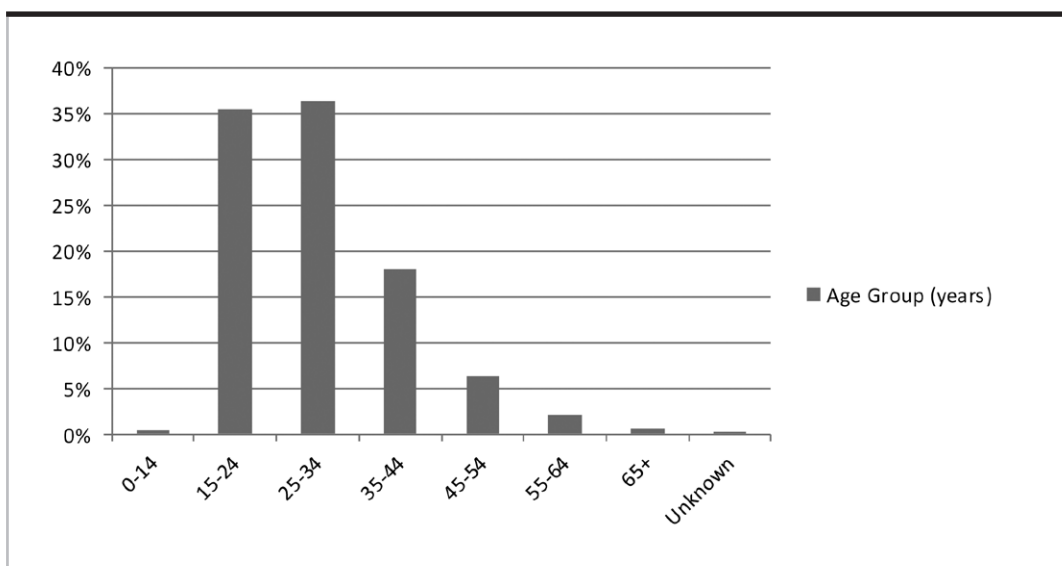
Specialist alcohol and drug treatment agencies offer a range of services to meet the needs of clients with problems with alcohol and other drugs (AOD). In Victoria, the data on people seeking treatment from AOD agencies is collected via the ADIS. Agencies are required to provide this data to the Department of Human Services (DHS) quarterly, and the DHS has provided the latest complete dataset for 2013-14. It is difficult to estimate the extent of service provision in its entirety, as practitioners outside the AOD sector (e.g. general practitioners) are also likely to see a number of patients with drug and alcohol-related problems, and these cases are not collected by the ADIS.

The ADIS data provides an insight into the demographics of specialist AOD clients as well as the type of treatment they are receiving. It also includes information about the client's primary drug of concern. Because this data is regularly collected, it is possible to identify trends over time. Cases in the dataset are based on 'Courses Of Treatment' (COT) which are defined as 'a period of service provision between a client and an alcohol and drug worker(s), with specified dates of commencement and cessation' (Department of Human Services 2006, p.2).

In 2013-2014, there were a total of 57,062 completed courses of treatment delivered to 33,371 individual clients in Victorian specialist AOD services. Of these, 38% (12,829 clients) identified alcohol as their primary drug of concern, followed by 21% (7,046 clients) who identified cannabis, and 19% (6,443 clients) who identified amphetamines. In the context of amphetamines where a client completed one or more courses of treatment, there was an increase from 3,321 clients in 2011-2012 to 6,443 clients in 2013-14 (refer to Attachment 1 in Appendix 9). It is important to note that these statistics be interpreted with caution in the context of the current Inquiry, given that the 'amphetamine' category includes crystal methamphetamine ('ice'), as well as other amphetamines.

Figure 5.20 presents the age distribution of clients receiving specialist treatment for amphetamine use in 2013-2014. The largest group of clients who identified amphetamines as their primary drug of concern were aged between 25 and 34 years (36.4% or 3,693 clients), closely followed by those aged between aged between 15 and 24 (35.5% or 3,600). These two groups, made up 73% of all clients receiving specialist treatment for amphetamines, with the next largest cohort (18%) being aged between 35 and 44 years.

Figure 5.20: Age Distribution of clients receiving treatment for their own amphetamine use



Source: ADIS Database 2013-2014

In 2013-2014, the five main treatment types delivered to clients in specialist alcohol and drug services for 10,140 amphetamine courses of treatment were¹⁸⁵:

- ◆ Counselling, consultancy, continuing care (56.9% or 5,768 COTs);
- ◆ Outreach (7.9% or 801 COTs);
- ◆ Therapeutic counselling (7.6% or 774 COTs);
- ◆ Residential withdrawal (7.6% or 769 COTs); and
- ◆ Residential rehabilitation (3.4% or 346 COTs).

These five service types accounted for 83% of all courses of treatment, where amphetamines were identified as the primary drug of concern. Apart from these categories there were also a significant number of courses of treatment (3.15% or 319 COTs) delivered by specialist Aboriginal AOD workers and also rural withdrawal services (2.16% or 219 COTs) this is of particular interest given concerns raised during the Inquiry about methamphetamine use in rural and Aboriginal communities.¹⁸⁶

The almost doubling in the total number and proportion of Victorian clients (from 3,321 to 6,443) who identify amphetamines (including methamphetamine) as their primary drug of concern when seeking treatment from over a three-year period (from 2011-2012 to 2013-2014) suggests that levels of harm to individuals from amphetamines has significantly increased and that more drug users are seeking out treatment.

¹⁸⁵ See Attachment 1 in Appendix 9.

¹⁸⁶ The Hon. Mary Wooldridge, Minister for Mental Health, Community Services, Disability Services and Reform, Correspondence, 13 August 2014.

DirectLine¹⁸⁷

Directline is a service provided by the Department of Health which provides 24-hour telephone counselling, information and referral services for Victorians wishing to discuss drug-related issues, for both drug users themselves, health professionals and concerned friends and family.

In the 2013-2014 year, Directline responded to 18,722 calls, and out of these calls 25.8% or 4774 calls of callers identified amphetamine as the drug of concern, which was the largest category, closely followed by alcohol, which represented 25.5% or 4774 calls, methadone (23.3% or 4362 calls), cannabis (12.9% or 2415 calls) and heroin (9.0% or 1684 calls).

Table 5.21: Number of calls where amphetamines were cited as drugs of concern

Year	Calls to DL	Amphetamines as drug of concern	% of drug-identified calls
2009/2010	18,511	1,074	5.8%
2010/2011	18,434	1,843	10%
2011/2012	18,830	3,069	16.3%
2012/2013	19,613	4,315	22%
2013/2014	18,722	4,830	25.8%

Source: Directline Database, unpublished data.

Table 5.21 shows the number of calls to Directline where amphetamines were cited as the drug category of concern during the period from 2009-2010 to 2013-2014. This shows that there has been an increase in the number and also the proportion of calls in relation to amphetamines over this period from 1,074 (5.8%) in 2009-2010 to 4,830 (25.8%) in 2013-2014.

Table 5.22 illustrates the gender distribution of calls made to DirectLine where amphetamines (including methamphetamine) were cited as drugs of concern. This table shows that females made up almost two-thirds of callers to DirectLine in 2013, where amphetamine was identified as a drug of concern.

Table 5.22: DirectLine 2013 — Amphetamine related calls

N=3953		
Gender	No	%
Female	2604	65.9%
Male	1349	34.1%

Source: Directline Database, unpublished data.

The largest group of callers were found in the 25–29 year old age group (16.7%), followed by the 30–34 year age (16.2%) and then those in the 50–54 (10.4%) (see Table 5.23).

187 The data on which this section is based are contained in Attachments 4 and 5 in Appendix 9 and in The Hon. Mary Wooldridge, Minister for Mental Health, Community Services, Disability Services and Reform, Correspondence, 13 August 2014.

Table 5.23: Age and gender of callers 2013

N=2761		
Age Range	No	%
0 – 14	0	0.0%
15 – 19	53	1.9%
20 – 24	238	8.6%
25 – 29	462	16.7%
30 – 34	448	16.2%
35 – 39	335	12.1%
40 – 44	278	10.1%
45 – 49	264	9.6%
50 – 54	288	10.4%
55 – 59	188	6.8%
60 – 64	126	4.6%
65+	81	2.9%

Source: Directline Database, unpublished data.

The almost five-fold increase in the number of calls to Directline in relation to amphetamines (including methamphetamine) between 2009-10 and 2013-14 reflects the heightened level of community concern around methamphetamine. It would be useful to further analyse whether the calls were made regarding the callers own use of amphetamines or whether the callers were calling in relation to others.

Fatalities: Methamphetamine detected in deaths investigated by the Coroners Court of Victoria

In addition to the harms already outlined in this section, the Committee was also able to draw on analyses of the involvement of methamphetamine in Victorian deaths investigated under the *Coroners Act* 2008. Under the Act, unexpected deaths and deaths resulting from unnatural causes (for example motor vehicle crashes, assaults and drug overdoses) must be reported to the Coroners Court of Victoria (the CCOV). Such deaths are referred to as ‘reportable deaths’ (see section 4 of the Act for more detailed information about reportable deaths).

Responding to a request from the Committee, the CCOV, through its Coroners Prevention Unit, provided an analysis on the frequency of reportable deaths where methamphetamine was detected during the period 1 January 2009 to 31 December 2013.¹⁸⁸ While there are limitations with the Coronial data¹⁸⁹, the findings of the Coroners Prevention Unit provide an overview of the most problematic of harms, death. This section draws exclusively and extensively, and reproduces or directly cites figures, tables and conclusions, from the Coroners Prevention Unit report which is reproduced, in whole, in Appendix 10.

Victorian fatalities where methamphetamine was present

According to the Coroners Preventions Unit, there were a total of 574 deaths identified in the period from 2009 to 2013. Deaths in which methamphetamine was present have

¹⁸⁸ The Coroners Prevention Unit report provided to the Committee is reproduced in whole in Appendix 10.

¹⁸⁹ Refer to the ‘Limitations’ sections of the Coroners Prevention Unit report contained in Appendix 10.

increased each year from 66 deaths in 2009 to 166 deaths in 2013. This represented a 165% increase over the five-year period.

Sex and age

Table 5.24 shows the majority of deaths (463 fatalities) involved males, ranging in age from 16 to 79 years. The remaining 111 deaths involved females, who ranged in age from 14 to 59 years.

Table 5.24: Annual frequency of deaths where methamphetamine was present by age group and sex, Victoria, 2009 to 2013

Age Group and Sex	2009	2010	2011	2012	2013	Total
10-19	3	-	1	2	2	8
20-29	5	10	5	8	14	42
30-39	4	3	5	7	12	31
40-49	4	5	4	3	9	25
50-59	1		2	2	5	
60-69	-	-	-	-	-	-
70-79	-	-	-	-	-	-
Sub Total Female	17	20	15	20	39	111
10-19	1	2	-	4	2	9
20-29	17	23	29	43	38	150
30-39	14	19	41	43	38	155
40-49	10	13	21	28	33	105
50-59	6	6	8	6	13	39
60-69	1	-	-	1	1	3
70-79	-	-	-	-	2	2
Sub Total Male	49	63	99	125	127	463
Total	66	83	114	145	166	574

Source: Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

Residential location of deceased persons

Table 5.25 shows that, where the location of usual residence for the deceased was known, the majority of persons usually resided in Metropolitan Melbourne. The annual frequency of deaths where methamphetamine was detected rose steadily over time for both the Metropolitan Melbourne and Rural groups.

Table 5.25: Annual frequency of deaths where methamphetamine was present by location of usual residence, Victoria, 2009 to 2013

Region of Usual Residence	2009	2010	2011	2012	2013	Total
Metropolitan Melbourne						
Eastern Metropolitan	9	6	11	12	14	52
Northern and Western Metropolitan	20	29	40	52	59	200
Southern Metropolitan	23	19	26	33	40	141
Sub Total Metropolitan	52	54	77	97	113	393
Rural Victoria						
Barwon South West	4	7	12	6	10	39
Loddon Mallee	1	3	6	11	14	35
Hume	2	5	7	6	12	32
Gippsland	2	6	3	5	9	25
Grampians	2	4	4	11	4	25
Sub Total Rural	11	25	32	39	49	156
Other Location						
Interstate / Overseas Resident	3	3	3	2	-	11
No Fixed Address	-	1	1	3	-	5
Unknown	-	-	1	4	4	9
Total	66	83	114	145	166	574

Source: Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

Case type, intent and mechanism

Overwhelmingly, methamphetamine was most frequently detected amongst persons who died from external causes (482 cases, constituting 84.0% of the total number of cases) rather than natural (85 cases) or unknown causes (7 cases). Among the 482 external cause deaths where methamphetamine was detected, deceased intent was classified as follows:

- ◆ 265 deaths (55.0% of the 482 external cause deaths) were unintentional. These included 157 unintentional poisoning deaths, and 89 unintentional transport deaths;
- ◆ 148 deaths (30.7%) were the result of intentional self-harm (suicide); and
- ◆ The remaining 69 external cause deaths included 40 assaults (8.3%), 23 deaths (4.8%) where the deceased's intent could not be determined, and six deaths (1.2%) in a context of legal intervention.

Drug combinations

Table 5.26 shows that in the overwhelming majority of deaths where methamphetamine was detected, other drugs were also detected (n = 498, 86.8%). The most frequently occurring combinations were as follows:

- ◆ Methamphetamine in combination with both illegal drugs and pharmaceutical drugs but not alcohol (n = 163, 28.4%).
- ◆ Methamphetamine in combination with pharmaceutical drugs but not illegal drugs or alcohol (n = 140, 24.4%).

- ◆ Methamphetamine in combination with illegal drugs but not pharmaceutical drugs or alcohol (n = 49, 8.5%).

Table 5.26: Frequency of deaths where methamphetamine was present by case type, deceased's intent, mechanism of death and drug combinations, Victoria, 2009 to 2013

Case Type, Deceased's Intent and Mechanism of Death	Methamphetamine only	Methamphetamine & Alcohol	Methamphetamine & Alcohol & Illegal Drugs	Methamphetamine & Alcohol & Illegal Drugs & Pharmaceutical Drugs	Methamphetamine & Alcohol & Pharmaceutical Drugs	Methamphetamine & Illegal Drugs	Methamphetamine & Illegal Drugs & Pharmaceutical Drugs	Methamphetamine & Pharmaceutical	Total
Natural Causes	13	-	1	3	3	11	23	31	85
External Causes									
- Assault	9	1	4	5	1	2	5	13	40
- Suicide	29	15	6	11	15	14	26	32	148
- Legal Intervention	-	-	-	-	1	1	2	2	6
- Unintentional									
<i>Transport</i>	17	8	17	4	4	10	16	13	89
<i>Falls</i>	-	-	-	1	-	-	-	-	1
<i>Poisoning</i>	6	1	1	22	11	7	78	31	157
<i>Threats to Breathing</i>	1	1	1	-	-	-	1	2	6
<i>Other Unintentional</i>	-	1	2	-	1	2	3	3	12
- Undetermined Intent									
<i>Transport</i>	1	-	-	-	-	1	-	1	3
<i>Poisoning</i>	-	-	-	1	1	1	6	8	17
<i>Other</i>	-	-	-	1	-	-	-	2	3
Unknown Causes	-	-	-	-	2	-	3	2	7
Total	76	27	32	48	39	49	163	140	574

Source: Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

Overall, aggregating across all co-detected drug types:

- ◆ Pharmaceutical drugs were detected in 390 of the 574 deaths (67.9%) where methamphetamine was detected;
- ◆ Illegal drugs were detected in 292 of the 574 deaths (50.9%); and
- ◆ Alcohol was detected in 146 of the 574 deaths (25.4%).

According to the Coroners Prevention Unit, when considering drug combinations in the context of both deceased intent and mechanism, the following were potentially notable findings:

- ◆ For the overwhelming majority of unintentional poisonings where methamphetamine was detected, other drugs were also detected (151 of 157 deaths, 96.2%). These included 78 deaths (49.7%) where both illegal and pharmaceutical drugs were detected in combination with methamphetamine;
- ◆ Among deaths where methamphetamine and alcohol were detected in combination, the majority were suicides (15 of 27 deaths, 55.5%); and
- ◆ Methamphetamine alone was detected in 76 deaths (13.2%), 29 of which (38.2%) were suicides.

The presence of poly-drug use in methamphetamine-related deaths is seen to be a pertinent finding according to the CCOV, because it 'indicates that methamphetamine use might be more productively approached as part of a broader substance misuse issue, rather than as a discrete phenomenon'.¹⁹⁰

190 Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

Overview of the coronial data

According to the CCOV, the available data indicates that ‘methamphetamine has been detected at an increased frequency in Victoria over the last five years. This increase has been observed across age groups, sex and location of usual residence’.¹⁹¹

‘Methamphetamine was detected most frequently amongst unintentional deaths including particularly deaths from unintentional poisoning, where it was frequently detected in combination with other illegal drugs and pharmaceutical drugs’.¹⁹² Suicide, motor vehicle crashes and natural causes were other death types where methamphetamine were commonly detected.

While the data indicates that there has been an increase in the frequency of deaths where the deceased had consumed methamphetamine, the CCOV notes that ‘interpreting the significance of this increase is more challenging’.¹⁹³ The key issue or challenge identified by the CCOV is whether the methamphetamine played a causal or contributory role in the reportable death.¹⁹⁴ That is, while methamphetamine may be present in a deceased person, being able to identify the contribution of the drug to that death is quite difficult. The CCOV made the following observations in its report, which are particularly noteworthy:

- There are certain types of deaths for which methamphetamine’s contribution is relatively certain: specifically, overdose deaths, where forensic medical experts are usually able to establish whether or not the toxic effects of methamphetamine played a causal or contributory role in the death.
- However, in other types of deaths the contribution of methamphetamine is less clear. A driver’s operation of a vehicle could potentially be impaired by use of methamphetamine, but determining whether the driver was actually impaired in a specific scenario and whether that impairment contributed to a fatal collision is very difficult. Another example is a drowning where methamphetamine was present; the methamphetamine could potentially have impaired the deceased’s ability to swim and contributed to the death, but this could probably not be established with any certainty in most cases.
- There are also deaths where the presence of methamphetamine probably played no contributory role. For example, if a person took methamphetamine and then died from injuries sustained as a passenger in a motor vehicle collision, the methamphetamine would probably not be contributory to the death, particularly if the motor vehicle was not at fault in the collision.¹⁹⁵

In addition to the difficulty in differentiating between methamphetamine as a causal or contributing factor in a reportable death, the CCOV also noted that it is challenging to measure the role and contribution of methamphetamine where the deceased is not the methamphetamine user.¹⁹⁶ By way of example, the CCOV observed that while there were ‘40 Victorian assault deaths between 2009 and 2013 where methamphetamine was detected in the post-mortem examination of the deceased, this data shed no light on the number of deaths where the offender may have been affected by methamphetamine, or where the assault may have been related to an argument over methamphetamine, a methamphetamine theft, or so on’.¹⁹⁷ Other challenges identified by the CCOV include the evaluation of natural cause deaths which involve methamphetamine use (for example, where the consumption of methamphetamine exacerbates a pre-existing condition and thus contributes to the death, or where the primary cause of the death was so severe, that the death would have occurred in spite of the consumption of methamphetamine) and where chronic methamphetamine

191 Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

192 Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

193 Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

194 Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

195 Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

196 Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

197 Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

use may have contributed to the circumstances that led to the death but was not present at the time of death (i.e. suicides after the development of a serious mental condition caused, or exacerbated, by methamphetamine use). Given these challenges, the CCOV concluded that 'methamphetamine use by the deceased is only part of the overall picture of methamphetamine involvement in deaths investigated by coroners'.¹⁹⁸

Discussion and findings

The findings from the surveys such as NDSHS and ASSADS discussed so far show that amphetamine use is not particularly prevalent in the general population and there has been a decline in use among young adolescents. While a small proportion of secondary school students were found to have used amphetamine, it has not been possible to provide an estimate of methamphetamine use in its various forms (e.g. 'ice') from these sources as they mainly provide findings using the broader classification of amphetamines.

The findings from the NDSHS 2013 demonstrate a non-statistically significant decrease in the use of methamphetamine in the general population between 1998 and 2013. The 2013 survey results show that ice is now the main form of methamphetamine used, as well as the form ever used, by respondents. This represents a statistically significant change from previous surveys in which powder was the preferred form of the drug used.

On the basis of the different sources examined, it appears that there is evidence to suggest that ice is being used more often than in the past among sentinel drug user groups. In the general community, however, the use of ice remains low and has been relatively stable over time. On the basis of several measures, ice use among regular drug users in Victoria surpasses that in most other Australian jurisdictions, particularly when the drug is smoked rather than injected.

It is apparent that in recent years, crystal methamphetamine smoking has been popular among recreational drug users due to the ease with which the drug can be administered. This has implications in terms of future awareness-raising initiatives that seek to inform potential users of the harms associated with using the drug. Methamphetamine use among a small group of young people has been found to be prevalent even though no significant increase in use has been detected in recent years. Methamphetamine use amongst police detainees has increased since 2009 in Australia and also, to a lesser extent, in Victoria. Amongst prison entrants in Australia in 2012, one-third of the sample reported using methamphetamine during the 12-month period prior to their current imprisonment.

The most recent figures from the EDRS, for 2013, stand out in comparison with other data sources and raise questions about whether the ice problem is continuing to the same extent in Victoria as it had in the preceding few years. The 2013 EDRS figures showed a clear and substantial reduction in methamphetamine use among ecstasy and other psychostimulant drug users between 2012 and 2013 nationally. Some measures of methamphetamine use in 2013 were the lowest since 2003. These observations raise the question of whether the results are due to actual reductions in drug use, or an artefact of some change in the survey methodology or analysis. In this respect it is important to note that the key relevant question in the EDRS records lifetime drug use, that is, whether the respondent had *ever* used the substance. If the study sample in any given year is equivalent to samples in previous years, lifetime use should never decrease markedly from one year to the next as a respondent who had used the drug at some point should still answer affirmatively, even if they did not use the drug in the past year. Therefore, the proportion of users who ever use the drug should only be reduced by small amounts each year, as long as the sample remains representative.

198 Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

The same is not true for increasing use, as it is possible that a substantial proportion of the sample may use a drug for the first time at any point in the year between surveys.

The marked decrease in 2013 in the proportion of EDRS respondents reporting they had ever used methamphetamine is therefore more likely to reflect a change in the survey methodology, such as a change in the sample population. In 2013 the EDRS sample was changed to include regular psychostimulant users. While it appears that many of these new respondents were also ecstasy users, this change in the sampling methodology may have resulted in the apparent decrease in use observed in the 2013 EDRS. This tends to be supported by the finding that crystal methamphetamine use in the previous six months also decreased among REU/RPU, both in Victoria and nationally, in contrast to findings from the IDRS. In the absence of further evidence and without being able to consider further time series data including RPU, it would be inappropriate to conclude the scale of the ice problem in Victoria is on the decline.

In relation to methamphetamine-related harms within Victoria and in Australia, front-line workers reported that recently such drugs have had a considerable impact on the delivery of vital services. In particular, the number of hospital admissions involving crystal methamphetamine in Melbourne and also within regional Victoria has increased between 2011-2012 and 2012-2013. The data on hospital-treated injury and poisoning in Victorian hospitals showed that the leading cause of methamphetamine-related hospital-treated unintentional cases, intentional self-harm cases, and cases of other and undetermined intent, was poisoning. The data from the Coroners Court of Victoria showed that harms associated with methamphetamine in Victoria have increased over the past five years across both Metropolitan Melbourne and rural Victoria, affecting both males and females, and covering a range of age groups. Nevertheless, challenges remain in trying to understand the contribution of methamphetamine in deaths investigated by the Coroners Court of Victoria.

It is clear from available evidence, including information given directly to the Committee through hearings and submissions, that the harms arising from crystal methamphetamine use are much smaller in impact on the overall Victorian community, as well as on emergency services personnel, than the use of alcohol. While the impact of ice on individuals and on emergency services personnel and others who have to deal with violent ice users should not be discounted, policy and operational responses to the ice problem should be commensurate with the scale of harm resulting from the misuse of other substances, whether licit or illicit.

Based on the evidence provided to the Committee and the analysis of this data by others and the Committee itself, the following conclusions can be drawn concerning the prevalence of methamphetamine use and the extent of associated harms in Australia and Victoria:

- ◆ National public perceptions of greatest harm continue to be attributed to alcohol, however methamphetamine was rated as the illicit drug of most concern in 2013;
- ◆ In Australia and in Victoria, methamphetamine was the fourth most prevalent type of illicit drug used in 2010 after cannabis, ecstasy and cocaine;
- ◆ In Australia, recent use of methamphetamine between 2001 and 2013 has declined, while use of ice has more than doubled between 2010 and 2013;
- ◆ In Victoria, recent use of methamphetamine between 2010 and 2013 has remained stable across the state, but increased significantly in remote and very remote areas;
- ◆ Between 2007 and 2013, the main form of methamphetamine used has changed from powder to ice;
- ◆ Injecting drug users in Australia and in Victoria prefer heroin followed by ice;

- ◆ Police detainees believe that the availability of ice has increased, while price and purity have remained stable;
- ◆ In 2012, one-third of prison entrants in Australia reported using methamphetamine during the 12-month period prior to their current imprisonment, an increase on usage in 2009;
- ◆ Between 2011-12 and 2012-13, there was an 88% increase in the number of ambulance attendances (per 1 million population) for methamphetamine within Metropolitan Melbourne and a 200% increase within regional Victoria;
- ◆ The frequency of psychostimulant-related injury and poisoning has generally increased over the period 1998-99 to 2012-13 with a peak in 2011-12. The same trend was present for methamphetamine-related injury and poisoning hospital admissions since 2008-09;
- ◆ The data on hospital-treated injury and poisoning in Victorian hospitals indicates that the leading cause of methamphetamine-related hospital-treated unintentional cases, intentional self-harm cases and cases of other and undetermined intent was poisoning;
- ◆ The data from the Coroners Court of Victoria shows that harms associated with methamphetamine in Victoria have increased over the past five years across both Metropolitan Melbourne and rural Victoria, across both males and females, and across a range of age groups;
- ◆ Methamphetamine was detected most frequently amongst unintentional deaths including particularly deaths from unintentional poisoning, where it was frequently detected in combination with other illegal drugs and pharmaceutical drugs. Suicide, motor vehicle crashes and natural causes were other death types where methamphetamine were commonly detected;
- ◆ The number of people receiving treatment for methamphetamine-related health issues is increasing. Because the available data does not disaggregate stimulants into the component parts (i.e. speed, ecstasy etc.) it is difficult to assess the extent to which methamphetamine-specific treatment cases have decreased, increased or remained stable. Nevertheless, the near doubling of Victorian clients who sought treatment and nominated amphetamines as their primary drug of concern includes those affected by methamphetamine and therefore is of concern;
- ◆ The five-fold increase in Directline services relating to amphetamines has largely been driven by female callers. The increase reflects a growing concern with amphetamines, which includes methamphetamine. Once more, given the lack of disaggregated data, it was not possible for the Committee to make more definitive findings on the extent and involvement of methamphetamine in driving the increase in amphetamine related Directline services.

Recommendation 50

The Committee recommends that the Australian Institute of Criminology explores options for funding to re-establish data collection sites in Victoria as part of its Drug Use Monitoring Australia research program.

PART C

Effects of Methamphetamine — Physical, Psychological and Social

6. Medical and Psychological Consequences of Methamphetamine Use

Introduction

A range of physical risks and harms are associated with the use of methamphetamine. However, the impact of methamphetamine use, particularly chronic use, cannot be artificially divided into categories such as physical, psychological and social harms. All of these issues are interconnected and related. It is the experience of many witnesses to this Inquiry including users, family members and professional agency workers, that people with complex methamphetamine-related health or mental health issues are equally likely to be experiencing, financial and legal problems, and often poverty, unemployment and family stress.¹⁹⁹ It also needs to be stated that for some people, particularly short-term or infrequent users, there may be few harmful consequences associated with their use. There is even some, admittedly contentious, research that suggests in some circumstances methamphetamine may have some positive effects on (short-term) cognitive functioning.²⁰⁰

This chapter contains an analysis of the medical, physical and psychological consequences or effects of using methamphetamine.²⁰¹

The effects of methamphetamine depend on numerous factors

The effects of methamphetamine and indeed any drug(s) are dependent on a number of factors, which vary depending on the individual. These may include the person's size, weight, general and mental health, the amount of the drug taken, the purity of the drug; the frequency of use and whether it is consumed with alcohol or other drugs (poly-drug use): 'For these reasons there tends to be considerable variation in drug effects between different users and even within the same user over time' (Jenner 2012, p.84). Whether the person is a new or experienced user of the drug in question may also have a bearing on its possible effects. The Committee was also advised by an Ambulance Officer of the differing effects of methamphetamine:

I think some of the campaigns have presented methamphetamine in a way that if you take one ingestion of it, you are going to turn into the Incredible Hulk and destroy the emergency department you are taken to. That is clearly incorrect. There is no safe method to use methamphetamine, and there is no safe amount of methamphetamine to use. Everybody reacts to it differently, depending on the day, the week, the month, when they last ate and how much sleep they have had. It affects people differently each time they use it. Nobody can adequately predict whether or not they will have

199 These issues are discussed in Chapter 7.

200 It has been noted for example that not all neurocognitive affects are necessarily negative at least not in small or acute doses of methamphetamine in the short term. Cognitive processing speed, psychomotor performance, memory recall, reaction times and attentiveness in healthy control subjects have been noted when methamphetamine is administered in low doses. See Carson et al. 2012 for a discussion of the debates surrounding any possible benefits associated with the neurocognitive effects of acute methamphetamine use.

201 A detailed medical, toxicological and pharmacological account of methamphetamine is beyond the scope of this Report. There are numerous learned journals and texts that the interested and expert reader can consult. For general accounts of the physical and psychological effects resulting from methamphetamine see: Anglin et al. 2000; Darke et al. 2008; Cruickshank & Dyer 2009; Allsop & Lee 2012; Bramness et al. 2012; McKetin et al. 2013a and b.

a pleasant experience or a negative experience when they use it. Not everybody gets violent; they all have the potential to get that way, and a lot of it has to do with the volume or the amount of the substance you have ingested.²⁰²

Similarly, Mr Daniel Eltringham, from the Emergency Department of Bendigo Health observed that people presenting to the Department exhibited a ‘whole spectrum’ of behaviours ranging from the agitated and bizarre to the relatively quiescent depending on the amount of the drug ingested and the stage at which their symptoms are exhibited.²⁰³

Moreover, whilst the harmful effects of drug use including that of methamphetamine are generally a function of dose plus frequency of use, some harmful consequences of use such as cardiovascular complications may not be dose or frequency related and can result in quite serious side effects. Toxic reactions, for example, can occur, ‘irrespective of dose, frequency of use or route of administration and have been reported with small amounts and on the first occasion of use’ (Darke et al. 2008, p.255).

Table 6.1 provides a list of the physical and psychological effects of methamphetamine use correlated to dose levels.

Table 6.1: Dose-related effects of methamphetamine use

	Low Dose	High Dose
Physical	<ul style="list-style-type: none"> Increases in systolic and diastolic blood pressure Sweating Palpitations Chest pain Shortness of breath Headache Tremor Hot and cold flushes Increases in body temperature Reduced appetite 	<ul style="list-style-type: none"> High blood pressure Rapid or abnormal heart action Seizures Cerebral haemorrhage Jaw clenching and teeth grinding Nausea, vomiting
Psychological	<ul style="list-style-type: none"> Euphoria Elevated mood Sense of wellbeing Increased alertness and concentration Reduced fatigue Increased talkativeness Improved physical performance 	<ul style="list-style-type: none"> Confusion Anxiety and agitation Performance or repetitive motor activity Impaired cognitive and motor performance Aggressiveness, hostility and violent behaviour Paranoia including paranoid hallucinations Common delusions including being monitored with a hidden electrical device, and preoccupation with ‘bugs’ on the skin

Source: Adapted from Lee et al. 2007.

Immediate and short-term effects of methamphetamine

Methamphetamine ingestion results in intoxication through the increased stimulation of dopamine and norepinephrine receptors in the brain. This results in a sense of euphoria, confidence and wellbeing. This alertness and euphoria lasts considerably longer than

202 Mr Allan Eade, Intensive Care Paramedic, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013.

203 Mr Daniel Eltringham, Drug and Alcohol Care Coordinator, Emergency Department, Bendigo Health, Public Hearing, Bendigo, 25 October 2013.

many other stimulant drugs such as cocaine. It is also metabolised at a slower rate than comparable drugs:

The timing and intensity of the 'rush' that accompanies the use of methamphetamine which is a result of the release of high levels of dopamine into the brain depend in part on the method of administration. The effects are almost instantaneous when methamphetamine is smoked or injected; they occur approximately five minutes after snorting or 20 minutes after oral ingestion. Immediate physiological changes associated with the use of methamphetamine are similar to those produced by the 'fight or flight' response and include increased blood pressure, body temperature, heart rate and breathing rate (Anglin et al. 2000, p.139).

The resulting euphoria is one of the key reasons why young people in particular may choose to use methamphetamine.²⁰⁴

In addition to the initial euphoria or wellbeing experienced, methamphetamine usually results in an increase in confidence, energy and enthusiasm, alertness and mental acuity. Such an outcome is of particular importance to consumers who are using the drugs to increase their performance such as long-distance drivers or students, as McKetin explains:

Studies have found that intoxication...speeds reaction time and can improve performance of activities that require sustained vigilance, giving its users the capacity to remain engaged in even the most tedious of tasks²⁰⁵...Signs of intoxication are difficult to detect at low levels, with the drug having no obvious deleterious effects on motor coordination; the only tell-tale signs of intoxication are that the person may appear more confident, talkative and enthusiastic than normal (McKetin et al. 2013, p.690).

Some other common short-term effects of methamphetamine use are:

- ◆ talkativeness
- ◆ reduction of appetite/weight loss
- ◆ dry mouth
- ◆ increased blood pressure and heart rate
- ◆ 'aged' or dramatic change in appearance
- ◆ nausea
- ◆ headaches
- ◆ stomach cramps
- ◆ restlessness
- ◆ irregular breathing
- ◆ sweating
- ◆ 'sunken' or 'hollowed out' appearance
- ◆ skin problems including scabs on face and arms
- ◆ loss of co-ordination.

Given the effects of methamphetamine as a stimulant and energy booster some of the above effects will be as much a result of sleep deprivation associated with the drug as it is a product of the drug per se.

204 See Chapter 13 for an account of the contributing factors as to why people may use or abuse methamphetamine.

205 See also Chapter 13 for a discussion of the reasons why methamphetamine may be seen by users as an 'attractive' drug.

Mr Alan Fisher, a drug clinician with Albury–Wodonga Health also told the Committee that a related side effect of methamphetamine use that can sometimes be overlooked is malnutrition: ‘We see people in states of malnutrition. Methamphetamine is a very strong appetite suppressant. People tend to not eat for days and weeks on end.’²⁰⁶

Medium to longer-term effects

Longer-term effects of methamphetamine are also well documented in the literature. However, there have been considerable debates over some specific consequences of use. These are detailed later in this chapter.

Some of the medium to longer term effects of using amphetamine may include:

- ◆ sleep problems
- ◆ extreme mood swings
- ◆ compulsive repetition of actions
- ◆ paranoia
- ◆ depression and anxiety
- ◆ panic attacks
- ◆ seizures
- ◆ social and financial problems
- ◆ cardiac arrhythmia
- ◆ headaches
- ◆ joint pains
- ◆ malnutrition and weight loss, even to the extent of anorexia²⁰⁷
- ◆ aggression
- ◆ high blood pressure
- ◆ reduced resistance to infection, poor immune system functioning
- ◆ dental problems including jaw clenching, bruxism, dental caries, and gingivitis.²⁰⁸

Severe medical consequences

There can be a range of severe medical consequences of methamphetamine use, although these are relatively rare. However, a number of witnesses, particularly medical or clinical professionals who gave evidence to the Committee, stressed that some of the more severe physical side effects, when they do occur, could be quite damaging. The comments of Dr Mathew Frei of Turning Point Alcohol and Drug Centre are indicative:

Sometimes we see people getting very overheated, and rhabdomyolysis is a breakdown of muscles which can lead to kidney failure. These are relatively rare but very significant toxic effects of methamphetamine. Occasionally we see cardiac events. You can imagine that a drug that increases your heart rate and increases your blood pressure might bring risk of a cardiac event, like myocardial ischaemia or a heart attack, and

206 Mr Alan Fisher, Clinical Leader, Drug and Alcohol Community Treatment Services, Albury–Wodonga Health, Public Hearing, Wodonga, 24 February 2014.

207 See Bramness et al. 2012. This is often one reason why methamphetamine is used for functional purposes — ie. deliberate weight reduction).

208 Although commentators have observed that such dental problems may largely be the product of poor dental hygiene resulting from a chaotic drug using lifestyle than any direct effect of methamphetamine (McKetin et al. 2013b, p.696).

occasionally we have seen seizures and actual strokes — so, injuries to the brain. Again, I need to stress that these are relatively rare but do happen and are potentially very serious adverse toxic effects, and they are all complicated when people combine the drug with alcohol or other drugs.²⁰⁹

Mortality

Methamphetamine is less commonly associated with overdose and overdose-related deaths than opioid drugs such as heroin. Methamphetamine 'overdose' is less clearly defined than that pertaining to heroin and does not necessarily entail a loss of consciousness.

Deaths can result, however, from the cardio toxic effects of the drug and cerebrovascular complications such as 'stroke' (McKetin et al. 2013b, p.696; Darke et al. 2008, pp.252-253). Hepatic and renal failure and coma, whilst less frequent, can on occasion be fatal (Cruickshank & Dyer 2009, p.1088). It is noted that deaths resulting from methamphetamine use are more commonly ascribed to indirect consequences including a lack of self-care due to a drug-related lifestyle, than a direct result of the properties of the drug. As Cruickshank and Dyer state:

Case reports indicate that methamphetamine associated fatalities arise most commonly from multiple congestion, pulmonary oedema, pulmonary congestion, cerebrovascular haemorrhage (attributed to hypertension) ventricular fibrillation, acute cardiac failure or hyperpyrexia. Other fatalities have arisen from septic injection or asphyxia by aspiration of vomitus.

A number of studies also suggest that a significant and possibly greater proportion of methamphetamine related fatalities arise from accidents, suicides and homicides suggesting severe psychological and behavioural disturbances at toxic doses (2009, p.1088).

Deaths may also occur from the long-term consequences of disease resulting from HIV, Hepatitis C infection or other blood-borne viruses (BBV). Methamphetamine use is associated with particularly high rates of HIV sero conversion²¹⁰ (Grund et al. 2010; Buchacz et al. 2005; Jenner 2012; McKetin et al. 2012a).²¹¹ HIV or Hepatitis transmission can result from sharing needles or drug-taking equipment such as water or filters. HIV and other BBV may also result from methamphetamine's capacity to increase libido and sexual risk taking (McKetin et al. 2012a).²¹² HIV transmission may also be increased due to impairment in decision making and cognitive processes as a result of the drug (Colfax et al. 2010, p.5).²¹³

It is also clear that when methamphetamine is used in conjunction with alcohol and/or other drugs the risks of mortality or serious morbidity is heightened, as can be seen from the methamphetamine-related deaths data discussed in Chapter 5.

An overview of the main physical and psychological complications of methamphetamine use conducted by Darke et al. in 2008 found that deaths due to methamphetamine toxicity occur typically among males, experienced injecting drug users and those aged in their mid-30s:²¹⁴

209 Dr Matthew Frei, Head of Clinical Services, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

210 Sero conversion is the development of detectable antibodies in a person's blood serum as a result of infection or immunisation. In general discussion it can refer to the process of becoming HIV positive.

211 Indeed in Europe the recent European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Drug Report has stated that injecting drug use may account for an interruption in the decline of HIV diagnoses and related morbidity/mortality rates in recent years; although overall the downward trend noticeable since 2004 continues (EMCDDA 2013).

212 For an extensive discussion of the relationship between HIV and methamphetamine use, see Colfax et al. 2010. A study of methamphetamine users in Sydney found that participants exhibited noticeable sexual risk-taking behaviours including multiple sex partners, unprotected sex and unsafe sexual practices (McKetin, McLaren & Kelly 2005, p.106).

213 See also later in this chapter a discussion of methamphetamine's effect on cognitive functioning.

214 For the risks associated with mortality and morbidity amongst women, particularly as a result of HIV resulting from sexual risk-taking and injecting drug use, see Semple, Grant and Patterson 2005 and the discussion in Chapter 14.

The older age profile of fatalities may simply reflect the cumulative risk exposure of repeated use. The effects of repeated psychostimulant administration are, however, quite distinct from those seen in the use of opioids. Repeated administration of either cocaine or methamphetamine results in a cumulative risk of cardiac and coronary artery disease, most commonly ventricular hypertrophy and coronary atherosclerosis. The accumulated damage from long-term methamphetamine use may increase the risk of myocardial infarction substantially as the user ages, and increase substantially the risk for each individual use episode over time (Darke et al. 2008, p.255).

As indicated, one indirect cause of death associated with methamphetamine use is suicide. The relationship between suicide, depression and methamphetamine use is discussed separately in this chapter.

Morbidity

A number of serious non-fatal consequences are associated with both acute and chronic use of methamphetamine. These include infections such as HIV and other BBV, liver and kidney disease and other illnesses. In the United States it has been noted that methamphetamine use places users at increased risk for tuberculosis transmission (Brecht et al. 2004). One of the most serious physical consequences of short-term or chronic use of methamphetamine and other stimulant drugs is that associated with cardiovascular and cerebrovascular conditions.

Cardiovascular and cerebrovascular side effects

The properties of methamphetamine (and other stimulant drugs) have the potential to cause serious problems related to the central nervous system, heart and brain functioning and circulatory system.²¹⁵ As Jenner summarises:

The consequences of acute or prolonged central nervous system (CNS) stimulation can include irregular heart beat (arrhythmia) constriction of the coronary arteries and the formation of blood clots (embolism), leading to oxygen deprivation of the heart muscle (myocardial ischaemia) and heart attack (myocardial infarction) (Darke et al 2008). Users with stimulant induced cardiovascular problems can complain of palpitations, shortness of breath, rapid heart-beat (tachycardia) and chest pain.

The consequences of the burden placed on the heart can also adversely affect blood circulation in the brain. There is substantial increase of stroke, secondary to either haemorrhage or lack of oxygen (ischaemia)... As Cruickshank and Dyer point out, while the acute effects of stimulants subjectively diminish within about 4 hours, cardiovascular effects are prolonged and repeated doses of stimulants increase users' risks of serious cardiovascular events (Jenner 2012, p.84).

These effects may be particularly severe for people with a known (or unknown) predisposition to cardiac-related problems.²¹⁶

It should be noted that cardio and cerebrovascular consequences are *not* influenced by the route of administration '[a]nd can occur among those who smoke, snort and inject stimulants' (Jenner 2012, p.85; Darke et al. 2008). Nonetheless, the mode of administration may have other important differential effects impacting upon the physical and psychological health of the user as discussed in the following section.

215 See Chapter 3 and generally Allsop and Lee 2012 for an account of how the pharmacology of the drug results in these medical side effects.

216 Mr Peter Wearne from the Youth Support + Advocacy Service told the Committee of a young footballer in Shepparton who was using methamphetamine as a sport's performance enhancer. The young man unfortunately died of a heart attack on the playing field. It was later established that not only did he have 'meth' in his system; he also had an undiagnosed pre-existing heart condition.

See Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

Dangerous modes of administration²¹⁷

The harms associated in using methamphetamine may also vary depending on the mode of administration. As noted previously,²¹⁸ the general consensus of medical opinion is that those who administer methamphetamine through intravenous injection generally run the potential risk of adverse health outcomes associated with that particular form of administration, most notably HIV or hepatitis infection but also vein damage, abscesses, skin infections and other serious medical conditions (see McKetin et al. 2013b; Allsop & Lee 2012; Lee et al. 2007).

Some witnesses have stressed to the Committee that the dangers and physical side effects associated with methamphetamine abuse are by no means solely restricted to injecting the drug. They indicated that smoking the drug also has clear dangers; for example long-term respiratory problems.²¹⁹

Even intra-nasal snorting of methamphetamine runs a potential risk of contracting hepatitis C because of the instruments used to share snorting.²²⁰ It can also result in damage to the epithelial cells lining the nose and septum 'potentially leading to sinusitis, nasal ulcers, septal necrosis and perforated septum' (National Centre for Education and Training on Addiction (NCETA) 2004 in Jenner 2012).

The 'come down' effects

Symptoms such as tension, aggression (even to the point of violence), panic attacks, mood swings, depression and exhaustion may be particularly noticeable during the 'coming down' stage when the (pleasurable) effects of the drug are wearing off. In the McKetin et al. study of methamphetamine users in Sydney the participants:

[c]ommonly cited the 'come down' or 'crash' related to methamphetamine as one of the particularly adverse aspects of using the drug. The methamphetamine come down is characterised by depression, anxiety, over self-consciousness or paranoia, lack of energy and sleep disturbance. The come down from methamphetamine may last two to three days and would overlap with symptoms of methamphetamine withdrawal which are very similar in nature. Several methamphetamine users commented that the come down from ice was worse than other forms of methamphetamine and users were also reported self-medicating the symptoms of the come down with benzodiazepines (2005, p.104)

In order to combat the 'come down' effects, users of methamphetamine may also use benzodiazepines; cannabis, opiates and/or alcohol. Regular users of methamphetamine may also use such drugs to counteract the long-term consequences of their use, such as insomnia.

Brain function, neurotoxicity and neurological disorders

The research into the effect of methamphetamine, ecstasy and indeed many illicit drugs on brain functioning and related issues of neurotoxicity is relatively embryonic. While there is a growing body of evidence strengthening the links between (chronic) methamphetamine abuse and cognitive impairment the link requires much further research (see also McKetin et al. 2013b). As previously indicated, it is also important to bear in mind that not all cognitive effects associated with (infrequent or short-term) use of methamphetamine will be negative.

217 For further discussion of the modes of administration associated with methamphetamine use, see discussion in Chapters 3 and 9.

218 See Chapter 3.

219 Mr Alan Fisher, Clinical Leader, Drug and Alcohol Community Treatment Services, Albury-Wodonga Health, Public Hearing, Wodonga, 24 February 2014.

220 See, for example, submission of Anglicare Victoria to the Drugs and Crime Prevention Committee, Inquiry into Amphetamine and 'Party Drug' Use in Victoria, October 2003.

Nonetheless, sufficient research has been undertaken to indicate chronic exposure to methamphetamine may result in neurotoxic damage. Methamphetamine neurotoxicity primarily involves the degeneration of dopamine neuron terminals, although other neurochemical systems (e.g. serotonin and noradrenaline) can also be compromised after very high levels of methamphetamine intake (McKetin 2013b).

Researchers have also investigated links between methamphetamine neurotoxicity and the neurodegenerative condition Parkinson's disease. Whilst some studies have identified psychomotor dysfunction consistent with the disease others have failed to make such links. On balance, however, it is thought that chronic methamphetamine use may be expected to result in an increased risk of developing Parkinson's disease later in life (Cruickshank & Dyer 2009). Despite such findings it is generally agreed that more research is required with regard to the relationship between amphetamine use, brain function and neurological disorders (Darke et al. 2008).²²¹

Cognitive functioning

Neurotoxicity as a result of long-term use may also be associated with behavioural and cognitive deficits, although the level to which a person's cognitive abilities are affected by the use, particularly long-term use, of methamphetamine is unclear. Turning Point Alcohol and Drug Centre refers to research by Topp et al., National Drug and Alcohol Research Centre (NDARC) that suggests:

[h]eavy amphetamine use has been associated with neuropsychological deficits that could not be accounted for by premorbid intelligence, concurrent polydrug use or acute intoxication (NDARC 2002b, p.131).

Simon et al. undertook one of the few early studies of cognitive impairment in individuals who were *currently* using methamphetamine. This 1999 study of 65 self-reporting methamphetamine users in San Bernardino, California, noted that methamphetamine users were significantly more impaired than non-users in a variety of cognitive functioning tests, including recall and memory tasks and the manipulation of information. Although the sample was small, the findings were an important 'first step in elucidating the consequences of methamphetamine use' (Simon et al. 2000, p.230).

Evidence given to the Committee from health services and drug and alcohol agencies also raised the issue of cognitive deficits amongst methamphetamine clients, particularly chronic users. For example, Ms Debbie Stoneman an AOD nurse clinician told the Committee:

From a nursing perspective ... I am seeing people with cognitive impairment in regards to ice. I looked after a man in his late forties who had been using ice for a long time. Because of the effect of the dopamine and the serotonin and the long-term effects on the grey matter in the brain, these people present as though they have Parkinson's disease. Memory, movement, mood regulation, mental health — definitely nursing people with cognitive impairments from ice. They are few and far between but they exist.²²²

There may also be other factors that affect a person's cognitive functioning in relation to methamphetamine use. For instance, given most methamphetamine users also use in conjunction with other drugs, including alcohol, 'the effects of other drug use on cognitive performance [may be] difficult to disentangle' (Colfax et al. 2010, p.5).

221 See Carson et al. 2012 for a comprehensive account of the neurocognitive effects of methamphetamine. The authors make the point that even today not only are psychostimulants including methamphetamine associated with adverse neurological outcomes but there is still interest in using them as legitimate treatments for some neurological disorders including obsessive compulsive, anxiety and attention deficit disorders. See 2013, pp.34 ff and the discussion in Chapter 14.

222 Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

See also the evidence of Dr Nic Reid, an Emergency doctor at Geelong Hospital. Dr Reid told the Committee that the effect on cognitive function due to methamphetamine use is a 'huge underlying issue'. Dr Nic Reid Emergency Staff Specialist, Emergency Department, Barwon Health, Public Hearing, Geelong, 28 October 2013.

The effects of impure drug combinations

Medical complications and adverse health effects can also be a consequence of using methamphetamine of impure quality. The purity or impurity of methamphetamine including the possible health consequences to the user is discussed in Chapter 3:

Effects on the foetus

Various studies have reported the use of amphetamine-type stimulants (ATS) during pregnancy can be associated with a range of deleterious effects:

[u]se of amphetamines during pregnancy is associated with low rates of prenatal care, low birth weight, increased frequency of hospitalization for pregnancy complications, perinatal mortality, preterm deliveries, maternal anaemia, premature membrane rupture, pre-eclampsia, meconium stained amniotic fluid, post-partum haemorrhage, unplanned caesarean delivery, vacuum extraction with forceps, and neonatal infection. Neonatal amphetamine withdrawal is uncommon, occurring in approximately 2% of affected neonates and generally resolves spontaneously within a week. The syndrome consists of poor feeding, drowsiness and tremor and is considered less severe than both neonatal alcohol and opiate withdrawal syndromes (Cruickshank & Dyer 2009, p.1093).

A submission from the Women's Alcohol and Drug Service (WADS) of The Royal Women's Hospital in Melbourne outlined the harms associated with methamphetamine use and pregnancy as documented in the research literature and exhibited by women who present to their clinic:

Use of methamphetamine in pregnancy is associated with a number of risk factors for maternal and neonatal morbidity and mortality including:

- Multiple admissions to hospital are common during the antenatal period for management of complications including antepartum haemorrhage (bleeding before birth and threatened preterm birth). This may be due to increased blood pressure, stroke, heart attack, and preterm birth (Good et al, 2010).
- Almost all substances are known to cross the placenta and have some effect on the foetus (Behnke & Smith, 2013). Methamphetamine may increase the risk of fetal growth restriction, preterm labour and preterm birth, thereby compromising a baby's health and development from birth (Smith et al 2006, Oei et al 2012; Wouldes et al, 2004).
- Cardiovascular collapse and seizures have been noted in pregnant women using methamphetamine (Catanzante & Stein, 1995; Smith et al, 2003).
- Women were more likely to be unemployed, have higher rates of domestic violence and their babies placed into adoption services when compared with the control population (Good et al, 2010).
- Prenatal methamphetamine exposure is associated with maternal psychiatric disorders and emotional distress (Shah et al, 2012).²²³

Representatives of WADS also spoke to the Committee in February 2014 about the harmful consequences of methamphetamine use for pregnant women and their babies.²²⁴ Dr Yvonne Bonomo, an addiction medicine specialist, stated that whilst the impact of ice on pregnancy is not conclusive there are clearly multiple adverse effects:

Typically these women will present late in the pregnancy and that makes their clinical care quite difficult. Instead of presenting in the first trimester of pregnancy they often come in much later than that. When they do come in they tend to be admitted to hospital more often than your non-ice-using pregnant woman. We know that of those women who cease their amphetamine use in the first trimester, they have better outcomes, and the kinds of adverse effects that we are seeing are both on baby and on mother. In terms of baby, essentially there is poor growth and development of the baby

²²³ Ms Teresa Lynch, Manager, The Royal Women's Hospital, Submission, 11 March 2014.

²²⁴ Including Aboriginal Victorian women. See discussion in Chapter 12.

and foetal distress; and the one we most worry about is premature birth because that delivers babies with immature lungs, immature organ systems, and then all the complications that occur with that, and also increased mortality.

The maternal complications of ice use are of course haemorrhage during pregnancy, stroke, heart attacks, and they are devastating consequences when you think that these women are still relatively young.²²⁵

Paediatrician Dr Ellen Bowman added her concerns about the effects upon the baby after birth:

Impaired growth is particularly noted, and the area of growth that is concerning and most consistently reported is of a small circumference of the head. People worry about that because it does have correlations with later intellectual functioning.

Infant behaviour directly after birth, [is also affected] and there are two sorts of ways that that presents. One is with a baby who is very floppy and just will not eat, which is not good; and the other is a baby with variable motor tone who is irritable and tremulous and just never relaxes. These babies are very hard to care for... Fortunately however it is rare that that will come to require pharmacological management. Usually it can be contained with various supportive management [strategies]. About 4 to 5 percent get to actually need medication where it is sole [meth]amphetamine use, but, with the vast majority of the babies that come to our attention — over half — the mother has had polysubstance use, and in that case there is a much higher pharmacotherapy requirement for the babies.

Regarding longer term impacts, the long-term issues are growth, particularly head circumference. At age 8 the sorts of things that are remarked upon are poor social adjustment and aggression and poor academic outcomes over the journey. Whether this is all the effect of the substances themselves or whether it is compounded by the often reduced social circumstances and emotional and social deprivation these children may well be subject to is uncertain.

The reasons for a prolonged [hospital] stay are multiple. One is the possibility of withdrawal of the infant. The second is the high risk of mental health disorders of the mother, assessing for their mental wellbeing, which can be upset by all the issues of actually having a baby. The third thing is that the social circumstances may not be well sorted out, the parent craft ability is not well understood, and necessary and vital referrals have not had an opportunity to be made because of the late presentation. It is complex.²²⁶

WADS states that care for women using ice and their baby is resource intensive. 'It is our clinical practice at WADS for infants exposed to methamphetamine to remain in hospital with their mothers for at least five days for assessment of withdrawal. These babies may be admitted to special care nursery for problems associated with ice use such as weight loss, poor feeding and somnolence'.^{227 228}

Some studies have been less clear as to whether there is a direct link between methamphetamine use and post birth complications, concluding that the consequences of prenatal exposure to methamphetamine may be confounded by poor prenatal care of mother and baby and the use of high rates of nicotine and/or alcohol (Golub et al. 2005; Good et al. 2010).

225 Dr Yvonne Bonomo, Addiction Specialist, Royal Women's Hospital Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

226 Dr Ellen Bowman, Paediatrician, Royal Women's Hospital Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

227 Ms Teresa Lynch, Manager, The Royal Women's Hospital, Submission, 11 March 2014.

228 The consequences of methamphetamine use for pregnant women and new mothers, particularly young girls, are not of course limited to the harmful physical effects on the foetus or new born child, they also extend to the social problems associated with child rearing, particularly in the formative years. As such these issues will be canvassed in more detail in Chapter 7.

Risk taking

Much of the research literature on methamphetamine use indicates a willingness to engage in risk-taking behaviour on the part of the user, despite the side effects experienced. Particular risk-taking behaviour manifested may include:

- ◆ Sharing of needles and injection equipment
- ◆ Sharing of pipes and smoking equipment
- ◆ No condom use during sexual activity
- ◆ Sexual activity including high risk anal sex with multiple partners; particularly prevalent with men who have sex with men
- ◆ Driving whilst under the influence of methamphetamine, and/or other drugs and alcohol
- ◆ Exhibiting violence and aggressive behaviour; for example 'picking' fights.²²⁹

Another potentially dangerous consequence of methamphetamine use relates to the drug's propensity to minimise the perception of pain. This may result in the instigation of high risk behaviours such as engaging in fights or assaults even whilst seriously injured.²³⁰

Tolerance, withdrawal and dependence

There are a number of complex and contentious issues pertaining to whether prolonged and heavy use of methamphetamine in particular can result in discrete withdrawal and dependence syndromes associated with increasing tolerance to the effects of the drug.

Tolerance

Prolonged use of methamphetamine may result in tolerance for the drug and increased use at higher doses ultimately resulting in dependence.

As with many drugs, it is possible for people, particularly regular or dependent users of amphetamines, to develop a tolerance to the drug whereby increasing amounts are needed to get the same effect that a lesser amount achieved originally. The quantity taken can reach a stage at which no further increase in the amount taken will produce the desired effect. Tolerance may be seen by a transition from non-injecting routes of administration to injecting methamphetamine 'using higher doses of the drug per episode, more frequent use and a preference for more potent forms of the drug, in the case of methamphetamine for crystallized methamphetamine [ice] rather than powder' (Darke et al. 2008, p.256).

Withdrawal

Cessation of regular methamphetamine use can result in a withdrawal condition listed by the American Psychiatric Association as 'amphetamine type substance withdrawal syndrome' (American Psychiatric Association 2013; Cruickshank & Dyer 2009).

Withdrawal from methamphetamine consists of an acute phase lasting approximately one week to 10 days (McGregor et al. 2005). During this period, withdrawal symptoms on cessation of use may include craving, irritability, fatigue, depression, anxiety or panic and sleep disturbance. Agitation, unpleasant dreams, and reduced energy are also apparent (Darke et al. 2008; McKetin et al. 2013b). Psychosis may also be a product of withdrawal and as discussed later in this chapter, dependent users of methamphetamine are much more

229 See generally Topp 2012 for a discussion of these and other forms of risk taking behaviours.

230 See comments of Dr David Eddy, Director of Emergency Medicine, Barwon Health, Public Hearing, Geelong, 28 October 2013.

likely to exhibit psychotic symptoms than their non-dependent counterparts (McKetin, McLaren et al. 2006; McKetin & Lubman 2011).

Low level symptoms of withdrawal in the sub-acute phase may last for a further two weeks after the acute withdrawal phase (McGregor et al. 2005; McKetin et al. 2013b). 'The severity of the withdrawal is related to the dosage and duration of the methamphetamine use' (Cruickshank & Dyer 2009, p.1092).

Addiction and dependence?

There has been much debate in past decades as to the existence of a discrete amphetamine withdrawal syndrome (see historically Churchill 1991; Hall & Hando 1994; Topp & Darke 1997; Hall et al. 1996; NDARC 2002b). For many years dependence on methamphetamine was viewed at most as a psychological rather than a physiological concept.²³¹ Other researchers have characterised methamphetamine, particularly in its crystal form, as 'highly addictive' (Bramness et al. 2012; McKetin, Kelly & McLaren 2006; McKetin et al. 2013b). It is now generally acknowledged that prolonged use of methamphetamine may result in an increase in tolerance and physical dependence and indeed a dependence syndrome, albeit perhaps less defined or marked than those pertaining to alcohol and opioids (Topp & Mattick 1997; Lee et al. 2007; Darke et al. 2008).

The World Health Organization's International Classification of Diseases (ICD10) includes (meth)amphetamine dependence in its taxonomy. It is advised that a diagnosis of dependence, however, should only be made if three or more symptoms or characteristics are manifested at some time during the previous year. Such symptoms can include inter alia a strong compulsion to take the drug, difficulties in controlling drug-taking behaviour in terms of onset, termination or levels of use, evidence of tolerance, and a physiological withdrawal state.²³²

In the context of methamphetamine and particularly with regard to its crystallised form, ice, McKetin, Kelly and McLaren (2006), state that:

Dependence on crystalline methamphetamine is likely to be strongly related to the reinforcing effect of the drug. Indeed crystalline methamphetamine users state that one of the reasons they prefer taking crystalline methamphetamine is because it provides a stronger high than other forms of methamphetamine. Crystalline methamphetamine could be a potent reinforcer because it delivers a particularly high dose of the drug or it may differ in its pharmacokinetic profile in a way that enhances the efficiency of the neurochemical changes that underpin the drug's rewarding properties career (pp.202-203 and the authors cited therein).²³³

The relationship between dependence, purity of the drug and mode of administration

Dependence has been found to be more common amongst those who use purer forms of methamphetamine such as ice (McKetin, McLaren & Kelly 2005, p.xvi, p.88; McKetin, Kelly & McLaren 2006; McKetin et al. 2013b). Whilst strong correlations have also been made between injecting the drug and dependence, smoked or 'chased' crystal methamphetamine due to its high purity can also cause dependence due to the intense effect or high similar to intravenous administration (Cho in McKetin, Kelly & McLaren 2006, p.199). Indeed, some

231 Up until the 1960s amphetamines were viewed as merely 'habituating' rather than truly addictive. Such a perspective needs to be looked at in the context of the time where in many countries amphetamines continued to be used for legitimate purposes. Postwar changes about the concept of addiction promoted by the World Health Organization saw amphetamines falling within a psychosocial model of drug dependency. See Rasmussen 2008 and Chapter 3 for an historical account of methamphetamine.

232 World Health Organization (WHO) 2007, *International Statistical Classification of Diseases and Related Health Problems (10th revision)*, WHO, Geneva.

233 This study of methamphetamine users in Sydney found that half of the users surveyed could be said to be dependent on methamphetamine, particularly ice (McKetin, Kelly & McLaren 2006).

researchers have noted that smoking the drug is not only more likely to lead to dependence than oral or intranasal methods but can also lead to levels of dependence approaching those seen in methamphetamine injectors (McKetin, Kelly & McLaren 2006).

The Committee was advised that the dependence on crystal methamphetamine was part of a pattern of poly-drug use whereby if one drug was not available another would be substituted.²³⁴ This suggests in some cases a psychological addiction to the *administration* of the drug as much as to the inherent physical properties of a particular drug itself. This may be particularly the case with regard to injecting drug use (Kaye & Darke 2000; Darke et al. 2008).

Contextualising dependence

Dependence on drugs generally can be influenced by numerous factors as McKetin, Kelly & McLaren explain:

Dependence on drugs is influenced by a range of individual, environmental and societal factors but is also strongly related to patterns of drug use. Drug use patterns that vary with dependence include route of administration, age of initiation into drug use, frequency of drug use and duration of drug use. Evidence suggests that although some of these patterns are strongly reinforcing and can therefore instigate dependence, their occurrence also reflects the natural progression of a drug using career (2006, p.198).

Many health workers in the field who gave evidence to the Committee, whilst acknowledging that there is a basis for physical addiction to methamphetamine, also pointed out that in many cases the psychological addiction to the drug was rooted in highly chaotic or stressful personal histories and disadvantaged backgrounds. For example, Ms Debbie Stoneman from Latrobe Community Health Services told the Committee:

Never have I nursed a person who ends up dependent on a drug who started with just occasional use. Always there are underlying issues and those issues are sexual assault, family violence, abuse, sometimes even the generational issue of people not having been able to learn how to be resilient. The illnesses and the injuries and the diseases that are occurring for people who end up using or end up dependent on ice start way before there. These illnesses unfortunately are unseen. They exist the same as diabetes or a broken leg or epilepsy but they are unseen.²³⁵

Thus an understanding of contextual factors of drug use is important,²³⁶ and is an issue discussed at greater length in Chapter 9.

Transition from 'recreational' use to dependence

Much drug research has noted a classic progression of drug dependence from experimental or occasional use to regular, heavy and then dependent use (McKetin, Kelly & McLaren 2006). However when it comes to methamphetamine, and particularly crystal methamphetamine, both the academic literature and workers in the field who gave evidence to the Committee have noted a relatively rapid escalation from initial to regular use of methamphetamine amongst *some* clients.²³⁷ Brecht et al., in their study of female users of methamphetamine in California, noted that this seemed to be particularly a feature of women who use the drug, but why this may be the case is unclear.

234 See for example comments of Mr Bill Wilson, Youth Outreach, Alcohol, Tobacco and Other Drugs Team, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014.

235 Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

236 See also the discussion of Zinberg's classic account of contextualising the 'drug, set and setting' in Chapter 9.

237 In a recent overview of methamphetamine use, McKetin and her colleagues cite epidemiological studies suggesting that around one in five users will make the transition from infrequent to regular and dependent use (2013b, pp.692-693).

Ms Cheryl Sobczyk from Bendigo Community Health Services told the Committee that in her experience the move from recreational to dependent use of methamphetamine is a much quicker trajectory than with other drugs, particularly heroin. 'Even with heroin use I have known people who have used heroin recreationally for years and years. We are not seeing that same trend with ice'.²³⁸ Ms Di Griffin from the Albury–Wodonga Aboriginal Health Service told the Inquiry that to her, a worrying concern was that many of her (Aboriginal) clients were initiating crystal methamphetamine as their first drug of choice rather than commencing with alcohol or marijuana and then progressing to a harder illicit drug:

[t]hey are smoking ice instead of smoking cannabis. What we know about ice is it seems to be more addictive and people develop dependency much quicker than they would with cannabis. A number of people can smoke cannabis and not become dependent on it, but the ice use seems to really grab these kids, particularly young people. It is grabbing them and not letting them go, that is what is really concerning.²³⁹

Mr John Ryan, CEO with Anex, also told the Inquiry that there is a trend for methamphetamine to become the first or initiating drug of choice, which was traditionally unusual for 'hard' drugs:

There used to be a belief that there was a kind of gateway drug from one to another, from a softer drug to a harder drug. It was never that well evidenced, and certainly in relation to methamphetamine it does not seem to be the case that people will start with, say, cannabis and move on to ice. Those sorts of continuities are not apparent... it is true to say that for a lot of people their first illegal drug consumption is methamphetamine.²⁴⁰

From a clinical perspective, Dr Dan Turner, Director of Emergency at Mildura Hospital told the Inquiry that the difference the Emergency Department is seeing with ice compared to the more traditional-type substances is the intensity and acuity of the onset of symptoms:

That means we are seeing people having overall social and physical dysfunction happening in a number of months, whereas in the past with cannabis and alcohol et cetera that onset could be over a number of years. We are seeing people presenting to us with depression and suicidal ideation over a number of weeks rather than a chronic major depressive episode, which is usually six months plus, and also the onset of psychotic features.²⁴¹

Other workers have also told the Inquiry that they are seeing people, particularly young people, becoming 'addicted' to methamphetamine relatively quickly, many of whom do not see themselves as having an addiction because they have not 'hit rock bottom'. For such young people addiction is exemplified by a heroin 'junkie' or an elderly itinerant alcoholic. As Ms Trish Quibell from Berry Street youth services in Shepparton told the Committee:

A lot of our young people would not see themselves as having an addiction; they would completely deny that they have an addiction. That would be prevalent regardless of what strata of society you come from. Most people do not believe they have got an addiction until something hits them and they have hit rock bottom. For our young people, our young women especially, they will continue to think that they are in control of it, they will continue to think that they are functioning, they will continue to think that they are in relationships that premeditate that drug usage, that are caring, unless their dealer or their pimp dumps them.²⁴²

238 Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013.

Similar comments were made to the Inquiry by Mary Bassi of Sunraysia Community Health Services in Mildura who said compared to other drugs she is seeing 'loss or damage happening to clients in a much shorter space of time'. Ms Mary Bassi, Manager, Primary Health, Sunraysia Community Health Services, Public Hearing, Mildura, 5 December 2013.

239 Ms Di Griffin, Aboriginal Drugs and Alcohol Counsellor, Albury–Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014.

240 Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

241 Dr Dan Turner, Medical Director of Emergency, Mildura Base Hospital, Public Hearing, Mildura, 5 December 2013.

242 Ms Tricia Quibell, Deputy Director, Hume region, Berry Street, Public Hearing, Shepparton, 25 February 2014.

Ex-users and family members may have more insight into the rapid trajectory from use to dependency as the following testimony to the Inquiry of an ex-user of ice illustrates:

I was on ice for eight months. It completely destroyed my life. In a matter of eight months' time I had nothing left. I had a car, I had a job, two beautiful kids, a gorgeous fiancée. I have lost it all, bar my fiancée. I am currently in the process of getting my two kids back... I had money, I had everything, I was living the dream, and then out of nowhere it started off at a party I would have one toke and then it would have been maybe a month later I done it again, and then a week later and then every day. It took control. It is too quick. It is a shocking drug. It is one of the worst drugs you could ever encounter.²⁴³

Concepts of 'addiction' can be unhelpful

Whilst the existence of a methamphetamine dependence syndrome is generally now acknowledged, some clinicians and alcohol and drug workers who gave evidence to the Inquiry are more wary about 'talking up' the nature of methamphetamine 'addiction', particularly given some of the media reporting in this context.²⁴⁴ Mr Peter Wearne from the Youth Support + Advocacy Service (YSAS) stated in this respect:

The concept that this is an instantly addictive drug is a misnomer. I think it clouds the issue, where there is a significant group of people within our community that are using this drug on a regular basis, it is really destroying a great part of their life in terms of breaking down family relationships, ending employment, seeing them get into all sorts of debt, but more importantly they are now liaising with criminal elements within the community... The fallout from that is that there will be people who start using that drug socially where that drug use will get out of control for them, they will not be able to control that use, for all sorts of pre-existing reasons and features within their own lives. Where one person can walk away from a drug, some other people find it very hard to walk away from that drug... but when people walk around and say, 'You have it once and you're instantly addicted', [that] is not helpful, because the first person that has the drug and is not instantly addicted knows that is a lie. So do not exaggerate the harm. There are harms enough in this drug without exaggerating them.²⁴⁵

Addiction medicine specialist Dr David Jacka for the most part agreed that a combination of media reporting and a misunderstanding of the true nature of addiction has contributed to a perception that methamphetamine results in more serious dependency issues than is in fact the case, at least compared to other drugs:

The vast majority of people never go beyond functional use. They never go beyond recreational use. It is nowhere near as addictive as cigarettes, nicotine. Crack cocaine is a really good example of something that is much more addictive. Heroin is much more addictive. Methamphetamine, crack and ice are perhaps more addictive than ordinary amphetamines, but it is still of the order of 15 to 20 percent of people who use the drug habitually will become dependent. It is not the majority by any means.²⁴⁶

Whatever the actual level of dependency on methamphetamine it is certainly true that many if not most people recover and stop using methamphetamine, some with treatment interventions and most without (Oppenheimer 2012, p.9).²⁴⁷ As Dr Amy Pennay, a drug researcher from Turning Point, told the Committee, 'It is important to note that most

243 Mr David Reid, Public Hearing, Wodonga, 24 February 2014.

244 See Chapter 24 for a discussion of media reporting of methamphetamine use, particularly that of ice.

245 Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Traralgon, 28 January 2014.

246 Dr David Jacka, Addiction Medicine Specialist, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

247 For example, Professor Paul Dietze from the Burnet Institute in Melbourne told the Inquiry of a study they had undertaken of methamphetamine users whereby 32 percent of the sample had simply stopped using methamphetamine at the time of follow-up one year after the sample was initially interviewed.

Professor Paul Dietze, Head, Alcohol and Other Drug Research, Centre for Research Excellence in Injecting Drug Use, Burnet Institute, Public Hearing, Melbourne, 30 September 2013. See transcript for further details pertaining to this survey.

Other users may stop using methamphetamine but switch to other drugs (Oppenheimer 2012; McKetin, McLaren & Kelly 2005).

methamphetamine users do not transition to regular use or dependence'.²⁴⁸ However, even if the level of technical dependence on methamphetamine is less than is commonly thought, this does not mean that users, their families and loved ones are not suffering considerable anguish as a result of the effects of this drug. Some of the behavioural and social aspects of habituation to methamphetamine can be almost as damaging as the manifestations of a clinical dependency syndrome.²⁴⁹

Mr John Ryan, CEO of Anex strikes a balance between not over or under emphasising the problems associated with methamphetamine use and its links to dependency:

Whilst the myth that you use it once and you will be addicted is mostly a myth, there are people who use it once and, because of the significant down period after use, the temptation to use again is very high, and so people do become quite tempted to use again and again. So the trajectory of use into addiction is much shorter than with other drugs such as alcohol or heroin, and therefore we see people going from their first use to potentially having a significant problem within 6 to 12 months of their first use. That is not to say that all people who use methamphetamine are addicted, and certainly not addicted automatically. It is a drug like any other, which means that some people are particularly vulnerable. For example, if part of the experience of using methamphetamine is that you feel 10 feet tall and very confident and you have previously not felt 10 feet tall and very confident, the temptation because of that vulnerability is high to use again and again.²⁵⁰

Psychological and behavioural consequences of methamphetamine use

Whatever the clinical status of a defined methamphetamine dependence syndrome, at the very least (heavy) users of methamphetamine can exhibit major psychological and behavioural problems including psychosis, anxiety states, depression and cognitive problems; although the extent to which these are clearly defined syndromes is still being debated.

Nonetheless, it is generally thought that the average mental health and wellbeing of methamphetamine users is below that of the general population. A study of methamphetamine users in Sydney found that:

One in five [had] severe disability in their mental health functioning. Dependent methamphetamine users were three times more likely to suffer impairment in their mental health functioning compared to non-dependent methamphetamine users. This finding iterates previous research in Australia that has also found a strong relationship between heavy methamphetamine use and psychological morbidity (McKetin, McLaren & Kelly 2005, p.105 and the authors cited therein).

Similarly the UnMet study conducted by Victoria's Burnet Institute found that the cohort of study participants exhibited relatively poor mental health with:²⁵¹

- 30% classified as 'highly' psychologically distressed according to the Kessler 10 Scale of Psychological Distress;
- 42% currently prescribed medication for mental health issues; and

248 Dr Amy Pennay, Senior Research Fellow, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

249 For example, alcohol and drug workers have commented upon the relatively short transition between users initiating methamphetamine use and then ending up caught in the legal system as a result of committing crimes to pay for their methamphetamine use.

See for example, Mr Hamish Fletcher, Chief Executive Officer, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014; Dr David Eddy, Director of Emergency Medicine, Barwon Health, Public Hearing, Geelong, 28 October 2013.

For the social and legal consequences of methamphetamine use, see discussion in Chapter 7.

250 Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

251 The UnMet study is a longitudinal study of 255 people who use methamphetamine, recruited during 2010 and followed up one year later during 2011. See Professor Paul Dietze, Deputy Director, Centre for Population Health, Burnet Institute, Submission, 21 October 2013.

- Reported illicit use of mental health medication was common (e.g., 65% had used illicit benzodiazepines an average of one day/week in the last month).²⁵²

Problems with mental health are also much more likely to be apparent in dependent methamphetamine users compared to non-dependent users, with dependent users 'three times more likely to suffer impairment in their mental health functioning compared to non-dependent methamphetamine users' (McKetin, McLaren & Kelly 2005, p.107).

The following table outlines the major psychological harms associated with methamphetamine use.

Table 2.2: Major psychological harms associated with methamphetamine use

Variable	Comment
Psychosis	
General	Unlike opioids, methamphetamine can induce psychosis. Usually transient, with delusions and hallucinations.
Comparisons	Psychostimulant users have higher levels of psychosis than users of opioids, benzodiazepines, barbiturates.
Dependence	Most likely among chronic, dependent users. Longer periods of psychostimulant use, and heavier use, increase risk.
Pre-existing pathology	High risk of psychotic symptoms of pre-existing schizophrenia, mania or other psychotic disorders.
Route of administration	Injection associated with increased risk.
Depression rates	
	Rates of major depression substantially higher than general population
Suicide	Rates of attempted suicide substantially higher than general population.
Risk Factors	Higher levels of depression and suicide associated with longer use careers, more frequent use, dependence and injecting.
Anxiety rates	
	Rates of anxiety disorders substantially higher than general population
Risk factors	Anxiety disorders associated with longer use careers, more frequent use, dependence and injecting.

Source: Adapted from Darke et al. 2008.

Methamphetamine psychosis

One of the key differences between psychostimulants such as methamphetamine and other drugs such as heroin or benzodiazepines, is that methamphetamine can induce a form of psychosis known as methamphetamine induced psychosis.²⁵³

252 Professor Paul Dietze, Deputy Director, Centre for Population Health, Burnet Institute, Submission, 21 October 2013.

253 Methamphetamine psychosis is recognised as a distinct syndrome in both the ICD (International Classification of Diseases Manual of the World Health Organisation) and the DSM (Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association). In order to meet the criteria for methamphetamine psychosis, the psychotic symptoms must:

- Occur during or within two weeks of methamphetamine use
- Persist for more than 48 hours
- And not exceed 6 months duration (ICD 10 in McKetin et al 2005, p.119).

The symptoms of methamphetamine psychosis are similar if not indistinguishable to those of acute paranoid schizophrenia or other non-drug-related psychotic episodes,²⁵⁴ and may include:

- Auditory and visual hallucinations
- Paranoid and persecutory delusions
- Illogical and tangential thought processes
- Uncontrolled violent behaviour (McKetin et al. 2013b; Jenner 2012).

This state usually disappears after the drug has been eliminated from the body. Symptoms typically only last a few hours and even in severe cases abate within a week of withdrawal of the drug although hospitalisation and sedation with antipsychotic medication may be required (Darke et al. 2008; McKetin et al. 2013b). For the most part studies reviewed by Cruickshank and Dyer indicate that in more than 50 percent of cases psychotic symptoms resolve spontaneously and without the need for long-term antipsychotic medication (2009). Nevertheless, if the drug is used again, the psychosis may recur (NDARC 2002a).

Methamphetamine psychosis is most prevalent among heavily dependent methamphetamine users. A higher risk is also associated with 'a younger onset of methamphetamine use; more frequent use, and a higher blood concentration of methamphetamine' (McKetin et al. 2013b, p.694).

Methamphetamine use has a bearing on psychosis in three main ways:

- Psychosis can be manifested in individuals with no prior experience of or history of psychotic illness²⁵⁵
- Psychotic relapse can be triggered in individuals with schizophrenia or other psychotic illnesses; and
- Methamphetamine may initiate an illness such as schizophrenia in individuals genetically or otherwise predisposed to such illness (Lee et al. 2007; McKetin et al. 2013b).

For many methamphetamine users, particularly those who are not chronic or dependent users, the symptoms may be relatively mild and transient. Some users, however even relatively infrequent users, can experience clinically significant psychotic episodes. A major study by McKetin et al. in 2006 found that interviews with 309 regular methamphetamine users revealed the prevalence of psychosis was 11 times higher than that of the Australian general population.²⁵⁶ The study also found the risk of psychosis increased with the severity of dependence, and dependent methamphetamine users were a particularly high risk group for psychosis even after adjusting for a history of schizophrenia and other psychotic disorders (2006, pp.1473ff). Other contextual factors associated with (heavy) methamphetamine use, such as a lack of sleep and a history of trauma can further increase vulnerability to psychosis (McKetin et al. 2013b, p.694).²⁵⁷

254 For a discussion of the relationship between schizophrenia and amphetamine psychosis, see Harris and Batki 2000. The authors state:

'Stimulant induced psychosis is common and increasing in frequency... Psychosis can be induced by amphetamine in non psychotic subjects and higher doses of amphetamine may be associated with production of a more complete replication of schizophrenic symptoms. Amphetamine use can also precipitate a schizophrenic episode or exacerbate symptoms in schizophrenic patients. Furthermore, once the psychotic develops with amphetamine use, recurrence can happen in response to psychological stressors without further amphetamine use, making the illness difficult to distinguish from schizophrenia' (2000, p.29).

255 The results of experimental induction of methamphetamine psychosis in healthy adults questioned theories that amphetamine psychosis was solely a manifestation of psychotic symptoms in predisposed individuals such as schizophrenics. See McKetin et al. 2005, pp.109ff.

256 Dr McKetin also spoke to this research when she gave evidence to the Inquiry in Canberra in February 2014. See Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

257 For example, Alan Fisher, a drug clinician with Albury–Wodonga Health told the Inquiry that sleep deprivation in combination with the psychoactive properties of methamphetamine increased the chances of users 'becoming psychotic or losing contact with reality'. Mr Alan Fisher, Clinical Leader, Drug and Alcohol Community Treatment Services, Albury–Wodonga Health, Public Hearing, Wodonga, 24 February 2014.

Another report by McKetin et al. (2008) found, however, that while these background and contextual risk factors for psychosis:

[c]ontribute to the high prevalence of psychotic symptoms among methamphetamine users, they cannot completely account for it. Experimental studies indicate that high doses of methamphetamine [of itself] can induce a psychotic reaction and this relationship has been repeatedly borne out in epidemiological studies and clinical case reports (McKetin et al. 2008, p.694).

A more recent longitudinal study by McKetin and her colleagues also examined the links between methamphetamine use and psychotic disorders (2013a). They found that an increase in psychotic symptoms during periods of methamphetamine use was related to the amount of drug taken. In other words the larger the amount of the drug taken the more likely it was that psychotic symptoms would manifest. The likelihood of experiencing psychotic symptoms was five times higher during periods of methamphetamine use than periods of no use. The risk of experiencing psychotic symptoms increased from a low baseline level of 7 percent during abstinent periods to 48 percent when participants were (heavily) using. Moreover, frequent and concurrent use of alcohol and cannabis also increased the odds of manifesting psychotic symptoms (McKetin et al. 2013a, pp.E3-E4).

One interesting finding to come out of this research was that although abstinence from methamphetamine use usually resulted in an abatement of psychotic symptoms there was a small minority of individuals who reported psychotic symptoms continuing during abstinence:

These individuals may have been experiencing a more chronic form of methamphetamine psychosis ... with symptoms persisting beyond drug use into periods of abstinence. These residual symptoms could also reflect a lasting vulnerability to psychosis with chronic methamphetamine use...leaving the individual prone to psychotic symptoms irrespective of their current drug use. Finally, the occurrence of psychotic symptoms in the absence of methamphetamine use may reflect a pre morbid state, for example participants who had sub threshold symptoms of a psychotic disorder, such as schizophrenia [but] which were not sufficient to meet DSM–IV criteria and therefore did not result in their exclusion from the [research] sample (McKetin et al. 2013a, p.E5).²⁵⁸

The impact of pre-existing psychiatric conditions on methamphetamine use is discussed in the following section. For the most part, however, users with no individual or family histories of psychotic illness and otherwise healthy, whilst susceptible to possible acute psychosis, are unlikely to sustain such psychosis in the long term (Bramness et al. 2012).

Pre-existing mental health conditions

Methamphetamine users are at high risk of manifesting psychotic symptoms if they suffer from a pre-existing psychotic disorder such as schizophrenia or mania. In such cases the drug, particularly when used frequently, can precipitate or exacerbate psychotic episodes (Darke et al. 2008). The clinical research indicates ‘overwhelming evidence’ that patients with psychotic disorders including schizophrenia have an ‘increased vulnerability to compulsive use of drugs of abuse including psychostimulants’ (Bramness et al. 2012, p.222).²⁵⁹ Certainly the evidence suggests that patients with schizophrenia or schizotypal personality disorders are more readily disposed to manifest psychotic symptoms after the use of methamphetamine (Bramness et al. 2012; McKetin et al. 2013b).

258 Prospective participants in the study who met the Diagnostic and Statistical Manual (DSM) criteria for life long schizophrenia or mania were excluded from the study.

259 And indeed also sedative type drugs such as alcohol, opioids and benzodiazepines; possibly in an attempt to ‘self medicate’ after the effects of a methamphetamine binge. This could be one reason why users develop serious problems with poly-drug abuse. See further discussion on poly-drug use in Chapter 10.

Methamphetamine users may be at increased risk when there is a family history of schizophrenia, mania or depression in first degree relatives. Research has indicated that such users are more likely to develop both acute and enduring psychosis rather than users without such a history (Chen et al. 2005; American Psychiatric Association). Genetic predisposition may then play a part. Indeed research by Bramness et al. indicates that schizophrenia spectrum disorder and [meth]amphetamine induced psychosis may be linked together 'by the finding of several susceptibility genes common to both conditions' (2012, p.221).

Further discussion on co-morbidity between substance dependence and mental health disorders is presented later in this chapter.

Violence and aggression and its relationship to methamphetamine psychosis

One issue pertaining to methamphetamine psychosis is gauging the extent to which violence and aggression manifests as part of the condition. Certainly some popular and media accounts have violence as being a commonplace feature of methamphetamine use and dependency, but the extent to which this occurs has probably been overstated.²⁶⁰ In any case, the exact relationship between violent behaviour and methamphetamine use is unclear. As Dr Matthew Frei of Turning Point Alcohol and Drug Centre told the Committee:

I think we need to probably look at the evidence to see whether there is a direct association — and it may well be the case — between the use of methamphetamine and violence... We need to look at... whether it is violent people who happen to take amphetamine, or whether it is methamphetamine and its pharmacological effects causing violent behaviour.²⁶¹

Nonetheless, whilst acknowledging this lack of a clearly established causal relationship between methamphetamine use, psychosis and violence, a number of studies have found that methamphetamine users were more likely to commit violent crime particularly when compared to heroin users (Cartier, Farabee & Prendergast 2006; Darke et al. 2010; Sommers & Sommers 2007). Overall however, the literature would appear to be inconsistent as to the exact links between methamphetamine use, violence and psychosis and further research is needed in this area.^{262,263}

Depression

Depression may also be a significant consequence of methamphetamine use; one which can have fatal consequences including suicide.²⁶⁴ What is not absolutely clear, however, is whether depressive symptoms including suicidal ideation always follows (prolonged) methamphetamine use or does a person with depression use methamphetamine to self-medicate his or her symptoms. Indeed, some researchers have expressed doubt about the relationship between depression and methamphetamine use. Semple, Grant and Patterson, for example, whilst not doubting there *is* a relationship, ask in the context of female users of methamphetamine:

Do the high levels of depression reported by [study participants] precede their meth use or does meth use lead to increased depressive symptoms? Similarly does meth use lead to high risk [sexual] behaviours or does the behaviours motivate the use of meth? Longitudinal data are necessary to disentangle these reciprocal relationships (2008, p.49).

260 See discussion in Chapter 24.

261 Dr Matthew Frei, Head of Clinical Services, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

262 See Ms Jacinta Pollard, Managing Director, Caraniche, Submission, 21 October 2013.

263 For example, other aspects of violence and crime relating to methamphetamine use, particularly that pertaining to profit making or acquisitive crime to fund a methamphetamine habit, are discussed in Chapter 8.

264 From a pharmacological perspective, depression may be related to the depletion of dopamine stores and transporters as a result of methamphetamine use over time. See evidence cited in Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, Submission, 21 October 2013.

Nonetheless, whatever the exact nature of the relationship, as with psychosis, higher levels of depression, suicide and anxiety *have* been associated with longer-term or chronic methamphetamine use, dependence, frequent use and injecting (Darke et al. 2008, p.257).

Darke et al. drawing from Australian and overseas studies state in this regard:

Among methamphetamine users, the majority report a lifetime prevalence of depression, and a recent study reported that a third of methamphetamine users had been diagnosed with depression at some point in their lives. As would be expected, given these high rates of depression, rates of suicidal ideation and attempted suicide are also high. By comparison, less than 5% of the general population have a lifetime history of attempted suicide (2008, p.258).

Another study of methamphetamine users in Sydney found that many of the users had previously been diagnosed with a mental health disorder and half had taken medication for a mental health problem at some point in their lifetime, most commonly for depression followed by anxiety disorders and less commonly psychosis (McKetin, McLaren & Kelly 2005, p.107).

Depressive conditions are also being seen by many health and alcohol and drug workers who interact with people who have had or continue to have methamphetamine-related substance disorders including some young people. For example, Ms Kerry Donaldson of the YSAS in Bendigo told the Committee that she had grave fears about the impact of methamphetamine on both children and young people's brain development and the depression that seems to accompany the withdrawal from the drug.²⁶⁵

Depressive conditions may either precede methamphetamine use or be part of the withdrawal syndrome, particularly when a person has made a conscious attempt to wean themselves off the drug:

These [depressive] types of mental health problems often precede drug use and may increase the risk of someone becoming dependent on methamphetamine...Ongoing methamphetamine use can further exacerbate some of these mental health problems...Withdrawal from heavy methamphetamine use can induce a pseudo depressive state that lasts several days to weeks...Such methamphetamine related mood disturbances can be sufficiently severe as to constitute a clinically meaningful entity in their own right (McKetin et al. 2013b, p.695).

The depression associated with the withdrawal syndrome can impede efforts to discontinue methamphetamine use. As one alcohol and other drug worker told the Committee in the context of young users of the drug:

It is really hard to maintain people in abstinence or controlled use when there is no joy in their lives. The things they used to find pleasure in they cannot find pleasure in, and it is really a very difficult state to hold young people in because they are so motivated and rewarded by joy, as they should be. Kids are joyful. It is a very sad thing to see children without joy.²⁶⁶

Depression, methamphetamine and self-medication

Interestingly and ironically it is not uncommon for some people to take methamphetamine as a way of self-medicating their depression or other mental illness.²⁶⁷ Some community health and alcohol and drug agencies advised the Committee that young people who had been diagnosed with Attention Deficit Disorder, after having been prescribed dexamphetamine or *Ritalin*, may as adolescents turn to methamphetamine as an attempt to self-medicate their condition.²⁶⁸

265 Ms Kerry Donaldson, Manager, Community Programs, Youth Support + Advocacy Service, Bendigo, Public Hearing, Bendigo, 25 October 2013

266 Ms Kerry Donaldson, Manager, Community Programs, Youth Support and Advocacy Service, Bendigo, Public Hearing, Bendigo, 25 October 2013.

267 See for example, Mr Eion May, Alcohol and Drug Worker, Gippsland Lakes Community Health Centre, Public Hearing, Traralgon, 28 January 2014. See also discussion in Chapter 13.

268 Mr Eion May, Alcohol and Drug Worker, Gippsland Lakes Community Health Centre, Public Hearing, Traralgon, 28 January 2014.

A submission from VincentCare, an agency working with the disadvantaged and homeless noted similarly that:

Our staff also report that methamphetamine seem to have particular appeal for clients with mental health problems, such as depression, as it ablates (dissipates) some of the symptoms people experience — they temporarily feel better.

Some clients, who self-report a history of Attention Deficit Hyperactivity Disorder (ADHD), claim that amphetamines, in general, provide a calming relief for their ADHD. Methamphetamine, as well as amphetamines, are subsequently sought by these people as Ritalin has allegedly become too difficult to obtain on prescription. Methamphetamine is actually prescribed in its hydrochloride form for the treatment of ADHD, under the brand name Dosoxyng®, in the USA.²⁶⁹

Mr James Dale, an acquired brain injury and alcohol and drug clinician with Latrobe Community Health Services in Gippsland, told the Committee for example that many of his clients with brain injuries and cognitive impairments are taking ice to 'make them feel normal again'. 'So whatever changes they have had to make to their life because of the brain injury and their cognitive deficits, taking ice makes them feel better'.²⁷⁰

Women interviewed as part of an American study on characteristics of female methamphetamine users were found to prefer 'meth' over prescription medications to manage their psychiatric conditions. As the authors ask 'If women are using meth to self-medicate psychological symptoms, why might this drug be perceived as more appealing than prescription medications?' (Semple, Grant & Patterson 2008, p.46). One possible explanation in the American context may be the relative low cost and wide availability of methamphetamine compared to prescription medication.

Depression and suicidal ideation

Dr Rebecca McKetin noted the links between methamphetamine use, depression and suicide when she gave evidence to the Committee. Whilst depression itself is clearly a factor that can lead to suicidal ideation, she told the Committee that the paranoia and delusional thinking that can result from methamphetamine use also plays a significant part.

Whatever the immediate cause, suicidal ideation is a genuine risk amongst methamphetamine users, particularly during withdrawal or post-withdrawal and especially for those people with pre-existing conditions of mental illness (Darke et al. 2008).²⁷¹

While there are well documented studies on the links between psychosis and amphetamine use, much more knowledge and research is needed on amphetamine use and non-psychotic co-morbid conditions such as depression and anxiety.²⁷² The relationship between psychostimulant use and depression, like that between amphetamine use and psychosis, is unclear and complex.²⁷³

269 Mr John Blewonski, Chief Executive Officer, VincentCare Victoria, Submission, 21 October 2013.

For a comprehensive account that examines methamphetamine use by people with ADHD, see Jukes 2012. Jukes argues that whilst it is easy to assume that the person with ADHD may use methamphetamine to self-medicate this will by no means always be the reason (2012, p.323). In other words, people with ADHD may use methamphetamine for the same reasons other people do; for example a sense of euphoria or energy etc. For an account of the reasons why people may use methamphetamine, see Chapter 14.

270 Mr James Dale, Acquired Brain Injury and Alcohol and Other Drug Clinical Consultant, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

271 For a discussion of suicide risk and co-morbidity amongst users of methamphetamine in Aboriginal communities, see discussion in Chapter 12.

272 See Chapter 30 on research gaps with regard to methamphetamine.

273 Co-morbidity and dual diagnosis is discussed in Chapter 28 pertaining to treatment issues.

Conclusion

Serious consequences can result from both the short and long-term effects of methamphetamine use, particularly at high and prolonged doses. As Darke et al. state, methamphetamine is by no means a benign drug:

To summarise, methamphetamine use is associated with a number of extremely serious negative health effects. While high profile consequences such as psychosis are given prominence in the public debate the sequelae (abnormalities) extend far beyond this. This is a drug class that causes serious heart disease, has serious dependence liability and high rates of suicidal behaviours. The current public image of methamphetamine does not adequately portray the extensive and in many cases, insidious, harm it causes (2008, p.259).

This situation has changed in the past few years, with an increased media emphasis on the harm caused by crystal methamphetamine, with the emphasis more on the harm to society and property than to the individual user.

Although the medical and psychological consequences that follow from the use of drugs such as methamphetamine are clearly sufficient to give rise to concern, these are not the only adverse considerations that need to be taken into account with regard to their use. The social (or antisocial) harms and costs that may occur through the use of these drugs are also significant.

7. The Social and Environmental Impacts of Methamphetamine Use

Introduction

I have lost my mum and dad — my parents, my brother and sisters do not want anything to do with me. They do not speak to me anymore, even still to this day. I saw my father down the street on the way here and he looked at me and turned and walked in the other direction. That kind of hurt a bit but I have to work towards what I can get back.²⁷⁴

The physical and psychological costs and consequences associated with methamphetamine use are not the only types of harms that may result from this particular drug. The social and economic consequences of methamphetamine use may also be considerable. These consequences have an impact on the individual user, his or her families and friends and the wider community. For example, individual users of methamphetamine particularly those who may be dependent on the drug, may 'lose the ability to make a positive contribution to their community due to the drug's damaging effects on their health, relationships, education and employability' (Anex 2014, p.3).

Methamphetamine use can also have a profound impact on the wider community when it is associated with crime and violence. For example, criminal activities undertaken in order to steal or purchase illicit drugs clearly will have an economic and emotional impact on members of the general public (Nicosia et al. 2009). The environmental impacts of clandestine laboratories, largely associated with methamphetamine production, are another impact that is felt at a community level. Even the negative impact on tourism and business viability in towns reputed rightly or wrongly to be 'ice hotspots' can be an economic consequence of methamphetamine use at community level (Anex 2014, p.12).

Yet, despite these wider effects on society as a whole, it is arguable that the negative consequences of methamphetamine use can most clearly be seen by the effect it has on the families and friends of the user. This at least has certainly been the message most consistently received in evidence given to the Committee. As indicated by the quote from the ex-methamphetamine user above, the effect of methamphetamine use on the families, friends and associates of users, has at times been devastating.

Family stress and breakdown: The social impact of methamphetamine

The Committee has received many personal and qualitative accounts outlining the multiple harmful consequences to family relationships due to methamphetamine and other drug use. Such accounts often involved cases where the child of the family is the methamphetamine user. However, evidence has also been given of cases where one or both parents are active methamphetamine users and the child or children of the users are being neglected, abused or otherwise put in danger.

274 Mr David Reid, Public Hearing, Wodonga, 24 February 2014.

Relationship breakdown

The Committee received advice from many witnesses who highlighted the harmful impact that a methamphetamine user's behaviour has had on their relationships with parents, children and other significant family members or friends.²⁷⁵ 'In particular the irrational behaviour, deception and violence associated with methamphetamine use have been reported to negatively impact relationships'.²⁷⁶

Many users of methamphetamine may become socially isolated, choosing because of their drug use to distance themselves from family members and friends with whom they may previously have had good relationships.²⁷⁷ Conversely, family members may isolate themselves from the drug using family member because they cannot cope with the stress or stigma associated with the habit. The overall impact on family members of a child who is a user of methamphetamine is illustrated by a mother who has described to the police the effect on her family of her son's dependence on ice. The use and dependence has resulted in:

- money regularly stolen from her purse
- family possessions sold or pawned to fund her son's drug habit
- locks put on the bedroom doors to stop theft
- having to come up with cash to pay her son's drug debts so no harm would come to him or the family
- violent mood swings in which her son threw things at walls and family members
- verbal abuse towards family members
- her son shows total disrespect for everyone but himself
- he sleeps all day, is up all night and has wasted months doing nothing
- he has no motivation to get a job and simply lives off Centrelink
- he has no interaction with the immediate family and no interest in attending family events.²⁷⁸

A major factor contributing to family trauma can be the user stealing from family members, or selling their valuables, in order to support their habit.²⁷⁹ Heather Pickard from the family drug support agency SHARC (Self Help Addiction Resource Centre) told the Inquiry that this is but one aspect of the impact ice is having on family cohesion. The overall consequences, she explained, are devastating — more so than the effect of other drugs in the past:

What we do see with methamphetamine use is an increase in the trauma reported by the families, and what we think is behind that is the high arousal that comes with continued and prolonged use of ice. ...resulting in behaviours that are very far removed from normal ethical values that we might see in

275 Notwithstanding the myriad concerns expressed to the Inquiry about the impact of methamphetamine use on family violence, the vast number of submissions and evidence the Committee received stated that overwhelmingly alcohol by itself or in combination with other drugs was the worst 'offender' in terms of both violence in general and family violence in particular.

See for example evidence from:

Associate Professor Tony Walker, General Manager, Regional Services, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013; Professor Paul Dietze, Head, Alcohol and Other Drug Research, Centre for Research Excellence in Injecting Drug Use, Burnet Institute, Public Hearing, Melbourne, 30 September 2013; Dr Roger Volk, Forensic and Other Drugs Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014; Dr David Jacka, Addiction Medicine Specialist, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014; Mr Mark Allen, Team Manager, Morwell Mobile Intensive Care Ambulance (MICA) Unit and Single Response Unit (SRU), Ambulance Victoria, Public Hearing, Traralgon, 28 January 2014; Dr Tony Chan, Emergency Department Director, Latrobe Regional Hospital, Public Hearing, Traralgon, 28 January 2014; Ms Dianne Barker, Acting Senior Manager, ICMS and Residential Care, St Luke's Anglicare, Bendigo, Public Hearing, Bendigo, 25 October 2013; Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013; Mr Mike Fuery, Paramedic, Ambulance Victoria, Public Hearing, Wodonga, 24 February 2014.

276 Dr Sherene Devanesen, Chief Executive, Peninsula Health, Submission, 21 October 2013.

277 On this point, see for example Mr Zach Mason, Youth Worker, Junction Support Services, Wodonga, 24 February 2014.

278 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

279 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014.

that young person.... you can imagine the impact on a family member who is seeing their loved one behaving in a way that is just so far removed from what their normal knowledge of a young person is. Very often we have to treat the trauma in the family and provide support strategies at that point before they can become helpful families in the actual treatment plan for the young person.

There is a significant increase in the presentation of trauma amongst families that seek support from us. It is really significant, even more significant than what we saw with speed epidemics, which we have had as well. A lot of our treatment focus on families when they first come in is about stabilising them as a unit and trying to set up some support strategies.²⁸⁰

Similarly, Ms Bev McIlroy from the Glenelg/Southern Grampians Drug Treatment Service told the Committee that her service was seeing many more family members than they have in the past. With regard to the use of methamphetamine compared to other drugs:

[w]e have noticed a 63 percent increase in the presentation and contacts with families, various components of families, whether it be parents, brothers, sisters, husbands, wives, ...The effect [of methamphetamine] on the families is so quick. They are naive drug users who we are talking about here, people who, for the most part, have not been long term or regular drug users. [Other drug users] have a sense of what harms are associated with drug use, and they are able to mitigate them or prepare for them. You cannot do that with methamphetamine, simply because it comes on so quickly... The message I am getting from parents is their fear. The family dynamic is destroyed within months. ... because of the change in the personality of the person Once the family dynamic is destroyed through drug use it is very difficult to get it back again, especially when oftentimes you have dual diagnosis, mental health issues going along with that as well.²⁸¹

Negative impacts on family members

Academics have examined in great detail how family members are affected by drug use and particularly drug dependence. Krishnan et al. identified a cluster of stresses which include:

- finding the user unpleasant to live with
- concern regarding the harmful effects of the use on the whole family and the home
- financial difficulties
- personal anxiety and worry
- concern regarding the health and wellbeing of the user
- feelings of helplessness and despair
- depression (Krishnan et al. 2001 in Ross 2012, p.99).

With the focus on the drug using member of the family, parents may have less time to consider the needs or emotions of other members of the family. Such stresses can readily result in physical, psychological and emotional problems for family members. Parents and siblings of the user may feel they have 'to walk on eggshells' around the using member in a state of hyper-vigilance — 'on edge' with their emotional states tied to the behaviour of the drug using family member (Ross 2012, p.94). Confusion and a failure to comprehend what is going on can be common emotions, particularly for previously stable and happy families with no prior experience of drug use.²⁸² Siblings in particular may feel the pain of their family member's drug use:

280 Ms Heather Pickard, Chief Executive Officer, Self Help Addiction Resource Centre, Public Hearing, Melbourne, 14 October 2013.

281 Ms Bev McIlroy, Manager, Glenelg Southern Grampians Drug Treatment Service (QUAMBY), Public Hearing, Warrnambool, 3 March 2014.

282 This failure to understand the circumstances of the drug abusing family member is a reason why family drug education is so important. See comments of Ms Heather Pickard, Chief Executive Officer, Self Help Addiction Resource Centre, Public Hearing, Melbourne, 14 October 2013 and the discussion on education in Chapter 23.

Siblings report frustration with the attention and resources a drug-using sibling takes up, coupled with distress and anxiety for the using sibling's wellbeing. Siblings describe feeling a need to minimise their own needs and distress and a need to be perfect or good to compensate somehow for the difficulties that their drug-using sibling has brought to the family (Ross 2012, pp.102-103).

Far too frequently the tensions of relationship breakdown, particularly between using and non-using members of the family, and the type of stresses listed above spill over into physical violence, according to AOD and health workers who gave evidence to the Committee.

Family violence

Whilst there is very little empirical evidence to support links between methamphetamine use and family violence, an increase in such violence would seem to be related to methamphetamine abuse according to many witnesses to this Inquiry. This is particularly the view of those working in the criminal justice, health and welfare areas.²⁸³

A reported increase in methamphetamine-related family violence cases

The Community Offenders Advice and Treatment Service (COATS) that provides drug treatment assessments and referrals for the forensic and criminal justice system has remarked upon a noticeable increase in family violence cases where the offender is using or dependent on methamphetamine.²⁸⁴ Such reports are also coming from COATS assessors not only in Melbourne but also from all corners of regional Victoria including both Aboriginal and Non-Aboriginal communities.²⁸⁵ Similar observations have been made from Magistrates sitting in metropolitan and regional courts.²⁸⁶ For example, Ms Stella Stuthbridge who presides in Mildura, Wodonga and Shepparton courts remarked upon an increase in the family violence lists in her courts where such violence is at least in part related to methamphetamine abuse:

283 Many of the alcohol and drug, health, welfare and law enforcement agencies who gave evidence to the Inquiry noted an increase in the numbers of cases of family violence they were seeing related to methamphetamine abuse. This was particularly noticeable for those agencies who employed a domestic violence worker. This was also equally the case for Aboriginal and non-Aboriginal agencies alike. See for example:

Oral Evidence:

Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Public Hearing, Shepparton, 25 February 2014; Ms Robyn Reeves, Chief Executive Officer, Ballarat Community Health Centre, Public Hearing, Ballarat, 18 November 2013; Superintendent Andrew Allen, Divisional Commander, Ballarat Division, Western Region, Victoria Police, Public Hearing, Ballarat, 18 November 2013; Ms Antonia Halloran-Lavelle, Chief Executive Officer, Zena Women's Services, Public Hearing, Geelong, 28 October 2013; Mr Peter Noble, Coordinator and Lawyer, Loddon Campaspe Community Legal Centre, Public Hearing, Bendigo, 25 October 2013; Superintendent Daryl Clifton, Victoria Police, Public Hearing, Bendigo, 25 October 2013; Ms Nahtanha Davey, General Manager, Health/Family/Community, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013; Superintendent Paul Naylor, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013; Mr Les Twentyman, OAM, 20th Man Fund, Public hearing, Melbourne 9 December; Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates' Court, Public Hearing, Traralgon, 28 January 2014; Superintendent Malcolm (Jock) Menzel, Divisional Commander, Eastern Region Division 5 — Morwell, Victoria Police, Public Hearing, Traralgon, 28 January 2014; Ms Jan Rowe, Chief Executive Officer, Mirabel Foundation, Public Hearing, Melbourne, 17 February 2014; Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Public Hearing, Wodonga, 24 February 2014; Ms Sharyn Jenkins, Aboriginal Family Violence Worker, Mungabareena Aboriginal Corporation, Public Hearing, Wodonga, 24 February 2014.

Submissions:

Ms Angela Ireland, Project Development, Self Help Addiction Resource Centre Inc. (SHARC), Submission, 3 October 2013; Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013; Ms Jacqui Watt, Director Client Services, Anglicare Victoria, Submission, 21 October 2013; Ms Stella Stuthbridge, Magistrate, Shepparton Magistrates' Court, Magistrates' Court of Victoria, Submission, 19 November 2013; Superintendent Paul O'Halloran, Superintendent and Divisional Commander Eastern Region Division 4, Victorian Police, Submission, 24 February 2014.

284 Ms Heather Carmichael, Community Offender Advice and Treatment Service (COATS) Manager, Australian Community Support Organisation (ACSO), Submission, 12 November 2013.

285 Ms Heather Carmichael, Community Offender Advice and Treatment Service (COATS) Manager, Australian Community Support Organisation (ACSO), Submission, 12 November 2013.

286 See also the comments of Mr Peter Noble from the Loddon Mallee Community Legal Centre where they are acting on behalf of family violence victims where the violence is related to methamphetamine abuse. Mr Peter Noble, Coordinator and Lawyer, Loddon Campaspe Community Legal Centre, Public Hearing, Bendigo, 25 October 2013.

I have observed a worrying increase in the level of family violence. A recent read of the 'Police applied for' intervention orders in Shepparton Court disclosed that ice featured in nearly every matter. A father's uncontrolled rage at his young family when unable to access the drug, a young girl, post withdrawal, engaging in 6 weeks of extreme violence towards her mother, and young men terrorising their partners and mothers to obtain cash. The litany of abuse and the level of uncontrolled violence are indescribable.²⁸⁷

Mr Clive Alsop Magistrate at the LaTrobe Valley Magistrates' Court also advised that:

There is a direct and palpable link between ice and domestic violence. In one region of Gippsland a major resource has been set aside for the assistance of women who have to leave home because of domestic violence [and] 100 percent of the people who are seeking services at this person's establishment are there because of ice related difficulties. The worst part is that there are occasions when victims of domestic violence — are forced into prostitution to provide the funds for their 'partner's' habit.²⁸⁸

Representatives from Victoria Police have made similar observations. Superintendent Daryl Clifton from the Bendigo region for example told the Inquiry that reports from his members suggest the rise of ice involvement in family violence is 'astronomical'.²⁸⁹ Similarly Superintendent Paul Naylor responsible for the Mildura region has also noted an increase in methamphetamine-related violence in the home:

There are many stories of tragedy within families in regard to the use of ice, and it is often pretty much left with police to clean up the mess. The sad stories around family violence, violence in the homes... We have seen families torn apart, we have seen assaults within family groups where it is a child assaulting a parent, and by 'child' I say up to and including the age of 24. We see youth offences increasing in the home.²⁹⁰

Superintendent Jock Menzel affirmed that the situation was much the same in the Gippsland region, and again whilst much of the information he receives is anecdotal many of his officers report that when they attend family violence incidents many of the offenders appear to be under the influence of the drug 'ice'.²⁹¹

According to Superintendent Allen of Victoria Police (Ballarat), whilst his intuitive feeling is that the numbers of people being assaulted in domestic violence situations related to 'ice' is similarly increasing, ascertaining the true figures is difficult. First the datasets covering family violence wouldn't necessarily pinpoint its relationship to methamphetamine. Secondly, in his experience often family members, out of feelings of concern for their family member or stigma and shame associated with drug use in the family, may not want to call the police but instead call an ambulance or hospital for the person's psychosis to be dealt with in the health system.²⁹²

Finally, in the west of the state, Superintendent Don Downes based at Warrnambool claims that in his region there is a marked increase in family violence linked to alcohol and drug abuse:

The escalation of violence in family homes is often attributed to the use of ice with many victims reporting severe and extreme violence, and the damage perpetrated by the person using or coming down from the use of ice.

287 Ms Stella Stuthridge, Magistrate, Shepparton Magistrates' Court, Magistrates' Court of Victoria, Submission, 19 November 2013.

288 Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates' Court.

289 Superintendent Daryl Clifton, Victoria Police, Public Hearing, Bendigo, 25 October 2013.

290 Superintendent Paul Naylor, Superintendent, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013.

291 Superintendent Jock Menzel, Divisional Commander, Division 5, Eastern Region, Victoria Police, Public Hearing, Traralgon, 28 January 2014.

292 Superintendent Andrew Allen, Divisional Commander, Ballarat Division, Western Region, Victoria Police, Public Hearing, Ballarat, 18 November 2013.

Similar observations were made by Superintendent Michael Sayer, Eastern Region, Victoria Police, Shepparton, 25 February 2014.

The Men's Referral Service has reported a rise, to us, in the last 18 months of the association between ice and significant family violence. Women's Referral Service has also reported to us similar incidents but only in the last 12 months. We have developed a dedicated family violence unit commenced in the last few years in south-west Victoria which has reported some premises being completely bare of all goods when they take out a warrant or arrest the perpetrator for family violence, and the assets are normally sold by the perpetrator to fund their drug use.²⁹³

Methamphetamine use and 'non-traditional' forms of family violence

According to witnesses from AOD agencies, methamphetamine-related family violence is not necessarily 'traditional', that is, based on intimate partner violence. It can also 'pitch fathers against sons, brothers against sisters, grandchildren against grandparents'.²⁹⁴

A submission from Anglicare Victoria is representative of the views being expressed by many AOD agencies:

Our family services programs report that people using ice, whether parents or adolescent-children, appear to be much more likely to perpetrate acts of violence against family members and to use much more severe violence when doing so. In some cases such perpetration of family violence seems only to occur when the perpetrator is ice-affected.

Further to this we have had parents of ice-using adolescents report that they hold great fears for the safety of their adolescent children's younger siblings, as well as themselves. It is important to make this point in order to emphasise that family violence does not always constitute "intimate partner violence" as it is sometimes called. It is also important to acknowledge that in some instances parents feel that they have no choice but to force their ice-using adolescent children to leave their homes so that the safety of other family members can be preserved.²⁹⁵

The Family Drug Support agency SHARC stated that one of the most difficult aspects for family members is coping with the extreme mood changes and unpredictability of the user member of the family which may lead them to 'just go off':

When he walks in the door we can immediately tell if he has been using by the look on his face. Quite often his body language is high arousal. We have found it is better not to tackle him verbally or try and restrain him. His mood can change in seconds from friendly to aggressive and abusive. Sometimes he can be paranoid and have delusions, for example being totally convinced there are drugs under the carpet and start ripping up the floor. This is extremely frightening for us as families as we don't know what to do. Do we throw him out or call ambulance or police, or both? All of these dilemmas are racing through our minds, and we had no idea what was right. In the meantime he may have picked a fight with his sibling and before you know there is a physical fight going on.

Sometimes at times like this I lock myself in my bedroom in fear of my own wellbeing. Where is my beautiful son? This is unbelievably hard to cope with.²⁹⁶

The specialist domestic violence agency Zena Women's Services in the Barwon region is another community agency that has noticed an increase in the number of cases being referred to the service where methamphetamine is involved. However, the Service cautioned that methamphetamine and indeed any type of alcohol or drug misuse should not be focused upon as a cause of the violence:

The use of methamphetamine in domestic violence cases is really complex. In cases where there has been domestic violence prior to methamphetamine use, the woman who has been the victim

293 Superintendent Don Downes, Western Region, Division 2, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

294 Mr Rob McGlashan, Executive Officer, Northern Mallee Primary Care Partnership, Submission, 21 October 2013.

295 Ms Jacqui Watt, Director Client Services, Anglicare Victoria, Submission, 21 October 2013.

296 Mother's story in the SHARC newsletter, reproduced in Ms Heather Pickard, Chief Executive Officer, Self Help Addiction Resource Centre Inc. (SHARC), Submission, 13 October 2013.

of violence has already experienced intense trauma and is often less often able to access support. In these cases the use of methamphetamine is not the cause of violence as we are of the opinion that it heightens the key traits which already exist but which are normally regulated. The use of drug and alcohol heightens risk but they are not the cause of domestic violence and should not be treated so.²⁹⁷

Moreover, Zena Women's Services have also noted that in many cases of methamphetamine abuse, intervention orders are not working because a condition of the order is often abstinence from the drug which many crystal methamphetamine users in particular are unable to comply with.²⁹⁸

Finally, rape, sexual violence and sexual exploitation may also be directly or indirectly linked to methamphetamine abuse. For example, Marg Bell from youth welfare agency Berry Street in Shepparton told the Committee that the sexual exploitation of young girls by older men, particularly those residing in out-of-home care,²⁹⁹ was of real concern to their agency:

I guess the reason that we become acutely aware of ice use is because of the sexual exploitation component to it...[exploiters] are not just targeting one specific young girl. They will have groomed one specific young girl really well. They have her highly addicted to ice and other drugs. Then they are getting her to actually bring other young girls in and they exploit other young girls at the same time. ...you have a young child who is suffering significant trauma and attachment issues and someone is giving them the daddy love that they assume they need.

I have had discussions with one of our young girls in our case management service who is no longer in our residential program but is still involved in our case management program. She talks to me quite openly about her substance issues and her use of ice and her boyfriend, as she calls him, who really cares for her — as she describes it. He buys her great gifts. He provides her with the drugs she needs. He puts a roof over her head, and he even drives her to and from locations to sleep with other men, and then he gets a percentage of the money, and she gets a small percentage of it as well. When they are that entrenched — and her need is not just for ice, it is also the need to be loved and cared for — we have no capacity to compete with them.³⁰⁰

Child neglect when parents use methamphetamine

Much of the previous discussion has centred on the problems for families when a child is the user of methamphetamine. In some cases, however, it may be the parents or caregivers who use or are dependent on methamphetamine and in such cases it is generally agreed that the children of the user/s are the family members most affected by parental drug use:

Amphetamine type stimulant [ATS] using parents may become withdrawn, self-focused, paranoid delusional; live a disorganised lifestyle, and experience interpersonal violence. They are likely to be preoccupied with planning, obtaining and using drugs as well as emotionally and physically affected by ATS use and the subsequent withdrawal and craving. This results in a reducing connection with a child. A study of ATS using parents found they reported feelings of anger and apathy towards their children (not balanced by expressions of interest or joy), difficulty keeping drug use away from their children (either not succeeding or removing children from their care to enable use) and exposure to domestic violence. These factors may contribute to children experiencing a compromised sense of security and an inability to rely on their parents for their basic needs (Ross 2012, pp.101-102).

In terms of developmental psychology, successful early life stages are essential to the formation of personality, identity and secure attachment. The family is fundamental in providing the environment in which children's social and coping skills are developed

297 Ms Antonia Halloran-Lavelle, Chief Executive Officer, Zena Women's Services, Public Hearing, Geelong, 28 October 2013.

298 Ms Antonia Halloran-Lavelle, Chief Executive Officer, Zena Women's Services, Public Hearing, Geelong, 28 October 2013.

299 See Chapter 13 for a discussion of methamphetamine users in out-of-home and foster care environments.

300 Ms Marg Bell, Senior Manager, Adolescent Specialist Support Programs, Shepparton, Berry Street, Public Hearing, Shepparton, 25 February 2014.

and the child feels safe and secure. In families in which drug use and particularly drug dependence is prevalent, the capacity of a parent or caregiver to provide these needs is compromised (Peleg-Oren & Teichman 2006; Ross 2012).³⁰¹

Witnesses to this Inquiry have also expressed their concerns about the ability of methamphetamine using parents to capably provide these needs. According to these witnesses, physical, social, emotional and developmental problems, including learning difficulties and ADHD disorders, are evident in many of the children brought up in homes where one or both carers may be abusing methamphetamine.³⁰²

Anglicare Victoria stated in this regard:

Typically, parents who are problematic ice-users are significantly impeded from being able to protect and nurture children in their care. To a significant extent this is no doubt due to the impacts that ice-use has on mood, arousal and cognitive abilities and its function in causing or exacerbating comorbid psychiatric disorders. Our family services programs report that such parents often exhibit substantial difficulties in being able to appropriately manage children's behaviour. This frequently manifests as either the use of an inappropriately permissive parenting style, an abusive and authoritarian parenting style or fluctuations between both these parenting approaches; with such fluctuations corresponding to the "ups and downs" of the parent's drug cycle.

[Methamphetamine using parents] also struggle to interact with their children in ways generally conducive to healthy development (by providing consistent emotional warmth and encouragement, stability, routine and so on). This frequently results in developmental, mental health and behavioural problems arising for children.³⁰³

The parent's neglect of their children can extend to even failing to supply basic needs:

Our family services programs report that parents who use ice are often unable to prioritise expenditure of income on necessities such as housing, utilities and groceries, which commonly results in children experiencing periods of deprivation or insecurity with regard to these essentials. Furthermore, when parents' cease their ice use and 'crash', they will typically sleep for very long periods over a course of days — particularly if such a crash is following a multi-day ice-binge. During these periods of prolonged sleep, children can be left neglected and unsupervised, or under-supervised. For very young children, this can present an immediate threat to safety; whilst for older children, the impact of harm is more cumulative than immediate, but significant nonetheless.

Such 'cumulative harm' is particularly an issue when children miss many days of school, which our programs report is of greater likelihood when they have an ice using parent (along with missing other important appointments, such as medical appointments). In such instances, these children may be 'parentified'; whereby they have to act as caregivers for younger siblings due to their parents' incapacitation. In our experience, such parentified children are more likely to experience negative outcomes and reduced life chances as they progress through late childhood and adolescence.³⁰⁴

301 In the United States child neglect costs associated with methamphetamine dependency have been estimated at \$905 million per annum:

[these] estimates are limited to children who are removed from their homes by the foster care system, so these costs are likely an underestimate of the full burden of meth abuse [on children]...The largest contributor to these costs is the medical, mental and quality of life losses suffered by children though the burden on the foster care system is similar in size (Nicosia et al 2009, p.xv).

302 See Ms Ruth Chattey, Family Support, Mirabel Foundation, Public Hearing, Melbourne, 17 February 2014.

303 Ms Jacqui Watt, Director Client Services, Anglicare Victoria, Submission, 21 October 2013.

304 Ms Jacqui Watt, Director Client Services, Anglicare Victoria, Submission, 21 October 2013.

Anglicare’s family service workers identified a further issue of concern, that of parents exposing children to criminal elements through their involvement in drug distribution networks and other criminal activities that enable them to afford their addictions.³⁰⁵

The following account from the Mirabel Foundation, exemplifies the many ways in which children, sometimes very young children, can be seriously harmed by their parent or significant other’s methamphetamine and other alcohol or drug abuse:³⁰⁶

You can imagine that young children... too often have to become the parent — particularly the older child has to become the parent for the younger ones. So there is a chaos within the family, and there is a trauma that they experience from various people coming in and out of the house. They witness the adults in the house using drugs, and they witness domestic violence... The children have experienced all that. Often they have had very unstable education, they have had intermittent dental and medical help and they have had a basically destabilised first few years of their life.

We have case studies whereby the children, particularly the boys, have a real anger within them. The eldest boy will quite openly say, ‘I’m angry at my mother. I hate drugs, and I hate the fact that she uses drugs because look what it has done to our lives. We’re her children but the drugs come first’. The grandma was dealing with these parts of all three children — their anger, their being behind in school and all of the emotional side. They have been linked up to Royal Children’s for that emotional side.³⁰⁷

An incident happened a couple of years ago where, due to the children’s mum’s associates, there was a threat to kill the kids. So grandma and the three children had to be moved by the police to their great-grandmother’s home, which was a unit. So there is great-grandma, grandma and the three children all in a small unit whilst the police were trying to track down this chap. How that affected all those people in that family would be something that I could not really understand without having lived it, but hearing them the fear is just so strong.

[Another] case involved children who learnt that that when mummy and daddy — or mum and boyfriend I think it was — went into a room and closed the door, they were not to interrupt them when they were in there doing drugs. We do not always know if it is meth plus whatever else. They had to knock on the door, and maybe they would get a response and maybe they would not. They could go for hours, days sometimes, without any food. They do not get to school, because the parents are not there to wake them up. They lead these chaotic lifestyles. There is a lack of routine. They do not learn to go to bed. They do not learn how to put themselves to sleep, because they are expected to fall asleep in front of the TV. When they start school, if they get to school, they are tired, irritable and restless.³⁰⁸

Mr David Giles from Anglicare Victoria expanded on his agency’s written submission when he gave evidence to the Committee by drawing on some real life case studies from Anglicare’s files. These accounts are also distressing, detailing intergenerational drug abuse, sexual, physical and emotional abuse of children and child neglect. The case studies are important glimpses into the types of problems facing drug and alcohol, family welfare, health and

305 Anglicare argues that despite all these serious consequences affecting the health and welfare of children there is insufficient capacity in the state child protection system to work with all the families that could be considered ‘high risk’:

‘Accordingly, pressure is applied by child protection to family services to continue working with high-risk, ice-using parents, even though the capacity to do so effectively is minimal. This particularly occurs when children are older (that is, school-aged), and when risk to them is not deemed as acute and immediate, but as constituting ‘cumulative harm’. Ms Jacqui Watt, Director Client Services, Anglicare Victoria, Submission, 21 October 2013.

306 The number of witnesses who mentioned the adverse consequences of methamphetamine on healthy child development are too numerous to list here. Some of the more detailed expositions however include:

Dr Ellen Bowman, Paediatrician, Royal Women’s Hospital Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014; Ms Fiona Harley, Deputy Executive Director, Mallee Family Care, Public Hearing, Mildura, 5 December 2013; Ms Antonia Halloran-Lavelle, Chief Executive Officer, Zena Women’s Services, Public Hearing, Geelong, 28 October 2013.

307 These types of problems require good paediatric and education assessments and intensive follow up according to Mirabel Foundation staff.

308 Ms Ruth Chattey, Family Support, and Ms Elizabeth McCrea, Advocacy and Family Support, Mirabel Foundation, Public Hearing, Melbourne, 17 February 2014.

child protection workers. They are too long and detailed to reproduce here, albeit to include one abbreviated account of a child with a developmental disorder, in part attributable to the circumstances of his upbringing including the mother's methamphetamine use:

The [second] case study I wish to present to you concerns a family comprising a mother, father and three children — a 10-year-old girl, a six-year-old boy and a five-year-old boy. The children lived with their mother, who was actively using ice at the time of our involvement with the family. The father did not live in the house, although he did see his children frequently and he often behaved abusively towards them. The mother and father had an on-again, off-again-type intimate relationship.

One of the children's grandparents was very involved with the children and the children frequently stayed with this grandparent at their house. There was some extensive child protection history with this family. The mother was a long-term drug user who had engaged in substance use whilst pregnant with all three children...the mother was what we call a dual diagnosis client. ... She experienced clinically significant drug abuse and dependence problems simultaneously with other mental health problems.

The six-year-old boy in this family had a serious neurological disability. He is a 'high-needs' child. The care he required at home was extensive and he needed to frequently see specialist doctors. Unfortunately his mother's recurrent incapacitation arising from her drug cycle meant that he frequently missed these appointments and seldom received from his mother the care that he needed at home. Ultimately it was left to the supportive grandparent involved with the children as well as the boy's 10-year-old sister to provide this care.

When the children were at home and not staying with their grandparent the mother injected ice in front of them and left syringes around the house. The 10-year-old girl who herself had developed an anxiety disorder had recurring nightmares about people trying to steal her blood using syringes. The girl was also diagnosed with attention deficit hyperactivity disorder and was appropriately prescribed methylphenidate, or Ritalin, as treatment. Unfortunately her mother would frequently withhold this medication, which is amphetamine based, and abuse it herself rather than giving it to her daughter.

All three children missed a substantial amount of school and were reported by teachers to be very behind academically. On the days when they did attend this was invariably due to the efforts of their supportive grandparent or, if they were staying at home, the 10-year-old girl whom we would describe as parentified. This young girl would wake her younger siblings up, bathe them, dress them and make them breakfast so that they were ready for school. Even then the children would invariably present to school late and so miss important lessons that took place in the morning, including those related to literacy and numeracy, which the school had a preference for teaching first thing during the school day. One time the children failed to attend school because their mother, whilst driving them there under the influence of ice, crashed the family car.³⁰⁹

Mr Giles added that service provision problems were also associated with this case. Child protection units were not involved with the family during this period as they deemed the protective influence of the grandparent sufficient. "This is a very common scenario with the incredibly overburdened child protection system, which needs to find some way to prioritise their response to the great many families about whom concerning reports are made."³¹⁰

Truancy and school disengagement

School truancy or non-attendance at school due to parental neglect is another serious issue arising from methamphetamine use in a family environment according to a number of witnesses to the Inquiry. For example, youth worker Mr Les Twentyman told the Committee that in his work he is seeing a number of children whose parent/s are using 'ice' who are

309 Mr David Giles, General Manager, Family and Community Services, Anglicare Victoria, Public Hearing, Melbourne, 3 February 2014.

310 Mr David Giles, General Manager, Family and Community Services, Anglicare Victoria, Public Hearing, Melbourne, 3 February 2014. See Chapter 22 for an account of problems associated with service provision.

being diagnosed with post-traumatic stress disorder because of their chaotic upbringings and are either not going to school or attending only sporadically:

... that a lot of these kids do not go to school, because their parents are addicted or dependent and addicted. They do not know what day it is. In one case, a young girl missed 120 days of her first two years at school. One of the issues there was that the vice-principal could not tell me whether or not the girl was at school, because of privacy. Eventually when it ends up in the Children's Court out come the terrible facts that these kids have hardly been at school at all. They fall so far behind that eventually they are at risk of an early exit from education and of becoming users themselves.³¹¹

Anex, the peak body for addressing injecting drug use in Victoria, also brought attention to this issue in a submission to the Inquiry:

Anex is aware that children are at risk of social exclusion and poor contact with the education system because of their parent's methamphetamine use. It has been reported to Anex during the course of its work throughout Victoria that this is a growing problem and warrants further investigation.³¹²

Of significant concern to the Commission for Children and Young People is the level of disengagement from school of children of Koori background across the state, particularly in the Mildura region. A submission from the Commission to this Inquiry stated that:

Disengagement from schools heightens risk and vulnerability. Ensuring that schools effectively engage vulnerable young people, including vulnerable Koori young people, *will* be an important protective factor and strategy for reducing the use of ice.³¹³

Disengagement from school may not only be an issue for the children of methamphetamine users who are neglecting their children's needs. Young people who are users themselves may have chosen to opt out of school or further education even at a very early age³¹⁴. For Fiona Harley, from Mallee Family Care in Mildura, this is one of the greatest problems associated with young people's use of 'ice' and other drugs:

Research indicates that young people who have a history of low commitment to education and failure at school are more likely to engage in drug use. Our young people do not engage as well as their peers across the state with education ... My experience is that these young people who are disengaged from education are also not involved in education, training or employment ... There are a significant number of young people in Mildura who are not involved in any of those things, who do wander the streets, who are down at the skate park and who are not connected with family.

...A lot of these young people are not connected to their families... So a lot of them are not even living at home. They are couch surfing. ...that becomes their lifestyle and their activity. That does involve drug taking and crime.³¹⁵

The endangerment of children in relation to methamphetamine production

One specific aspect of child neglect that requires close attention is when children are raised in an environment in which methamphetamine is being manufactured or 'cooked'. Their lives are endangered when they are living in or near premises that are used as clandestine laboratories. A submission from the Victoria Police expresses their concerns on this matter:

The presence of children in residences used as clandestine laboratories greatly concerns Victoria Police. Children can be exposed to significant contamination from the laboratory site in addition to the

311 Mr Les Twentyman, OAM, 20th Man Fund, Public Hearing, Melbourne, 9 December 2013.

312 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013

313 Mr Bernie Geary OAM, Principal Commissioner, and Mr Andrew Jackomos PSM, Commissioner for Aboriginal Children and Young People, Commission for Children and Young People, Submission, 25 October 2013.

314 For further discussion of disengagement from school in context of drug use see Chapter 22.

315 Ms Fiona Harley, Deputy Executive Director, Mallee Family Care, Public Hearing, Mildura, 5 December 2013.

chemicals and liquids stored in the home. Liquids are frequently stored in clear plastic drink bottles in refrigerators and freezers where food is also stored.

There has been an increase in children located at premises when searches are conducted by CLS [Clandestine Laboratory Squad]. Recently, CLS conducted a forced entry to a residence where children were present. The offender was dressed with a face mask and gloves while the children, including an infant, were left unprotected. Due to the volatile nature of laboratories, searches by CLS are dynamic entries involving a number of police wearing full protective clothing including masks, which can traumatise children present.³¹⁶

Victoria Police also note that there is no legislation in Victoria dealing specifically with offenders who are responsible for children being in laboratory environments. Several other states of Australia and New Zealand have specific provisions of aggravating circumstances which cover children found in these circumstances. This issue is discussed further in Chapter 16 addressing methamphetamine production and distribution.³¹⁷

The effects of methamphetamine abuse on grandparents and other significant carers³¹⁸

The preceding accounts and case studies indicate the important role some grandparents play as substitute carers for their grandchildren when the parent is incapable of looking after the child due to their methamphetamine abuse. Numerous submissions and oral evidence to the Inquiry addressed how grandparents or extended family members may have to take responsibility, sometimes reluctantly, for their grandchildren's upbringing.³¹⁹ Mr David Giles from Anglicare Victoria told the Inquiry that extended family caregiving:

[is] fairly common. In many families where there are grandparents or siblings of parents who are available and who are fairly functional and involved in the lives of their grandchildren or nieces and nephews, they will step in and play a role. We see it frequently, and a lot of the time it is actually a very good solution. The children have an established relationship with these people, so it is not like yanking them out of their family unit and sticking them with people they do not know. It does happen a lot. It probably happens informally, when services are not even aware of these cases — it is just something families arrange — or it is something that social workers may try to get families to volunteer to do or that the Children's Court will actually step in and order when required. As to whether it is in the best interests of children, that is always a case-by-case decision, but...we need to be quite vigilant in screening grandparents and other people in these families to ensure that that is the case.³²⁰

On this issue Peter Noble from the Loddon Mallee Community Legal Centre told the Inquiry how an increasing number of grandparents were coming to the legal service seeking assistance in child protection matters where they seek to become official carers for their grandchildren when one or both of the parents is a methamphetamine user.³²¹

Notwithstanding the amazing work being done by many grandparents in raising these children, evidence received indicates that sometimes the care given is only marginally better than that of the birth parent; indeed in some cases of intergenerational drug abuse the grandparent may also be using alcohol and other drugs, including methamphetamine.

316 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

317 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

318 For a discussion of Aboriginal grandparents and other extended family members raising children because of a parent's methamphetamine use, see Chapter 12.

319 See: Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013; Ms Fiona Harley, Deputy Executive Director, Mallee Family Care, Public Hearing, Mildura, 5 December 2013; Mr Peter Noble, Coordinator and Lawyer, Loddon Campaspe Community Legal Centre, Public Hearing, Bendigo, 25 October 2013; Mr Les Twentyman, OAM, 20th Man Fund, Public Hearing, Melbourne 9 December 2013.

320 Mr David Giles, General Manager, Family and Community Services, Anglicare Victoria, Public Hearing, Melbourne, 3 February 2014.

321 Mr Peter Noble, Coordinator and Lawyer, Loddon Campaspe Community Legal Centre, Public Hearing, Bendigo, 25 October 2013.

Despite this, child welfare workers may still push for kinship agreements allowing for informal foster care relationships with extended family rather than take children into out-of-home care. This may be largely due to the budgetary and other constraints facing the child protection system.³²²

The impacts on grandparents or extended family members are not just social — at a time in their lives when many older people may be thinking of retirement, the financial burden on grandparents left raising their grandchildren due to their children's drug abuse can be considerable. It is yet one more flow-on effect resulting from methamphetamine dependence. This issue of financial cost burden is discussed later in this chapter.

Parenting and child support issues

One of the unforeseen consequences of methamphetamine and/other alcohol and drug use is unplanned and in many cases unwanted pregnancies.³²³ Women, sometimes very young women, can struggle with both drug use and in many cases raising a child with few supports. According to some workers, many young women, some as young as 14, are unaware of the harms of methamphetamine to themselves or their babies. Comprehensive parenting and education programs are therefore urgently required.³²⁴ This is particularly the case given some young women are telling agency workers they have no intention of ceasing methamphetamine use either during or after pregnancy.³²⁵ Other women who receive intense support from a range of services, may decide to give up their methamphetamine habits for the duration of the pregnancy:

Occasionally, our family services programs have worked with families in which a child has been born dependent on ice. This occurs when such children's mothers have continued to use the drug whilst pregnant. Within our Cradle to Kinder program, we have worked with a number of women who used ice in the early stages of their pregnancy, but stopped use of this drug once they learned that they were pregnant, and were informed of the possible effects of such drug-use on their unborn children. This is commendable behaviour, although we believe that without the support of highly intensive interventions such as Cradle to Kinder, it would be much harder — possibly prohibitively so — for such women to have begun and sustained this behavioural change.³²⁶

Given the circumstances of young women with methamphetamine dependence, a number of witnesses have stressed the importance of developing programs that support infants (and mothers) in the first two years of life. On this issue Dr Paul MacCartney, a doctor with the Primary Care Connect agency in Shepparton, told the Inquiry:

The evidence around the world is that drug education does not make that much difference in schools, but what does make a difference,³²⁷ the one thing that has been shown, is that if you support at-risk children in their first two years of life — that is, you are supporting their family — by identifying at-risk mothers and supporting those children, then 15 years later those children will be much less likely to be using drugs than anybody else, or people who did not receive that support. In the UK [there is]...a

322 Mr David Giles, General Manager, Family and Community Services, Anglicare Victoria, Public Hearing, Melbourne, 3 February 2014.

323 The physical complications associated with methamphetamine use before, during and after pregnancy were discussed in Chapter 6. See in particular the evidence given from representatives of the Women's Alcohol and Drug Service at the Royal Women's Hospital.

324 See Chapters 22 and 23 in the context of educating about methamphetamine.

325 See for example, the evidence of Melanie Vidler from The Bridge youth support agency in Shepparton. The Bridge has an antenatal program for young women including young women who are using methamphetamine. The agency workers try and address the dangers of methamphetamine use generally and during pregnancy in straightforward but non-judgemental ways.

Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Public Hearing, Shepparton, 25 February 2014.

326 Ms Jacqui Watt, Director Client Services, Anglicare Victoria, Submission, 21 October 2013.

327 For the debates as to whether drug education particularly in schools does indeed 'make a difference', see discussion in Chapter 22.

program of providing support in the first two years, with a midwife attending the home, providing monthly support to the mother or the primary caregiver, to learn how to parent a child. That makes a difference 15 years later. But it is a challenge for any government to be planning that far out. But that is what makes a difference.³²⁸

Moreover, a not insignificant aspect of the impact that methamphetamine abuse has on family relations and family structure is the number of male users who are not providing positive male role models for their children, either because they are in gaol, are isolated from the family due to their preoccupation with scoring and using the drugs, or are simply disinterested in providing a role model for their children.³²⁹ Parenting education aimed at young men is therefore also a necessary component of any interventions to assist current and ex-users in the upbringing of their children.³³⁰

Road safety, drugs and driving

Victoria Police and community representatives expressed concern about the use of methamphetamine while driving or in control of a motor vehicle. Such consumption may be for instrumental reasons, for example the use of amphetamines by truck drivers to stay awake while maintaining punishing delivery schedules, or a consequence of recreational use, for example driving home from a party when there is no public transport available.³³¹

Driving under the influence of amphetamines and more recently methamphetamine has been a relatively common practice of transport workers. Tight deadlines and turnaround schedules, penalties for late delivery and products requiring urgent delivery have resulted in the use of amphetamine type stimulants and both illegal and prescription stimulants by a number of truck drivers, particularly long-distance or interstate drivers.³³² These are used for staying awake and indeed 'energising' the driver. This can result in risky driving. Drug driving has also occurred in the clubbing and party going scene and in travelling to and from outdoor music festivals:

The remote rural location of these festivals poses limitations on the availability and accessibility of public transport, resulting in a number of festival goers taking their own transport... It is likely that some festival goers are also under the influence of dance drugs as they drive to and from these sites (Akram & Forsyth 2000, p.267).

The Committee received similar evidence about the relationship between methamphetamine use and driving from raves or parties in regional areas of Victoria:

For rave parties even as far as, say, Cobram, teenagers will travel in groups as far as they need to go to access these parties, and they will take the methamphetamine while they are there, and they will drive home.³³³

Clearly, such behaviour raises concerns. Evidence from a number of senior officers indicates that the issue of driving whilst intoxicated on methamphetamine alone (or in combination with a 'cocktail' of other drugs) is also of concern to Victoria Police.³³⁴

Victoria Police have observed methamphetamine-related driving incidents in three main populations: those who are dependent users; occupational or situational users such as

328 Dr Paul MacCartney, Medical Practitioner, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014. See also discussion in Chapter 22 on promoting resilience in children from birth.

329 Mr Terry Robinson, Co-ordinator, Barwon Youth, Public Hearing, Geelong, 28 October 2013.

330 See also discussion in Chapter 23.

331 See Neale 2001 for an examination of these issues.

332 For an earlier discussion of amphetamine type stimulant use by truck drivers and other transport workers, see Drugs and Crime Prevention Committee, Inquiry into Amphetamine and 'Party Drugs' Use 2004.

333 Ms Kate Hunt, Collaborations and Development Officer, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

334 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

transport or shift workers; and those who are using it as part of social or recreational use such as at clubs or parties:

The substance dependent drug driving cohort has a broad age range, a significant level of unemployment, a high level of invalid driver licence status and a history of offending behaviour.

The occupational use drug driving cohort is associated with occupations where fatigue through long periods of wakefulness occurs such as long distance truck drivers. This cohort is predominantly involved in stimulant type drug use to combat fatigue when working. This group also uses sedative type drugs to rest after prolonged periods of wakefulness induced by stimulant type drug use. Members of this cohort usually have a valid driver licence and an offence history relating to driving offences.

The social use drug driving cohort is predominantly persons between 18 and 30 years of age with no significant history of illegal behaviour. The use of illicit drugs appears to have become normalised as part of the social activity of this group. There seems to be little recognition of the consequences of using illicit drugs and driving, or the effect of drug use on driving ability. They believe the likelihood of being detected for drug driving is low.³³⁵

In addition to the concerns of the Victoria Police, a number of AOD, health and welfare and youth support agencies have expressed misgivings about the propensity of some methamphetamine users to drive whilst intoxicated. For example, representatives from Junction Support Services in Wodonga expressed concern about the sense of 'invincibility' young drivers exude when on 'ice' – a feeling that they are immune to the general consequences of dangerous driving.³³⁶

This feeling of 'invincibility' is not restricted to young people in regional Victoria. Melanie Raymond, Chairperson of the Youth Projects Agency based in the northern suburbs of Melbourne, told the Committee that this sense of invincibility was also very much part of the culture of city youth and their relationship to driving whilst intoxicated by methamphetamine.³³⁷ Ms Raymond added that the car had a particular primacy in the culture of drug use for young people who are seen by her agency, because vehicles provided a place away from parents for young people to partake in drug-taking activity. She also suggested that in these circumstances young people were subject to a culture that normalises drug driving, where risk perception is dramatically different to what we think makes sense and what is logical. Ms Raymond also stated that:

We are seeing a high prevalence of drug driving amongst illicit drug users. We think that there is a perception that you might more likely be detected if you are using alcohol and driving but there is a much lower risk if you are using drugs. We think for some in emerging communities and different religious and ethnic groups there is a prohibition on alcohol where they perceive there is no such prohibition on illicit drug use. So that is a better way to get high.

Some community agencies, particularly in rural areas, are also concerned about the lack of programs and education initiatives to address drug-driving in their districts. A submission from the Northern Mallee Community Partnership based in Mildura for instance states:

Currently there are only two areas in Victoria that provide the Drug Driving Education for offenders, necessary to regain a driver's licence. One of these is located in the rural community of Kerang and the other location is in Melbourne.

This means that offenders (without a driving licence) are expected to find transport to Kerang or to travel to Melbourne. Last year approximately twenty-five offenders needed to leave the area and travel the considerable distance to access the assessment and training.³³⁸

335 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

336 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014.

337 Ms Kate Hunt, Collaborations and Development Officer, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

338 Mr Rob McGlashan, Executive Officer, Northern Mallee Primary Care Partnership, Submission, 21 October 2013.

In Melbourne, according to metropolitan community agencies, methamphetamine involvement is not uncommon in cases presented to assessment programs for people whose driving licence has been suspended or cancelled for driving under the influence of a drug. A submission from Youth Projects based in the northern suburbs of the city outlines preliminary research conducted by Wilson and Wilson in 2010 that looked at a sample of Melbourne drug-users' perceptions of drug-driving. The sample group of drug users aged between 18 and 24 participated in interviews and self-reported surveys. On the basis of the sample responses one of the findings concluded that methamphetamine was the main drug of choice used when drug-driving took place.

Moreover, it was found that cars are an important means of freedom for youth, particularly where to access to public transport is limited. Furthermore, cars offer a safe and private space for youth to consume drugs, as well as facilitating the purchase and preparation of drugs in some cases (Wilson & Wilson, 2010, p.50). Interestingly, the report also found that the respondents feared Random Breath Testing (RBT) [for alcohol] more than they feared drug testing. As a result, when the possibility of being detected for drink driving proved high participants in the survey reported taking drugs as a safer alternative to being caught drink driving. Other participants reported the use of methamphetamine as a means of staying alert and awake when returning home late from parties and social events.³³⁹

The submission stated further that findings such as these highlight the on-going nature and associated risks faced by young people in the northern and western suburbs, 'particularly where youth in these regions are more reliant on their own personal transport therefore increasing the likelihood of drug/methamphetamine driving'.³⁴⁰

Quantifying the prevalence and risks of methamphetamine use and driving in Victoria *Statistical analysis of drug driving in Victoria*

Victoria Police provided the Committee with statistics on drug-driving offences arising from random roadside drug testing for methamphetamine between 2008 and 2013. Table 7.1 shows the number of positive roadside tests for methamphetamine by gender and region. During this period, a higher number of male drivers both in metropolitan and rural regions tested positive to methamphetamine than did female drivers. An increase in the number of positive tests has also been found in recent years amongst all drivers, which could be due to an increase in roadside drug testing by Victoria Police in recent years.

Table 7.1: Number (n) of methamphetamine positive roadside tests by gender and region

Year	Total number of drug tests	Metro		Rural		Total
		Male	Female	Male	Female	
2008	25,006	238	40	61	4	343
2009	28,083	158	29	57	3	247
2010	41,642	342	52	140	18	552
2011	25,140	759	107	365	39	1270
2012	47,745	1080	156	761	146	2143
2013	39,471	1136	158	676	125	2095
Total	207, 087	3713	542	2060	335	6650

Notes:

The data relate to Random Drug Testing (RDT) only and does not include drivers detected under the Drug Impairment Assessment process.

The detections include Oral Fluid and Blood (where a sample was obtained).

339 Ms Melanie Raymond, Youth Projects, Submission, 22 October 2013.

340 Ms Melanie Raymond, Youth Projects, Submission, 22 October 2013.

The detection rates cannot currently be broken down by drug. Therefore the overall 'strike rates' and an overall percentage where methamphetamine was detected has been included.

This includes drivers with poly-drugs (a combination of meth, MDMA and THC).

The Region/Division for some records cannot currently be determined.

The data may be subject to variation over time as additional data is received or errors are identified and corrected.

Source: Road Policing Drug and Alcohol Section, Victoria Police; Acting Deputy Commissioner Shane Patton (Victoria Police), Committee Correspondence – Supplementary information for the Joint Committee on Law Reform Drugs and Crime's *Inquiry into the supply and use of methamphetamine, particularly 'ice', in Victoria*, 8 July 2014, unnumbered.

Data were also provided by Victoria Police on the age of drivers who tested positive to drugs in roadside tests from 2011 to 2013. Table 7.2 shows that approximately half of the drivers who tested positive were between the ages of 18 and 29 years followed by those between 30 and 39 years.

Table 7.2: Number (n) of positive roadside tests by age and year

Year	2011	2012	2013
<18	2	4	5
18-29	756	1,205	1,408
30-39	437	732	776
40-49	234	343	353
50+	50	69	71
Total	1,479	2,353	2,613

Notes:

The data relate to Random Drug Testing (RDT) only and does not include drivers detected under the Drug Impairment Assessment process.

The detections include Oral Fluid and Blood (where a sample was obtained).

The detection rates cannot currently be broken down by drug. Therefore the overall 'strike rates' and an overall percentage where methamphetamine was detected have been included.

This includes drivers with poly-drugs (a combination of meth, MDMA and THC).

The Region/Division for some records cannot currently be determined.

The data may be subject to variation over time as additional data is received or errors are identified and corrected

Source: Road Policing Drug and Alcohol Section, Victoria Police.

Table 7.3 shows detection rates for all three proscribed drugs including methamphetamine by year and region. There has been a steady increase in the rate of roadside drug testing detections especially in rural regions during recent years. The percentage of methamphetamine-related detections was high during these years.

Table 7.3: Detection rates (%) by year and region

Year	Metro	Rural	State
2008	1 : 76.5	1 : 57	1 : 73
2009	1 : 129	1 : 65	1 : 114
2010	1 : 86	1 : 47	1 : 75
2011	1 : 19	1 : 22	1 : 20
2012	1 : 23	1 : 20.5	1 : 22
2013	1 : 18.6	1 : 19	1 : 19

Notes:

The data relates to Random Drug Testing (RDT) only and does not include drivers detected under the Drug Impairment Assessment process.

The detections include Oral Fluid and Blood (where a sample was obtained).

The data includes all 3 prescribed drugs as well as Refusals. Where possible, it has been split between methamphetamine based drug and cannabis/refusal.

This includes drivers with poly-drugs (a combination of meth, MDMA and THC).

The Region/Division for some records cannot currently be determined.

The data may be subject to variation over time as additional data is received or errors are identified and corrected.

Note on ratios:

The ratios provided in Table 7.3 have been calculated using the total number of drug tests conducted each calendar year by Victoria Police over the period 2008–2013 and the total number of positive roadside tests for methamphetamine use provided in Table 7.2. Further, the ratios reflect a rounding up where the ratio was greater than .5, for example 1 in 17.8 is rounded up to 1 in 18.

Source: Road Policing Drug and Alcohol Section, Victoria Police; Acting Deputy Commissioner Shane Patton (Victoria Police), Committee Correspondence – Supplementary information for the Joint Committee on Law Reform Drugs and Crime's *Inquiry into the supply and use of methamphetamine, particularly 'ice', in Victoria*, 8 July 2014, unnumbered.

The data indicate clearly that there has been an increase in the number of positive tests across the time period covered. Interestingly, the data indicate that the high point since 2009 was 2010. Since then, the number of positive tests as a proportion of all the random drug tests conducted has fluctuated between 17.5 and 22. While the ratios provided in Table 7.3 suggest an increase in the number of positive road side tests for methamphetamine use when comparing the period 2008-2009 and 2010-2013, it is necessary to contextualise these increases by reference to the substantial increase in the use of random tests over that period, and the application of targeted enforcement. In the period between 2008 and 2013, the number of random roadside drug tests increased from 25,006 to 39,471. Further, Victoria Police statistics indicate the highest proportion of positive drug tests occurred in the North West Metro police command region (these included positive tests for methamphetamine, MDMA and cannabis).³⁴¹ The high level of positive tests in this region may suggest that targeted enforcement has been used by police which in turn may explain the increasing number of positive tests as reflected in the ratios above.

The Committee also notes that of the 6,650 positive tests for methamphetamine use, 657 drivers had two or more tests. While that represents less than 10% of the total number of positive tests, these drivers may represent a small group of recidivist offenders who may be operating beyond the reaches of Victorian road safety and its associated regulatory interventions.

In addition to the evidence in the Victoria Police submission discussed above, the Committee has also received oral evidence from most of Victoria's regional police superintendents. Nearly all have commented on the increase in drug-driving relating to methamphetamine and their concern about how 'ice' is giving people a misplaced overconfidence in their driving abilities.³⁴²

Considerable evidence was also given to the Committee that despite approximately 15 percent of fatal motor vehicle crashes in Victoria being attributable to drug-driving³⁴³ there are insufficient resources to allow a comprehensive coverage of random drug testing (RDT)

341 Acting Deputy Commissioner Shane Patton (Victoria Police), Committee Correspondence – Supplementary information for the Joint Committee on Law Reform Drugs and Crime's *Inquiry into the supply and use of methamphetamine, particularly 'ice', in Victoria*, 8 July 2014, unnumbered.

342 See for example: Superintendent Andrew Allen, Divisional Commander, Ballarat Division, Western Region, Victoria Police, Public Hearing, Ballarat, 18 November 2013; Superintendent Daryl Clifton, Victoria Police, Public Hearing, Bendigo, 25 October 2013.

Superintendent Don Downes of Victoria Police Western Region based in Warrnambool told the Inquiry that incidents of drug-related road rage and dangerous driving, one of which resulted in a fatal head on collision, were unfortunately not uncommon in his district.

See Superintendent Don Downes, Western Region, Division 2, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

343 Superintendent Paul Pottage, Division Commander, Division 1 (Geelong) Western Region, Victoria Police, Public Hearing, Geelong, 28 October 2013.

facilities in the state. In the Geelong context for instance, Superintendent Paul Pottage claims that:

[t]he ability to drug test is limited to a relatively small number of traffic enforcement units. Certainly the Geelong Highway Patrol currently does not have that capacity. There is, it is fair to say, a fair level of frustration where the evidence is mounting that there is a significant road trauma issue with not just the traditional alcohol but certainly cannabis and amphetamine use.³⁴⁴

Similar comments were made by Superintendent Paul O'Halloran in the context of the north-eastern region of Victoria centred in Wodonga:

I think we have the right technology but it is in relation to the testing, the kits and the availability of that. I think it is going to be an ever-increasing focus of Victoria Police to be in a position to be able to conduct those tests, given the evidence that more and more young people are using drugs – a combination of drug and alcohol. We need to be in a position – I think it is very important that we provide sufficient preliminary oral fluid tests and the machines that will support that.³⁴⁵

Perceived risks of using methamphetamine and driving

While the earlier sections outlined the perceived risks of using methamphetamine and driving, and community views on such driving, there has also been specific research on these risks. In terms of prevalence, available research undertaken in 2007 and 2009 suggests a low prevalence of methamphetamine use among Victorian drivers that were drug tested. Boorman (2007) reporting on two years of Random Drug testing (RDT) in Victoria noted that there were 25,000 drivers screened at the roadside, with methamphetamine the most commonly detected drug – 364 cases or 1.4% of those screened (Baldock & Woolley 2013, p.2). A follow-up of the Victorian RDT in 2009 by Doecke and Grigo, indicated that there were 298 confirmed drug positive cases from 27,883 roadside screening tests, a detection rate of 1.07% which was also the lowest in Australia (Baldock & Woolley 2013, p.3). The most recent assessment in 2010 yielded a higher detection rate of one in 60 tests (Baldock & Woolley 2013, p.3). Other research conducted by Drummer et al. found low rates of methamphetamine use among a sample of 1714 Victorian drivers, with 3.1% testing positive, as compared to alcohol (29% of those tested) and THC (9.8% of those tested) (Drummer, Gerastamoulos et al. 2004, p.14). In addition to these assessments of the prevalence of methamphetamine by reference to positive RDT screening, researchers have also identified different categories of drug-using drivers. Aligning with Victoria Police observations noted earlier in this section, Boorman and Owens have suggested that there are three distinct groups of drug-drivers: those who use drugs recreationally, those abusing drugs (who are more likely to be detected through RDT) and those using drugs as an occupational aid (Baldock & Woolley 2013).

While there is some research into the prevalence of methamphetamine use among Victoria drivers, there is no research into the role of RDT. A review of RDT as a measure to reduce rates of drug driving by Baldock and Woolley (2013) found that there have not been any evaluations of the effect of RDT on rates of drug-driving related crashes. Similarly, there appears to be limited, and sometimes conflicting, research into drug use and risk of road crashes. An international meta-analysis of 66 studies into the crash risk of drug-driving found there were small or moderate increases in crash risk from drug use. However, the analysis noted that the poor quality of many of the studies in this area made it difficult to

344 Superintendent Paul Pottage, Division Commander, Division 1 (Geelong) Western Region, Victoria Police, Public Hearing, Geelong, 28 October 2013.

345 Superintendent Paul O'Halloran, Divisional Commander, Eastern Region, Division 4 North-East, Victoria Police, Wodonga, 24 February 2014. A call for more drug-testing on regional roads and highways has also come from community agencies; see for example Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

assess the risks because of the variability among the studies.³⁴⁶ Interestingly, international researchers have identified mixed effects from using methamphetamine on driving capability. For example, Miller et al. undertook a simulator study which suggested that some drivers could experience improved driving performance with methamphetamine (cited in Penning et al. 2010). Similarly, Silber et al. studying the performance of drivers using a drug with effects similar to methamphetamine found that while it negatively affected simulated driving performance during daytime testing, it did not during night-time testing (cited in Penning et al. 2010). Gustavsen et al. suggested that low doses of methamphetamine might actually improve the performance of fatigued drivers, although they also found that there was a positive relationship between drug concentration and driving impairment (cited in Penning et al. 2010). A review of the material in this area by other researchers suggests that lower doses of methamphetamine may ‘increase alertness and reduce sleepiness and reaction time’, effects which may improve driving capability. Conversely, higher doses were unsafe because of the impact of euphoria, hallucinations and delusions coupled with the withdrawal phase of the drug (Penning et al. 2010).

In terms of methamphetamine as a cause or contributing factor in road crashes, there is a relationship between using methamphetamine, driving and crash causation. Victorian research into crash culpability, the presence of drugs and injuries, found that in a sample of 837 road crashes 7 percent of those injured tested positive for amphetamine (there was no breakdown by type) (Ogden et al. 2010). Interestingly, the researchers found that when a ‘stimulant alone was present at “therapeutic levels” there was no increase in responsibility for the collisions’. However, when these stimulants were combined with others, ‘particularly alcohol, responsibility for collisions increased dramatically’ (2010, p.2). Nevertheless, there is evidence that methamphetamine is linked to culpability. For example, a 10-year research project conducted by the Victorian Institute of Forensic Medicine (VIFM) found that the risk of being involved in a fatal crash by professional drivers was nine times greater for those drivers who consumed amphetamines (VIFM in Drummer et al. 2004, cited in Boorman 2004). It also concluded that stimulants including methamphetamine had the strongest measures association with culpability (Drummer et al. 2003).

Methamphetamine and road crash fatalities

Moving beyond the assessment of methamphetamine as a cause or contributing factor in road crashes, the Committee sought to quantify its role in Victorian road fatalities. The Coroners Court of Victoria (the Court) provided the Committee with an analysis of ‘reportable deaths’³⁴⁷ that involved methamphetamine. According to the analysis conducted by the Coroners Prevention Unit (the Unit), in the period from 2009 to 2013 there were 89 unintentional transport deaths that involved victims who had consumed methamphetamine. In the same period Victoria recorded 1389 road fatalities.³⁴⁸ Of the 89 deaths, 72 involved victims who were found to have consumed multiple drugs in addition to methamphetamine, with 33 cases involving methamphetamine in conjunction with alcohol and other drugs. To better understand the nature of these crashes, the Committee undertook its own analysis of the data provided by the unit. The table below sets out the road crashes where methamphetamine was detected and information such as the number of deaths, road user type, and information about the crash type.

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Elvik 2013 ‘Risks of road accident associated with the use of drugs: A systematic review and meta-analysis of evidence from epidemiological studies’, *Accident Analysis and Prevention*, vol. 60, November.

347 The *Coroners Court Act 2008* requires that deaths that are unexpected or result from unnatural causes be reported to the Coroners Court of Victoria. These deaths are referred to as ‘reportable deaths’ and are investigated by a Coroner and subjected to a finding about the identity of the victim, the cause of the death and other information. Refer to the *Coroners Act 2008* (Vic) and s. 4 in particular for more information.

348 Transport Accident Commission, *Road Toll – Annual*, accessed August 2014 at <http://www.tac.vic.gov.au/road-safety/statistics/road-toll-annual>.

Table 7.4: Victorian road fatalities 2009–2013 involving methamphetamine³⁴⁹

Year	Total deaths	Vehicle type	Additional comments
2009	13	7 Drivers 2 Passengers 3 Pedestrians 1 Motorcyclist	9 involved a single crashes 2 heavy vehicle drivers (one involved an interstate driver)
2010	15	9 Drivers 2 Passenger 2 Pedestrians 2 Motorcyclists	9 single vehicle crashes
2011	19	11 Drivers 2 Pedestrians 3 motorcycles 1 Bicyclist 2 Unclear status	8 single vehicle crashes 2 heavy vehicle drivers
2012	24	11 Drivers 2 Passengers (one of whom was a pillion passenger) 2 Pedestrians 4 Motorcycles 5 Unclear status	9 single vehicle crashes
2013	18	8 Drivers 3 Passengers 7 Motorcyclists	10 single vehicle crashes

Source: Coroners Prevention Unit (Coroners Court of Victoria).³⁵⁰

The Committee notes that generally, in each of the years covered by the Coronial data, the road crashes involving a person that had consumed methamphetamine and had subsequently died comprise a small number of the total road toll (between 4.5% in 2009 to 8.5% in 2012 which was the highest recorded). Further, there were four heavy vehicle crashes involving drivers who had consumed methamphetamine, but had not consumed alcohol. Heavy vehicle crashes which draw attention due to the nature of the risk posed by these vehicles to other road users did not appear as consistently as media reports would suggest, although the Committee did not receive data as to the number of crashes involving road users who had consumed methamphetamine but had not died. Overwhelmingly, the coronial data indicates that half of those who die on Victorian roads and who consumed methamphetamine are involved in single vehicle crashes, where the only victim is themselves. In terms of the contribution of methamphetamine in the fatality data provided to the Committee, the Unit noted that its contribution was less clear. The Unit used a number of examples to further illustrate the difficulty in assessing the contribution of methamphetamine as a crash cause:

A driver's operation of a vehicle could potentially be impaired by use of methamphetamine, but determining whether the driver was actually impaired in a specific scenario and whether that impairment contributed to a fatal collision is very difficult. Another example is a drowning where methamphetamine was present; the methamphetamine could potentially have impaired the deceased's ability to swim and contributed to the death, but this could probably not be established with any certainty in most cases.

There are also deaths where the presence of methamphetamine probably played no contributory role. For example, if a person took methamphetamine and then died from injuries sustained as a passenger in a motor vehicle collision, the methamphetamine would probably not be contributory to the death, particularly if the motor vehicle was not at fault in the collision.

³⁴⁹ Refer also to Chapter 5, Prevalence and Harm.

³⁵⁰ Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

As the examples given here demonstrate, the presence of methamphetamine in a deceased person often tells us little about whether the methamphetamine played a causal or contributory role in the death.³⁵¹

The data provided to the Committee by the Coroners Court of Victoria, and its own analysis of coronial data help contextualise the earlier concerns raised by Inquiry participants, including Victoria Police. The Australian research into the involvement of methamphetamine in car crashes and the fatality data compiled by the Victorian Coroners Prevention Unit suggest that the presence of methamphetamine among road crash victims is relatively small when assessed as a proportion of the overall road fatalities in Victoria. Additionally, the incidence of methamphetamine among heavy vehicle drivers who were killed in the period from 2009 to 2013 was small, with only four recorded cases, and with none since 2012.

While it is difficult to assess the contribution of methamphetamine as a cause or contributory factor in road crashes, for a number of reasons, the data indicate that at least half of those killed in the period between 2009 and 2013 were involved in a single vehicle crash and in many of the other cases, were the only victims of the crash. In the absence of other information and data, for example about the involvement of methamphetamine among non-fatal injuries and its role in road crashes, the available data support the conclusion that methamphetamine is present in a small number of those killed on Victorian roads, and in about half of these cases the only victim of the crash is the person who consumed the methamphetamine, and that its role in terms of crash causation is unclear. Given the available data, and the evidence assessed by the Committee, it appears that methamphetamine in the context of road safety is a less substantive issue than other factors such as alcohol. Given the sophisticated legislative framework that exists in Victoria in terms of police powers to test for drug-driving, to prosecute those who have breached drug-driving laws and the range of available sanctions for such breaches (discussed in Chapter 18), the Committee feels that policy tools already exist to deal with methamphetamine based drug driving.

Violence, crime and (meth)amphetamine use

Not all people who abuse drugs turn to crime, as not all criminals are drug-dependent. There are, however, links to be drawn between drug use and crime even if the exact relationship is hard to delineate. There is also a range of well documented methodological problems related to drawing links between drug use and crime, not the least of which is that many of the studies that seek to explain the links rely on captive samples, usually those in prisons, youth detention centres or drug treatment facilities.³⁵² However, not surprisingly, it is thought that the heavier the use of methamphetamine the greater the potential for using the proceeds of crime to obtain the drugs.

Criminal behaviour serves not only such 'functional' purposes (that is, drug acquisition), it can also be a lifestyle by-product of the violent and even psychotic behaviour associated with some, particularly heavy, amphetamine use.³⁵³ One area of crime that is clearly relevant is burglary and theft of amphetamines and amphetamine precursors from pharmacies, chemists and pharmaceutical warehouses.

Due to the significance of the association between crime, violence and methamphetamine use, these issues are discussed separately and comprehensively in Chapter 8 of this Report.

351 Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria, Submission, 7 August 2014.

352 For an account of drug-related criminal behaviour among detainees in participating watch-houses across Australia see Chapter 8, which includes an analysis of data from the Drug Use Monitoring in Australia (DUMA) survey funded by the Commonwealth's Illicit Drug Strategy.

353 The specific links between violence as a possible outcome of methamphetamine psychosis were discussed in Chapter 6.

Environmental hazards and consequences associated with methamphetamine production

There are clearly significant environmental costs associated with the production of methamphetamine. Not least of these is the fact that producing methamphetamine requires the use of toxic, corrosive and volatile chemicals which can result in fires, explosions and the degradation of land and water.³⁵⁴ American analyses have shown that for each gram of methamphetamine 'cooked', 5 to 6 grams of toxic by-product is also produced, which can seep into the surrounding environment resulting in significant decontamination costs (Cherney, O'Reilly & Grabosky 2005; Lineberry & Bostwick 2006; Potera 2005). One social cost of methamphetamine production that is often overlooked is the danger and public health consequences to not only those who manufacture the substances or those living in the vicinity but also to police and emergency personnel who are investigating or otherwise responding to emergency events at clandestine laboratories (see, for example, Nicosia et al. 2009). The dangers that children are exposed to by living in or near clan labs, as previously discussed, are considerable.

Environmental consequences at a local level

Local communities are also affected through the impact of methamphetamine on local environments and the costs associated with decontamination and clean-up of lab sites, evacuation of affected areas, destruction of neighbouring property and flow on insurance costs this may entail and the storage of toxic waste. Both the economic and environmental costs of disposing of toxic waste are considerable. As a report by Cherney, O'Reilly and Grabosky 2005 stated:

Producers of synthetic drugs will use a variety of methods to dump their waste in order to avoid possible detection. This will include emptying the waste directly into soil or rivers, down drains and toilets, placing it in someone else's garbage bins or in landfill, or setting alight stolen cars that are loaded with chemical waste. Such methods also place residents, property owners, local authority workers and police at risk (Cherney, O'Reilly & Grabosky 2005, p.9).

The establishment and ongoing maintenance of specialist 'clan lab' police and emergency worker units are also a significant cost to the taxpayer. These 'community costs' were addressed in submissions to the Inquiry from two local government municipalities in Melbourne; the City of Casey and the Banyule City Council. Both councils reported that Environmental Health Officers [EHOs] are responding to an increasing number of clandestine laboratories reported to them by Victoria Police. The Councils are required to issue clean up and improvement notices to the landowner under the Public Health and Wellbeing Act 2008 (Vic); the provisions of the Australian Government's Clandestine Drug Laboratory Remediation Guidelines 2011 (Cth); and the state Department of Health's Clan Laboratory Remediation Practice Note 2012 (Vic). Under the 2012 Practice Note and the *Public Health and Wellbeing Act 2008* (PHWA) the responsibility for the remediation of a clan lab and any costs associated with the process are those of the legal landowner. This includes the costs associated with the recovery of costs from a tenant where applicable. However, there can still be ongoing costs to both Council and the ratepayer. This is particularly the case when the landowner/landlord may have been unaware of how their property was being used, cannot afford to pay or cannot be traced.

³⁵⁴ The types of chemicals involved in methamphetamine production that can be toxic are solvents, acids, metals, salts and corrosives. Contamination by inhalation or contact with the skin including serious burns or scalds are common hazards but inhalation of volatile gases can result in short and long-term illnesses including liver and kidney disorders, chest pain, respiratory problems. For a full account of the potential harmful health effects that can result from 'cooking' in clan labs, see EMCDDA 2009; Cherney, O'Reilly and Grabosky 2005.

The Guidelines indicated that it is the owner's responsibility to engage an approved assessor experienced in hazardous chemicals and wastes to determine risk to public health. However the cost to owners for engagement can be seen as prohibitive and therefore may require (if applicable) Council to bear these costs which is an issue when there are already limited financial resources.³⁵⁵

The process of remediation

When a clan lab is discovered the Victoria Police Clandestine Drug Laboratory Squad and Forensic Services Unit will usually investigate the site and collect samples of drugs, chemicals and apparatus for evidentiary and prosecution purposes. Victoria Police is not responsible for the assessment and remediation of the site following the completion of the investigation. At this stage Victoria Police will contact an Environmental Health Officer (EHO) from the Council where the lab is located. The EHO will then liaise with the police investigator to discuss an appropriate remediation strategy.

Responsibility for managing the site, including remediation, returns to the property owner once the police have completed their investigation and removed material of evidentiary value from the property. Council can utilise their relevant powers under the PHWA to ensure that a clan lab site is remediated and can also prohibit unauthorised access (Department of Health 2012).

The EHO and landowner will liaise over the management of the property prior to the remediation assessment. This may include preventing unauthorised access to the site and notifying neighbours who may be at risk. If a landowner does not take steps to remediate the property the local council may issue a landowner with an improvement notice to abate the nuisance under Section 66 of the PHWA.³⁵⁶ In cases where the landowner is either unknown or cannot be located the Council may take action to abate the nuisance under the PHWA.

Once the EHO and landowner have discussed the initial plans for remediation, a professional assessor such as an occupational hygienist will be engaged to conduct an initial assessment report. If it is felt further action is required a remediation plan will be prepared by an authorised professional cleaning contractor. The remediation plan will be guided by both any findings of the Victoria Police investigation and the report of the assessor. Following the remediation, the original assessor should provide written verification to the Council and landowner that the site is no longer contaminated. Table 7.4 provides an account of the various roles and responsibilities of the stakeholders in the remediation process.

355 Ms Lisa Raywood, Manager Health and Aged Services, and Ms Kaylene Hodgkin, Health Services Project and Policy Coordinator, Banyule City Council, Submission, 21 October 2013.

356 Under Section 58 of the PHWA any action which is noxious or dangerous to health can constitute an offensive nuisance. Contamination associated with clan labs is clearly a nuisance for the purposes of the PHWA 2008 (Department of Health 2012, p.9).

Table 7.4: Roles and Responsibilities for Remediation of Clandestine Laboratories in Victoria

Individuals and Groups of Individuals	Responsibilities
Victoria Police	<p>Initial investigation of clan lab and relevant prosecution activities.</p> <p>Notify Council EHO, by phone, of the presence of a clan lab, transferring powers to them for further action.</p> <p>Provide a follow-up letter of a clan lab investigation to the EHO and contact details of the police investigator.</p> <p>Process and organise packaging, transport and disposal of equipment and chemicals found in a clan lab that are relevant to the police investigation.</p> <p>Provide relevant details of contamination at a site to the EHO upon request.</p>
Local Government — Environmental Health Section Authorised Officers	<p>Respond to potential residual contamination at a clan lab site after notification has been received from Victoria Police or complainant of such a nuisance.</p> <p>Liaise with police investigator to clarify potential contamination at the site.</p> <p>Issue improvement and/or prohibition notice to property owner of a clan lab site.</p> <p>Facilitate prohibition of unauthorised access to a clan lab site.</p> <p>Notify potentially affected parties of risks and hazards of a clan lab, e.g. neighbours.</p> <p>Engage and liaise with assessment/cleaning/demolition contractors as required.</p> <p>Oversee the remediation of residual contamination at a clan lab site.</p>
Property Owner(s)	<p>Appoint an assessor to assess contamination at a clan lab site.</p> <p>Manage the remediation of the site.</p> <p>Submit the assessor's report to Council confirming that contamination levels are within acceptable levels.</p>
Assessors (suitably qualified professional)	<p>Assess potential contamination, hazards and risks at a clan lab site.</p> <p>Confirm in writing, to the property owner and/or Council that a property previously used as a clan lab:</p> <ul style="list-style-type: none"> —does not require remediation <p>OR</p> <ul style="list-style-type: none"> —has been remediated to a satisfactory level and is fit for its intended use.
Chemical disposal/transport contractor	<p>Transport and dispose of equipment and chemicals found at a clan lab site.</p>
Cleaning contractor/ remediation professional	<p>Write a remediation plan before commencing.</p> <p>Remove contamination and hazards from a clan lab property.</p> <p>Remediate the site so that it is fit for its intended use.</p>

Source: Department of Health (Victoria) 2012, *Clandestine Laboratory Remediation, Environmental Health Practice Note*, p.11.

Problems associated with the remediation process

Whilst the remediation process is relatively straightforward, some witnesses who gave evidence to the Committee have argued there are some issues which have not been satisfactorily dealt with. For example, the City of Casey based in Melbourne's south eastern suburbs has argued that because the remediation costs to landowners of cleaning up a site are for the most part the same no matter how big or small the property may be, there is the capacity for both Council and individual landowners to be unfairly burdened with unnecessary costs:

The current regulatory system applies a singular approach to all clandestine laboratories reported to Council, irrespective of the size, the nature of chemicals on site, and the observations of the assessing Officer from Police Forensics.

...[w]ithout adaption to take account of site specific characteristics [the system] has the capacity to result in a very costly process for property owners whilst consuming Council resources to a point which may well be beyond what is necessary to address chemical contamination limits in affected properties.³⁵⁷

The City of Casey recommended instead that there be a tiered system of notifications based on the size of the lab or site and the effort needed to clean it up:

A cost-effective and more targeted way of effectively managing the issue, albeit still based on the Department of Health Practice Note, would be to make use of a risk tier system revolving around methylamphetamine. A low risk tier rating (i.e. Tier 1) might equate to small scale production and therefore have proportionate assessment and clean-up requirements that Council would impose on the property owner. Those clan labs which present higher risk characteristics (i.e. associated with explosion or larger scale production), may be given a higher tier rating and so more extensive remediation requirements would apply. A similar tier model is currently being applied in WA with reported success.³⁵⁸

The City of Casey also believed, notwithstanding the relative streamlined process under the Practice Note, that there needs to be greater communication, clarity and liaison between stakeholders in the remediation process;

Whilst by and large appropriate outcomes are realised utilising the practice note, areas of improvement lie in:

- Council EHOs having access to a consistent point of contact within the reporting Police stations. Written follow up of verbal Police reports is received on an ad-hoc basis, presenting difficulties in obtaining further information by Council's EHOs;
- Obtaining consistent remediation reports of identified clandestine laboratories from different Occupational Hygienists; and
- The majority of reported clan labs involve rented properties. Current communication protocols do not reflect the role real estate agents hold in these instances where premises are leased.³⁵⁹

As such the City of Casey believes it would be useful to establish a Memorandum of Understanding between Victoria Police, Local Government, Occupational Hygienists and Real Estate agents to formalise and provide clarity in the communication between each party in clan lab remediation.³⁶⁰

The City of Banyule also believes council EHOs require better training in addressing the environmental damage caused through the operation of clan labs:

It is of our opinion that the skills training of EHOs within local government need to be enhanced to provide an appropriate response to the potential public health issues that may be posed by clandestine laboratories in their municipality. Including but not limited to dealings with the police, occupational hygienists, and nuisance evidentiary procedures.³⁶¹

Further issues pertaining to methamphetamine production and the problems associated with 'clan labs' is discussed in Chapter 16.

357 Mr Jake Repacholi, Team Leader Public Health, City of Casey, Submission, 18 October 2013.

358 Mr Jake Repacholi, Team Leader Public Health, City of Casey, Submission, 18 October 2013.

359 Mr Jake Repacholi, Team Leader Public Health, City of Casey, Submission, 18 October 2013.

360 Mr Jake Repacholi, Team Leader Public Health, City of Casey, Submission, 18 October 2013.

361 Ms Lisa Raywood, Manager Health and Aged Services, and Ms Kaylene Hodgkin, Health Services Project and Policy Coordinator, Banyule City Council, Submission, 21 October 2013.

Economic and financial costs of methamphetamine use

The use of methamphetamine as with other licit and illicit drugs, can result in economic costs to the individual user, family members and the community overall.

Costs to the individual user

Methamphetamine use and particularly dependent use can financially affect the user in a number of ways. First, if the user is in paid employment, their work performance may be notably affected. Second, if unemployed the user may find it very difficult to afford the basic necessities of life once their drug expenditure is taken into account. Third, the user may owe substantial sums as drug debts, often to criminal elements.

Jeopardising employment or studies

Some agencies report that methamphetamine users have told them they have lost their jobs because of erratic behaviour due to their drug use (absenteeism, aggression etc) or because they have lost their driving licence, an essential component of their job requirement, due to drug driving.³⁶²

Many if not most clients, however, with whom drug and alcohol agencies come into contact, are unemployed. Methamphetamine abuse may also contribute to the costs associated with high levels of absenteeism from the workplace, school or university/college. Nicosia et al. state from the American context that:

Costs associated with productivity losses represent another substantial category of costs. The best estimate for total productivity losses is \$687 million. Most of the productivity losses are due to absenteeism (\$275 million) and incarceration (\$305 million). Smaller contributors are the costs due to a lower probability of working among meth users (\$63 million) and the cost of employing drug testing (\$44 million). We do not attempt to estimate any losses embodied in the potential changes in wages paid to meth users vis-à-vis nonusers. Nor can we include any estimates of the higher health care and workers' compensation costs paid by employers because of employees' meth use (Nicosia et al. 2009, p.xiv).

The 'comedown' period off methamphetamine and related drugs can be quite lengthy and this may also impact upon work attendance and/or performance. Although the amount of time needed to 'recover' from the drug's effects will vary between individuals and will depend upon such extraneous factors as the amount of drug used, the activity performed while using (and the weight, health and personality of the user), it is fair to state that it is not unusual for a moderately heavy user of the drugs to require at least three days to be operating at optimal performance levels. Apart from paid employment or study, the comedown period may also affect a person's performance of home duties or carer responsibilities for children (Measham, Aldridge & Parker 2001).

Failing to 'make ends meet'

Even if methamphetamine is a relatively 'affordable' drug compared to other drugs, including alcohol, the nature of drug dependency is such that there may be little money left to spend on food, rent, utilities etc once a dealer is paid his or her 'cut'.

For instance, Figure 7.1 provided by Junction Support Services (JSS), a youth support agency in the Wodonga region, profiles the average income and expenditure of a 21-year-old unemployed male before the financial costs of his drug use is factored in.

362 Dr Sherene Devanesen, Chief Executive, Peninsula Health, Submission, 21 October 2013.

Figure 7.1: Estimated financial burden on a 21-year-old methamphetamine user at Junction Support Services

<p>Newstart Allowance = \$509.50 a fortnight</p> <ul style="list-style-type: none"> • Rent (Public Housing) = \$130 f/n • Utilities = \$50 f/n • Cigarettes = \$100 f/n • Food = \$160 f/n • Phone = \$30 f/n <p>= \$470 f/n — Leaving them with \$39.50 until their next pay day</p>

Source: Provided in submission of Junction Support Services 2014.³⁶³

At \$100 for a point of a gram, such a young person would have a serious shortfall.³⁶⁴

Indeed, in the case of JSS clients, it was not unknown for people to be spending up to \$7000 per week for 28 grams (1 ounce).³⁶⁵ Given that most JSS clients are in receipt of Centrelink payments, whatever the current market rate for the drug, it is not ever going to be cheap or 'budgetable', as one of the agency's workers told the Committee.³⁶⁶

Drug dealing, credit and debt

In many cases acquisitive crime such as theft may be the only means available to finance a methamphetamine habit. Alternatively, 'on dealing' may be necessary in order for the user to afford drugs for personal use. A vicious circle is created whereby the user needs to deal or commit other crimes to finance his or her habit, resulting in a criminal record. This in turn makes the prospects of ongoing or future legitimate employment difficult, resulting in no regular income other than state benefits.³⁶⁷

Welfare agency VincentCare advised the Inquiry that the impact of what has been termed 'drug induced poverty' is:³⁶⁸

...that people lose their accommodation through inability to pay rent. People also become entrapped in a dangerous state of drug debt. This results in very substantial risks of reprisal through extortion, coercion, or placed under duress to engage in criminal activity to raise the required funds to repay debts.

Methamphetamine appear to create a dangerous positive feedback loop of destructive behaviours that keep people trapped in an endless loop of poverty, gambling, criminal activity, drug usage and violence... Women who are users can enter prostitution in order to maintain drug habits or repay drug debts.³⁶⁹

363 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014.

364 As indicated in Chapter 3 varying (and contradictory) evidence has been given to the Inquiry about the price of crystal methamphetamine in the 'open market'. Bearing in mind that cost will vary according to location, purity and quality, even if one was to take a lower estimate of \$100.00 for a point of a gram, this still leaves a dramatic shortfall in what the person profiled in Figure 7.1 would need to make up.

365 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014.

366 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Public Hearing, Wodonga, 24 February 2014.

367 Youth worker Les Twentyman told the Committee that methamphetamine use amongst young people must be seen against a background of high youth unemployment particularly in the western suburbs of Melbourne. See Mr Les Twentyman, OAM, 20th Man Fund, Public Hearing, Melbourne, 9 December 2013.

For an account of some of the reasons why people, particularly young people, may use methamphetamine including because of unemployment and poverty, see discussion in Chapter 13.

368 For a discussion of methamphetamine use by homeless people, see discussion in Chapter 14.

369 Mr John Blewonski, Chief Executive Officer, VincentCare Victoria, Submission, 21 October 2013.

Ms Melissa Lonsdale from Sunraysia Community Health Services in Mildura, made similar comments to the Committee about the expense of methamphetamine and the incurring of debts:

We have quite a significant number of clients who are coming in reporting ice and who have huge unmanageable debts. Trying to work with somebody around their ice use...when they have perhaps \$10,000, \$15,000 or higher worth of debt and are still having to have contact with dealers and people living that lifestyle is [difficult]. It is not a cheap drug, so people do need the money or financial means to be able to use. Whether or not they change to criminal activity for that, we are actually seeing people who have been working, who have cars, houses, quite significant possessions and things like that and who have actually lost a lot of that wealth trying to pay back debts to people they have been buying from.³⁷⁰

Ms Bev McIlroy from the Glenelg/Southern Grampians Drug Treatment Service made the point that because many young people who get caught up in methamphetamine use are 'naïve' drug users, it comes as somewhat of a shock to find that they have drug debts that are spiralling out of control:

We have had drug deaths associated with drug debts. We have had deaths, I should say, murders, associated with drug debts. It is very real in our community... Naive drug users do not know about these harms, they do not know how to deal with them. The drug debts create a fear such that they have never known before, and the fear stops them from engaging. They will come along with mum and they will cry and they will sit there and say they want to stop this, but then they walk outside and they know that they are looking over their shoulders the whole time, and that is real.³⁷¹

The financial burdens are increased when users are allowed 'credit' by their dealers creating a vicious circle of use, dependence and debt. As Tim Church, an Aboriginal agency worker, told the Committee:

Hook them up on credit — that's how I have seen them get into trouble and that is why [users] need to go to rehab because they are so deep into it they cannot backtrack and get out of it. They have no employment, they have no job. [Credit] is definitely a big thing.³⁷²

And according to Superintendent Don Downes of the Western Region of Victoria Police, the extreme violence associated with recovering relatively low level debt is completely disproportionate to the amount owed.³⁷³ This is of considerable concern to the Committee.

Costs to families and third parties

It is not only the costs to the individual user that need to be considered. The social, economic and personal costs to the family of the user can be very high. In the context of economic cost, witnesses have stated that it is not uncommon for the families of 'small time users' to be extorted, threatened and harmed to pay for their children's debts.³⁷⁴ A representative from Mungabareena Aboriginal Co-operative in the Wodonga region stated that even in cases where families were not being 'heavied' to pay the user's debts there were still financial consequences for which they (literally) paid the price:

370 Ms Melissa Lonsdale, Team Leader, Drug Treatment Services, Sunraysia Community Health Services, Public Hearing, Mildura, 5 December 2013.

371 Ms Bev McIlroy, Manager, Glenelg Southern Grampians Drug Treatment Service (QUAMBY), Public Hearing, Warrnambool, 3 March 2014.

372 Mr Tim Church, Aboriginal Drugs and Alcohol Worker, Albury-Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014.

373 Superintendent Don Downes, Western Region, Division 2, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

374 See for example submission of Wodonga Police. Superintendent O'Halloran told the Inquiry in evidence that he was aware of cases where family members had been subject to arson attacks, serious assaults and property damage in order for dealers to enforce their children's drug debts; sums of which could be up to \$40,000. See Superintendent Paul O'Halloran, Divisional Commander, Eastern Region, Division 4 North-East, Victoria Police, Wodonga, 24 February 2014.

You see families suffer, you see kids missing out on things, missing out on food in their mouth because their parents are using ice. The money is going towards the ice instead of feeding the children or doing what needs to be done there, and then from that comes the family violence because there is no money to spend and arguments start. It is a vicious cycle, the whole thing, and there are so many paths it can take.³⁷⁵

Financial responsibilities may be particularly onerous when grandparents are responsible for raising their grandchildren when their drug using child is not capable or willing to do so. According to some welfare workers grandparents may even forego much needed medicines or other necessities to provide for those in their care:

It was not how they envisaged [their retirement years], but the grandmothers see it as their responsibility. They cannot afford to get sick, they cannot afford to go around Australia, they cannot even go out for meals with their friends anymore because they have kids to think about... And to be able to pay for the children's food and the iPads and all of this for the children, they often do not buy their medication. They say, 'Oh, well, I won't buy the latest script for blood pressure tablets' or whatever... And they delay operations like hip replacements and knee reconstructions because they cannot afford to take time off, because who is going to look after the kids?³⁷⁶

Costs to the community

It is exceedingly difficult to quantify the economic cost of drug use to the community. One of the difficulties for economists being: what does one include in the reckoning of what counts as tangible or intangible costs of illicit drug use? In most analyses of drug-related economic data, costs do not include ambulance services, welfare (payments), absenteeism or crime as many economists regard such matters as 'unquantifiable' (Doran 2012).

It is beyond the scope of this Inquiry for the Committee to present an expert economic analysis of the cost of methamphetamine production and use to the community. Such an analysis also depends on too many factors that are manifested on a national level and therefore beyond the scope of this Inquiry.

Academic studies on the cost of methamphetamine abuse

Very little research has been undertaken with regard to the economic costs specifically of methamphetamine abuse. One American study in 2005 (Nicosia et al.), however, provides some insight as to both the quantifiable and hidden costs of methamphetamine supply and use/abuse to the community. The authors found in summary that most of 'meth's costs are due to the intangible burden that addiction places on dependent users and to premature mortality' (2005, p.xiii).

This study also found that crime and criminal justice costs are the second largest cost category to the community, after mortality and morbidity costs, associated with methamphetamine use:

Crime and criminal justice costs represent the second-largest category of costs at \$2.5 billion to \$15.8 billion and a best estimate of \$4.2 billion. Meth specific offenses represent more than half of these costs, totalling \$2.4 billion. These are the costs associated with processing offenders for the possession and sale of meth. Meth-induced violent and property crimes that are generally attributed to actions of people under the influence of meth or in need of meth represent an additional \$1.8 billion in costs. Finally, an additional \$70 million is due to parole and probation violations for meth offenses. It is possible that these costs are significantly under-estimated, however, as the scientific literature regarding the causal association

375 Ms Sharyn Jenkins, Aboriginal Family Violence Worker, Mungabareena Aboriginal Corporation, Albury-Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014.

376 Ms Ruth Chattey, Family Support and Ms Elizabeth McCrea, Advocacy and Family Support, Mirabel Foundation, Public Hearing, Melbourne, 17 February 2014.

between meth and property and violent crime is inconclusive. We conducted our own analyses to explore the causality and association and, in our best estimate, find sufficient support to include an estimate of meth-induced property crime, but no violent crime. The very large bounds on this element are due to alternative assumptions of causality that warrant additional research (Nicosia et al. 2009, p.xiv).

More recent (Australian) data on the costs of incarceration for (all) types of crime both to the inmate and to the community, are analysed in Ritter, Bright and Gong's evaluation of drug law enforcement interventions directed towards methamphetamine (2012). The authors acknowledge, however, that such costs are imprecise and very difficult to quantify because of the inherent difficulty of the task and lack of research interest in this area (2012, pp.106ff).³⁷⁷

Community views on the cost of methamphetamine abuse

Evidence has been given to the Inquiry of the economic burden to the taxpayer of methamphetamine use and dependence. For example, a submission to this Inquiry from Northern Mallee Community Partnership acknowledges that the economic costs of methamphetamine and other drug abuse are both direct and indirect:

Direct costs involve increased costs of police, courts, military, treatment programmes, welfare payments to drug addicts and their families, as well as increased security measures by businesses. Indirect economic costs include the displacement of legal industries; diminished control over the economy; spending money for drugs and inappropriate use of money gained from drug sales; and fiscal problems related to the inability to tax the drug economy.

A very important indirect cost of the drug industry is a result of the fact that governments are not able to tax it. In such a case, governments have no choice but to increase taxes on those who can be expected to pay. However, the externalities of the drug industry, i.e. the hidden economic and social costs of illicit drug production and trafficking, cannot be charged back to those involved. They are, therefore, an added burden to the law-abiding population.³⁷⁸

Similarly, Figure 7.2, provided in a submission to the Inquiry from JSS, gives some indication of the many interventions required for an average and particularly heavy or dependent (methamphetamine) user that have to be funded by the community.

Figure 7.2: Interventions required for a drug user

Some of the many interventions required for drug user:	
<ul style="list-style-type: none"> • Child Protection • Homelessness Services • Food Bank • Emergency Relief • Police • Family Violence Services • Youth Justice/Corrections • Office Of Housing • Detox Facility • Rehab Facility • Drug And Alcohol Counselling 	<ul style="list-style-type: none"> • Mental Health — Child/Adult mental health • Refuges • Hospital — Health Services • GP • Generalist counselling • Psychologist • Psychiatrists • Emergency Accommodation • Financial Counselling • Victims of Crime

Source: Junction Support Services 2014.

377 The work of Ritter, Bright and Gong (2012) in terms of cost analysis primarily focuses on the aggregate costs and losses to illicit drug enterprises due to various drug enforcement activities. Although partly touched upon in Chapter 19, for the most part such an analysis is beyond the scope of this Report.

378 Mr Rob McGlashan, Executive Officer, Northern Mallee Primary Care Partnership, Submission, 21 October 2013.

Conclusion

The 'costs' and consequences of the use of methamphetamine, as with any form of licit or illicit drug, extend beyond purely medical or health considerations. The social costs of drug abuse are many and varied. Moreover, such costs are felt by more than just the individual user of the drug. They impact upon the family unit, friends, co-workers and members of the general community.

Combining methamphetamine use with driving a motor vehicle is increasingly being detected by roadside drug testing and is particularly problematic according to witnesses who gave evidence to this Inquiry and the academic research, particularly among young people and those in rural and regional Victoria where public transport options are limited. However, further research with regard to links between methamphetamine and road crashes is needed, as are evaluations of random roadside drug testing as a harm reduction tool.

There are other social consequences of methamphetamine use that clearly need to be addressed. The links between methamphetamine use, crime and violence is an important issue that needs to be discussed. These issues are discussed in detail in Chapter 8.

Finally, one important issue that must be continually borne in mind is that today it is fanciful to speak of the costs, be they physical or social, of any one type of drug. The reality is that whether drug use is licit or illicit, functional, recreational or a mixture of both, most people who suffer from substance abuse will have been using more than one type of drug, including alcohol. The concept of poly-drug use and its effects on the user and his or her community must therefore be factored into any discussion of methamphetamine use and its consequences.

8. Methamphetamine Use and Links to Crime

Introduction

The Committee has received anecdotal evidence from witnesses who have, in the course of their work or in their family environment, observed drug users displaying increased aggression and engaging in violent acts, which they attribute to the use of methamphetamine. However, an association between methamphetamine use and violence has not been consistently shown in academic research. Studying the causal relationship between drug use and crime is methodologically challenging as the pharmacological effects of drug use are mitigated by factors such as use of other substances, drug potency, dosage, body composition, personal drug tolerance, and the social context in which drugs are consumed (Gizzi & Gerkin 2010). Thus, physiological and psychological effects may vary between users for a consistent methamphetamine dose. In addition, a lack of synthesis between criminology-based and health-care research, and differences in the way that methamphetamine use and violence have been measured in studies, has hampered research efforts to understand underlying causal relationships.

This chapter presents evidence from submissions made to the Committee, criminal justice data and academic research on the relationship between methamphetamine use and crime, and violent offending in particular. The chapter begins with first-hand accounts of violent and aggressive behaviour engaged in by methamphetamine users, provided to the Inquiry by emergency and health-care professionals. Goldstein's Tripartite Conceptual Framework is then discussed to provide a theoretical explanation that may account for an association between methamphetamine use and violent offending. This is followed by an examination of findings from criminal justice data and the academic literature. Criminal justice data presented in this chapter include: Australian Crime Commission (ACC) data on amphetamine type stimulants (ATS) arrests and submissions regarding activity in the domestic methamphetamine market; Australian Institute of Criminology (AIC) Drug Use Monitoring in Australia (DUMA) data in support of a comparison of national and Victorian-based methamphetamine using detainees involvement in criminal offending by crime type; and Victorian Police data on ATS-related criminal activity. The chapter concludes with a review of the relevant academic literature and a discussion of the factors that may influence the presence, and strength, of an association between methamphetamine use and violence.

Violence observed by emergency and health-care professionals

Violent behaviour and aggression displayed by methamphetamine users is a concern for emergency personnel who often deal with users during acute intoxication and under adverse circumstances. Anecdotal evidence presented to the Inquiry by emergency and health-care professionals illustrates the volatile and hostile behaviour that methamphetamine users can exhibit.³⁷⁹ However, the Committee was made aware of similarly volatile interactions that occur between individuals intoxicated with alcohol and emergency and health-care

379 For an account of the pressures facing emergency room staff, see Armstrong and Guthrie, 2012, 'The impact of amphetamine type stimulant use on emergency department services', in Allsop and Lee 2012, pp. 149–153.

professionals. Ambulance Victoria, during a Committee hearing, argued that a higher number of ambulance attendances relate to alcohol use than to crystal methamphetamine use:

We looked at the use of crystal methamphetamine in Victoria. Certainly our organisation is experiencing an increase in the number of calls regarding the use of crystal methamphetamine, and that has risen from 69.16 cases per 1 million population in 2010–11 to 142 in 2011–12, with a mean increase in attendance per day from 0.77 to 1.62. We attend approximately 650 to 700 cases per annum for crystal methamphetamine. I think it is an important issue but fades in significance around the numbers of cases of alcohol we attend. Alcohol has a much bigger impact on our organisation with regard to volume; however, as we talk about throughout this presentation, some of the behavioural and violence issues that can be associated with crystal methamphetamine do have an impact on the organisation and our paramedics particularly. The demographic is increasing. The social impact is, in our view, broadening, and we see a disproportionate amount of violence anecdotally, violent behaviour, police co-attendance and time it takes to manage cases where crystal methamphetamine is involved.³⁸⁰

Ambulance Victoria estimated, in conversation with the Committee, that its attendances in respect of cases of crystal methamphetamine use has increased 109.9 percent since 2010–11, but the numbers remain relatively low in comparison with alcohol-related attendances.³⁸¹

Peter Guest, a paramedic with Ambulance Victoria in Mildura, spoke to the Inquiry about his experience with ‘psycho-toxic’ patients, describing how the drug-induced strength that users display can make the usual techniques of de-escalation and even some sedative medications woefully inadequate.³⁸²

Mark Allen, an ambulance officer from Morwell, felt that it was the unpredictability of ice users that gave his colleagues the most concern:

[Paramedics] are used to dealing with patients who are agitated or upset. There might be a social reason or drugs or alcohol. They are particularly good at calming off those situations.

... The problem with ice — methamphetamine generally — is that they become generally much more irrational to deal with. ‘Unpredictable’ is certainly a word that is bandied around quite a lot with patients who are affected by ice, and you just do not know what you are going to get. They will be lying quietly one minute on your stretcher. You have been to the scene, you have carried out your interventions, and the next minute they are in the back of your vehicle and they are up and going — out of the blue, unexpected. Again, if it is purely alcohol, most paramedics would feel like they had some element of, ‘Okay, I think I can deal with this. I think I can manage it’. That feeling is much less with people who have been taking ice and methamphetamine.³⁸³

Richard Marchingo, a paramedic from Bendigo, voiced his concern about the propensity of methamphetamine users to manifest violent and psychotic behaviour particularly in comparison to his past experiences with heroin users:

... we are getting patients spitting at us, punching, pummelling and threatening, and it is becoming more common. Over the years the heroin-type addict patients were more sedate, but the ice patients are just difficult for us to deal with. They present as homicidal, suicidal — those types of symptoms. It varies. As the ambulance on the road we have put them into two basic categories. Initially the one that is on ice is the aggressive, agitated, irrational patient that is difficult to deal with. The second one is the one

380 Associate Professor Tony Walker, General Manager, Regional Services, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013.

381 Associate Professor Tony Walker, General Manager, Regional Services, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013.

382 Mr Peter Guest, Mobile Intensive Care Ambulance Paramedic, Ambulance Victoria, Public Hearing, Mildura, 5 December 2013.

383 Mark Allen, Team Manager, Morwell Mobile Intensive Care Ambulance (MICA) Unit and Single Response Unit (SRU), Ambulance Victoria, Traralgon, 28 January 2014.

who has been on ice and has symptoms of things like elevated temperature, diarrhoea, tachycardia, crawling skin, depression and all those sorts of things.³⁸⁴

Dr Andrew Crellin, Director of Emergency at Ballarat Health Services, also expressed concern at the propensity of patients 'high' on methamphetamine to be violent in the emergency department. He provided the following statement to the Inquiry:

What problems do medical and allied health staff face? Our main problem is aggression. These patients are often very violent. They are often very uncooperative. They often require high levels of restraint in the initial stages of their management and, as a duty of care, you are often forced to restrain these people for prolonged periods, either with chemicals, so sedation, or contact restraints, so point restraints.³⁸⁵

Dr David Eddey, the Director of Emergency at Geelong Hospital, made similar observations when he presented to the Inquiry expressing serious concerns as to the potential for methamphetamine to make 'normal' people violent.³⁸⁶

Detective Leading Senior Constable Jason Bray stated, as an aside, that one of the other effects of methamphetamine that he is seeing is that it gives criminals the energy to engage in higher levels of offending:

When they are taking this drug, they are able to stay awake for three, four days on end, they are a lot more active, and therefore when they are a lot more active they are offending a lot more. In the last year, for instance, we had a career criminal that I have known for probably 10 years. In the past he may go out and do a burglary or a break-in of some sort, once every week or two weeks, depending on what his circumstances are at the time. On this particular night he did upwards of 20 crimes. He did four aggravated burglaries, six burglaries, broke into 12 cars, and he says he was on ice that night and did not know what he was doing, but a lot more active. He was able to leave home and stay up all night. That is probably one of the greatest problems in that you have career criminals now taking this drug and becoming more active.³⁸⁷

Health-care personnel not involved in emergency care, such as drug and alcohol agency and community health service personnel, told the Inquiry they are less likely to see clients who are manifesting violent behaviour. For example, Robyn Reeves from the Ballarat Community Health Centre told the Committee:

Violence and aggression have been referred to a lot in the media as side effects of ice and, whilst we are aware that in the emergency department and police experience, that may well be the case, that is not necessarily what we are seeing in clients presenting to our service.³⁸⁸

Similar observations were made in the context of young people presenting with methamphetamine-related issues to youth workers at Barwon Youth in Geelong. Such youth rarely presented with violent or aggressive behaviours.³⁸⁹ On the other hand, Melanie Vidler of the Bridge Youth Service in Shepparton reported seeing a 'massive' increase in violence amongst young people, particularly males, presenting to the agency with methamphetamine-related issues. Again the extent to which this can be attributed to a methamphetamine-related psychosis is unclear.³⁹⁰ Determining a causal link between illicit drug use, in this case the use of methamphetamine, and criminal behaviour requires consideration of the underlying mechanisms through which an association may occur.

384 Mr Richard Marchingo, Ambulance Paramedic, Ambulance Victoria, Public Hearing, Bendigo, 25 October 2013.

385 Dr Andrew Crellin, Director of Emergency, Ballarat Health Services, Public Hearing, Ballarat, 18 November 2013.

386 Dr David Eddey, Director of Emergency Medicine, Barwon Health, Public Hearing, Geelong, 28 October 2013.

387 Detective Leading Senior Constable Jason Bray, Wangaratta Criminal Investigation Unit, Victoria Police, Public Hearing, Wodonga, 24 February 2014.

388 Ms Robyn Reeves, Chief Executive Officer, Ballarat Community Health Centre, Public Hearing, Ballarat, 18 November 2013.

389 See: Mr Terry Robinson, Co-ordinator, Barwon Youth, Public Hearing, Geelong, 28 October 2013.

390 See Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Shepparton, 25 February 2014.

The Goldstein Tripartite Conceptual Framework

In his 1985 paper *'The Drugs/Violence Nexus: A Tripartite Conceptual Framework'*, Goldstein described a theoretical framework for investigating the relationship between drugs and violence. The three models proposed by Goldstein to explain this association remain relevant today.

1. Psychopharmacological violence

The psychopharmacological violence model represents the premise that violent behaviour can be directly attributed to the short and long-term impact of drug use on cognitive and physical functioning. Goldstein proposes that the psychopharmacological violence model can explain violence that results through either the offender or victim's drug use — as with an offender's drug use, a victim's drug use may lead to confrontational or other problematic behaviours that trigger violent reactions, in this case, from the offender (Goldstein 1985). Information on the physical and psychological effects of methamphetamine use has been presented in Chapter 6.

2. Economic compulsive violence

The economic compulsive violence model identifies violent behaviour as being motivated by economic factors, for example, robbery perpetrated to fund drug habits (Goldstein 1985). In this way, consumption of methamphetamine may increase the need to engage in crime for economic gain, which may or may not at its outset be violent in nature. Violence may arise during commission of a crime due to factors, such as the social context, the perpetrator's nervousness or fear, the victim's reaction, the involvement of weapons by either the offender or victim and the intercession of bystanders (Goldstein 1985). If economic motives underlie the violent offending of illicit drug users, it would be expected that the removal of the need for substance purchase, either through reduction in dependency or by providing a reduced cost alternative, should result in a reduction in criminal offending. Some support for this assertion can be garnered from studies illustrating that a reduction in violent crime among heroin users was observed with the rise in prescription of heroin substitutes, such as methadone (Klee & Morris 1994).

3. Systemic violence

The systemic violence model is based on the premise that violent behaviour occurs with a greater frequency among the drug using population than among non-drug users, due to the inherent violent nature of the drug market. Violent behaviour is viewed by Goldstein (1985) to be used as a means to regulate and facilitate transactions in an illegal, unregulated and lawless market. Examples of systemic violence could be:

- xvi. disputes over territory between rival drug dealers;
- xvii. assaults and homicides committed within dealing hierarchies as a means of enforcing normative codes;
- xviii. robberies of drug dealers and the usually violent retaliation by the dealer or his/her boss;
- xix. elimination of informants;
- xx. punishment for failing to pay one's debts;
- xxi. disputes over drugs or drug paraphernalia; and
- xxii. robbery violence related to social ecology of copping³⁹¹ areas (Goldstein 1985, p.6).

391 A 'copping area' is a place from which drugs are procured.

In Australia, the involvement of organised crime groups and criminal syndicates in the production and distribution of methamphetamine provides the preconditions necessary to support a systemic violence model.

Statistical evidence on methamphetamine and related crime

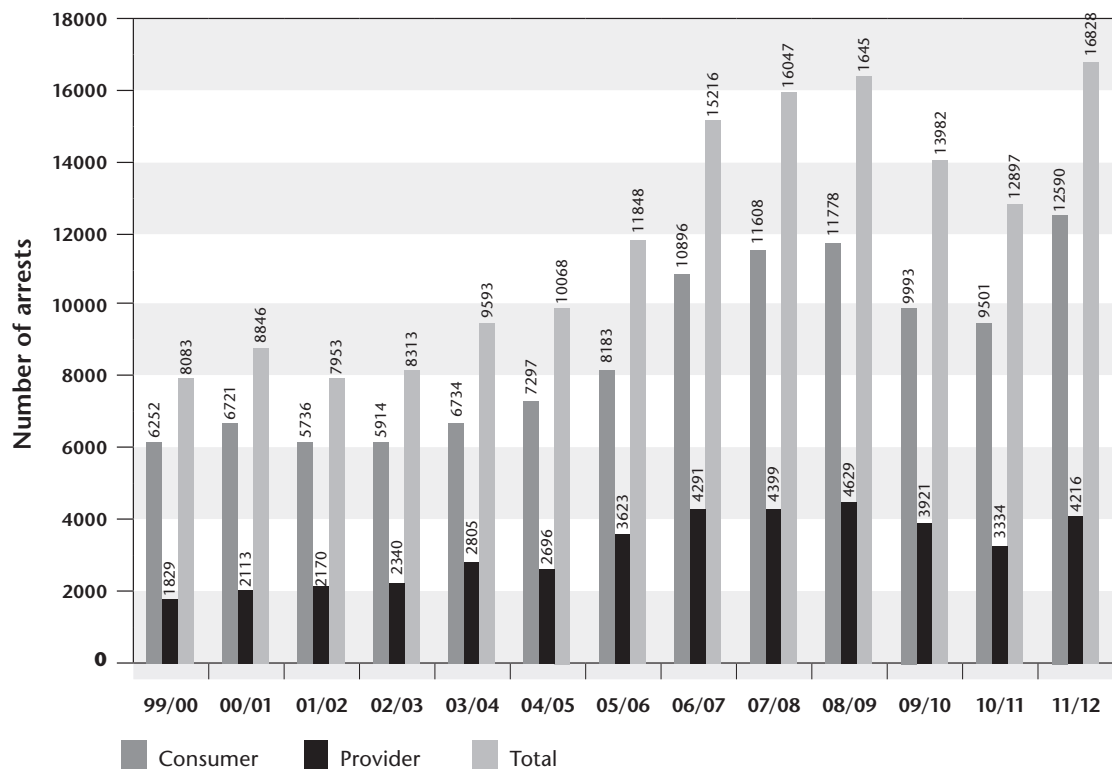
Examining national and Victorian statistics on offending and methamphetamine-related crime serves to identify the types of criminal offending engaged in by methamphetamine users and the pattern of that offending over time.

Illicit drug markets (Australian Crime Commission)

Each financial year, the ACC publishes its *Illicit Drug Data Report (IDDR)*. The report provides a statistical overview of illicit drug arrests, seizures and purity levels as well as the national impact of illicit drugs and emerging trends. The information is based on data collected by law enforcement agencies, forensic laboratories and other government agencies across the country. The report presents the most authoritative data on the illicit drug environment in Australia and helps to inform evidence-based responses that can target illicit drug activity (ACC 2014).

Prior to publishing the IDDR, data on arrests of ATS consumers and providers was collected by the Australian Bureau of Criminal Intelligence (ABCI). Combining these datasets provides an indication of how consumer and provider arrests have changed over a 13-year period (Figure 8.1), although a number of jurisdictions that contributed these data did not differentiate between arrests connected with ATS and phenethylamines (the class of drugs to which ecstasy belongs). In Figure 8.1, both drug categories have been aggregated. Consumer and provider arrests for ATS have increased generally over the 13 years from 1999-2000 with total arrests in 2011-12 being the highest recorded (Sindicich & Burns 2014).

Figure 8.1 Amphetamine-type stimulants: consumer and provider arrests, 1999/00–2011/12



Source: Sindicich & Burns (2014, p.133).

The latest IDDR for 2012-2013 showed that the number of ATS arrests increased by 31.9 percent, from 16,828 in 2010-2011 to 22,189 in 2012-2013 (Table 8.1) (ACC 2014). The ACT and Tasmania were the only jurisdictions that reported decreases in ATS arrests, although relatively small numbers were involved. While accounting for a small proportion of the overall number of arrests, the Northern Territory saw a dramatic increase in the number of arrests in 2012-13, well over 10 times that in 2011-12. The greatest number of ATS arrests was in Victoria, which also had the second highest percentage increase (50.5%) after the Northern Territory. New South Wales had the second highest number of ATS arrests, equating to a 32.7 percent increase, followed by Queensland with an 18.0 percent increase between these two financial years.

Table 8.1: Number and percentage of national ATS arrests, 2011-12 and 2012-13

State/Territory ^{ab}	Arrests		
	2011-12	2012-13	% change
New South Wales	4,451	5,905	32.7
Victoria	4,494	6,762	50.5
Queensland	4,188	4,941	18.0
South Australia	1,049	1,312	25.1
Western Australia	2,347	2,870	22.3
Tasmania	161	125	-22.4
Northern Territory	14	169	1,107.1
Australian Capital Territory	124	105	-15.3
Total	16,828	22,189	31.9

Notes:

- The term amphetamine-type stimulants (ATS) encompasses drugs included under both the amphetamines and phenethylamines groupings
- The arrest data for each state and territory included Australian Federal Police data.

Source: IDDR 2012-2013 (ACC 2014, p.50).

The report also presented data on consumer and provider arrests during 2012-2013 within the different jurisdictions (Table 8.2). These data provide an important indication of the extent of activities in ATS markets across Australia. The greatest number of consumer arrests occurred in Victoria, New South Wales and Queensland, equating to 30.1 percent, 26.6 percent and 25.8 percent of the total, respectively.

In regard to provider arrests, Victoria and New South Wales had a higher proportion of arrests (32.4% and 25.2% respectively) in comparison with other jurisdictions. Interestingly, Queensland only had 12.1 percent of the total provider arrests even though that state reported a much higher proportion of consumer arrests. It is important to note that Victoria has consistently had higher proportions of ATS arrests in recent years. There were increases in both consumer arrests (26.5% to 30.1%) and provider arrests and (27.4% and 32.4%) between 2011-2012 and 2012-2013.

Table 8.2: Amphetamine-type stimulants (ATS), number and percentage of consumer and provider arrests, by state and territory, 2012-2013

State and territory	Consumer		Provider		Total (a)	
	No.	%	No.	%	No.	%
New South Wales	4,411	26.6	1,379	25.2	5,905	
Victoria	4,993	30.1	1,769	32.4	6,762	
Queensland	4,281	25.8	660	12.1	4,941	
South Australia	610	3.7	685	12.5	1,312	
Western Australia	2,024	12.2	846	15.5	2,870	
Tasmania	82	0.5	43	0.8	125	
Northern Territory	113	0.7	56	1.0	169	
Australian Capital Territory	81	0.5	24	0.4	105	
Total	16,595	100.0	5,462	100.0	22,189	

Notes:

Arrest data for each state and territory includes Australian Federal Police data.

a. Includes those offenders for whom consumer/provider status was not stated. Total may exceed the sum of the table components due to rounding.

Source: Adapted from the IDDR 2012-13 (ACC 2014, p. 231).

The findings based on ATS-related arrests reported by the ACC are likely indicative of the growth in the market in Australia and highlight some of the concerns regarding increased activities raised by law enforcement agencies during the Inquiry. At the same time, it should be noted that police-recorded offence and arrest data can be an indicator of levels of police activity as much as levels of offending behaviour. If police conduct operations targeted at methamphetamine manufacturers, distributors or suppliers in a given year, the data will usually show increases in arrests compared with previous years where there were no targeted operations, even though the level of activity in the methamphetamine market has not changed.

The IDDR for 2012-2013 also examined the number of seizures of ATS throughout Australia. Between 2011-2012 and 2012-2013 these increased by 38.6 percent from 15,191 in 2011-2012 to 21,056 in 2012-2013. The weight of ATS seizures also increased by 304.4 percent, from 1,572.6 kilograms in 2011-2012 to 6,453.7 kilograms in 2012-2013. New South Wales accounted for the highest proportion of the number (41.6%) and weight (68.2%) of national ATS seizures. Victoria reported the largest percentage increase (50.5%) in the number of ATS seizures in 2012-2013 amongst all jurisdictions (ACC 2014).

In regard to the national market characteristics, the price of a gram of amphetamines in 2012-2013 ranged between \$150 and \$800. However a gram of crystal methamphetamine during the same period ranged between \$400 and \$1,600, compared with a range between \$300 and \$2,000 in 2011-2012 (ACC 2014, p. 43). The wide fluctuations in price appear to be largely due to varying levels of purity in the final products being sold. The ACC in a submission to the Committee described the purity of methamphetamine in different jurisdictions:

Over the last decade, the median purity of methylamphetamine has ranged from 4.4 percent to 60 percent. With the exception of Tasmania, all jurisdictions reported an increase in the purity of methylamphetamine samples analysed in 2011-2012. Victoria reported the highest annual median

purity in the last decade, increasing from 19.6 percent in 2010-11 to 60 percent in 2011-2012 (ACC 2014).³⁹²

The evidence from the ACC shows that the demand for methamphetamine in Australia has increased in recent years and there has been increased interception of highly pure forms of the drug at state and national borders. The ACC emphasised that crystal methamphetamine in particular is a drug of concern for law enforcement agencies. In conversation with the Committee, Ms. Judith Lind from the ACC noted the importance of understanding issues relevant to the methamphetamine market in Australia:

The ice problem is a growing one for Australia; there does not seem to be any doubt in relation to that. The increasing use of this form of methylamphetamine and generally in a higher purity than we have seen before is demonstrated by both higher seizure and arrest data and also ambulance presentations. There are very serious wide-ranging harms from abuse of ice. The fact that crystal methylamphetamine is smoked, as opposed to being injected, removes one of the psychological barriers imposed by injecting drug use. Ice can create an intense and rapid high generated by this method of administration, and it creates corresponding severe and adverse reactions when the effect wears off.³⁹³

As suggested by Ms Lind, the increase in demand for the crystal methamphetamine may be linked to the fact that the drug can be smoked, compared to other more invasive methods of administration such as injecting. Furthermore, the psychopharmacological properties allow users to experience more immediate effects compared to other forms of methamphetamine. Stable prices and easy availability are also likely contributors to increases in demand and use.

The submission from the ACC also indicated that a range of criminal activities have been linked to the manufacture and use of methamphetamine.³⁹⁴ In particular, the link between regular and heavy users of methamphetamine and property crime was identified:

Results from a New South Wales Bureau of Crime Statistics research study using regression modelling revealed that heavy users of amphetamine — who reported at least 16 days of use in the month prior to arrest — had 53 percent more property charges recorded at arrest compared to detainees who were less frequent users and non-users. Higher rates of property offences among methylamphetamine users were also associated with younger individuals, being unemployed and having reported illicit use of benzodiazepines in the 30 days prior to arrest.³⁹⁵

The ACC also highlighted issues involving corruption and infiltration within methamphetamine markets by outlaw motor cycle gangs (OCGs) to facilitate criminal activity:

A number of organised crime groups in the methylamphetamine market have been linked to murders and violent assaults to protect or increase their market share, or for reasons unrelated to their drug manufacture and supply. In the latter case, the motivations have included personal revenge, and on occasions the only link to the methylamphetamine market was that this was the context in which the criminals first became associated. Extortion is another potentially violent activity in which groups represented in the methylamphetamine market have regularly come to notice.³⁹⁶

Police detainees — AIC's Drug Use Monitoring in Australia (DUMA) program

Since 1999, the AIC's DUMA program has collected and monitored Australian drug use and crime data. Data is collected via an interviewer-assisted self-report questionnaire administered to Australian police detainees on a quarterly basis and through the collection of a voluntary urine sample (for details on the methodology of DUMA see Chapter 5).

392 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

393 Ms Judith Lind, Executive Director, Australian Crime Commission, Public Hearing, Canberra, 10 February 2014.

394 The ACC uses the terms methamphetamine and methylamphetamine interchangeably.

395 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

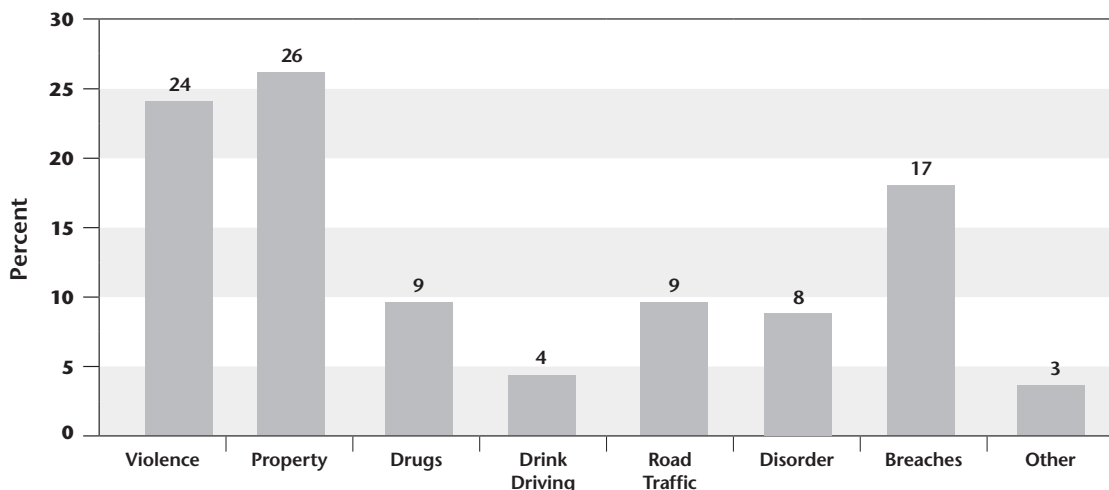
396 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

An examination of national data

Figure 8.2 shows the percentage of criminal charges alleged against detainees testing positive to methamphetamine in the national detainee sample that fell into each charge classification. The data shown encompasses the period of 1999 to 2012. The police stations and watch-houses involved in DUMA data collections varied during this period. Detainees could have multiple charges recorded against them. Charges were classified as violent, property, drug, drink driving, traffic, disorder and breach offences. Charges not otherwise classified were recorded as 'other offences'. During the 1999 to 2012 period, 20,402 police detainees tested positive to methamphetamine. The highest proportion of charges recorded against these detainees were property offences (26%) followed by violence offences (24%), breaches of criminal justice orders (17%), drug offences and traffic offences (both 9%).

Nationally, property offences constituted the highest proportion of charges for which methamphetamine users were being held by police. This is consistent with findings from the New South Wales Bureau of Crime Statistics and Research, referred to in the ACC submission. Violent charges were the second most common charge recorded against methamphetamine users.

Figure 8.2: Percentage of charges by offence classification for Australian police detainees who tested positive to methamphetamine, 1999–2012



Notes:

The number of detainees tested varies across sites.

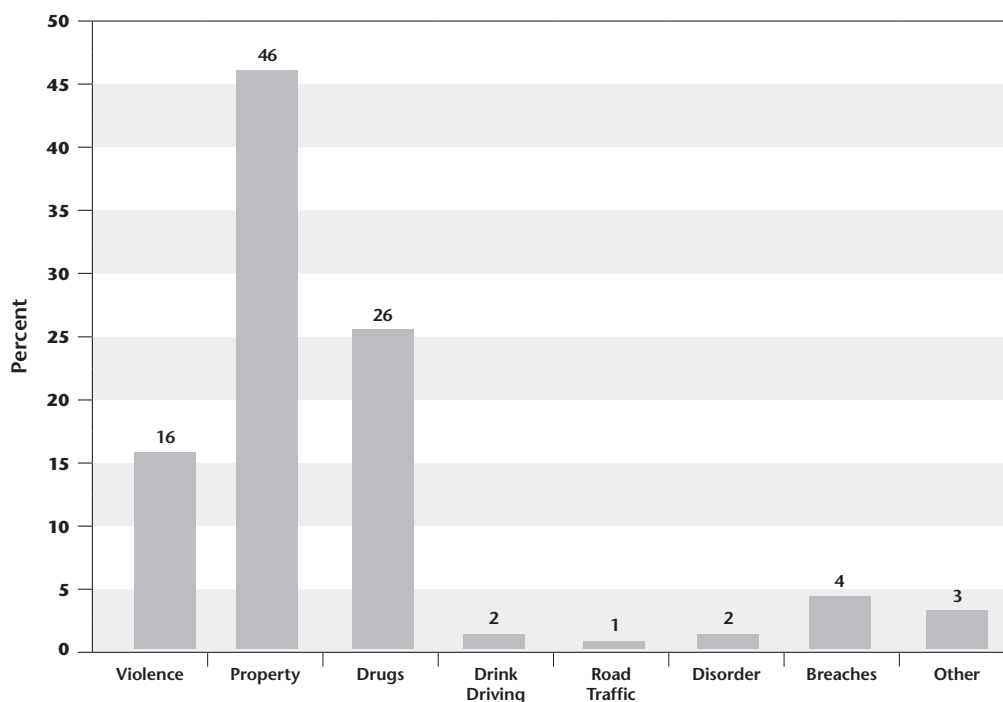
A detainee could be charged with one or multiple offences.

Source: AIC DUMA collection 1999–2012 (computer file).

A comparison between national and Victorian data collected on a quarterly basis from 2006 to 2012 (inclusive)

As indicated in the discussion of prevalence (Chapter 5), 736 detainees interviewed at Footscray Police Station between 2006 and 2012 tested positive to methamphetamine. Figure 8.3 shows the percentage of criminal charges that fell into each charge classification for Footscray detainees who tested positive to methamphetamine. As with the national data, police detainees could have multiple charges recorded against them. Consistent with the national data, property offences constitute the highest proportion of offences recorded (26%), however this proportion was smaller in magnitude to that recorded nationally (46%). Unlike the national data, in Footscray the second most common offence recorded was drug charges (26%) followed by violent offence charges (16%).

Figure 8.3: Percentage of charges by offence classification for Footscray detainees who tested positive for methamphetamine, 2006-2012



Notes:

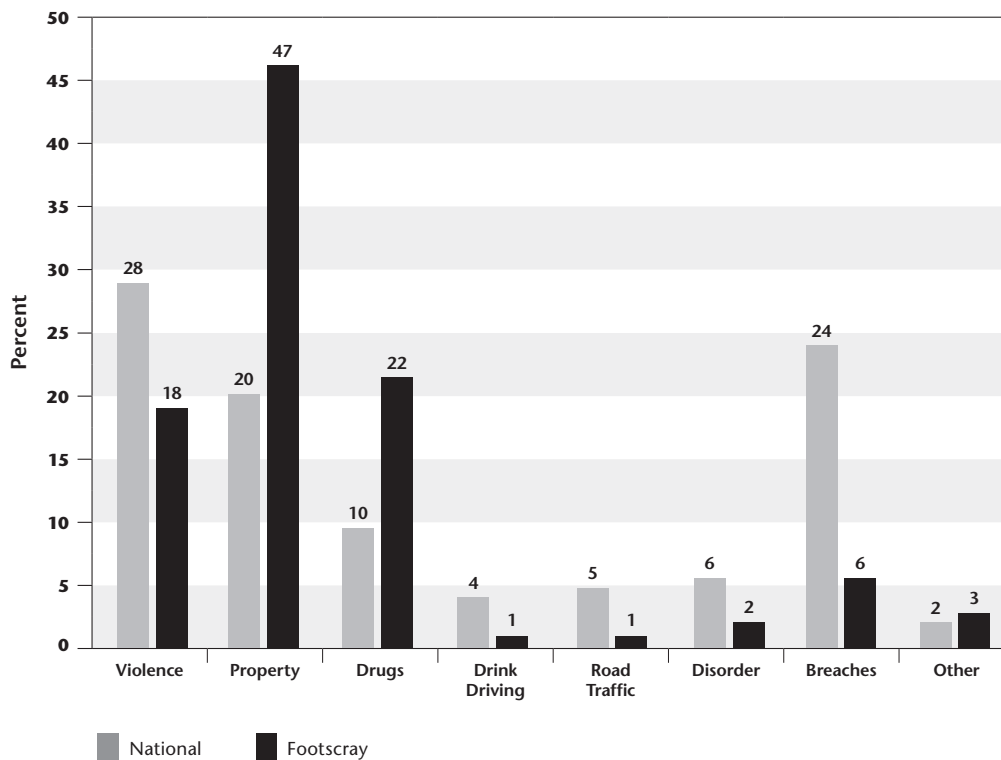
The number of detainees tested varies across sites.
 A detainee could be charged with one or multiple offences.

Source: AIC DUMA collection 1999–2012 (computer file).

A comparison between national and Victorian data for 2012

To control for any changes in prevalence of methamphetamine use and offending over time, the national and Footscray comparison was repeated using only data from 2012, the most recent year for which data had been collected. Figure 8.4 shows the percentage of criminal charges that fell into each charge classification for detainees testing positive to methamphetamine at Footscray Police Station and in the national sample.

Figure 8.4: Percentage of charges by offence classification for Footscray and National methamphetamine using detainee samples, 2012



Notes:

The number of detainees tested varies across sites.

A detainee could be charged with one or multiple offences.

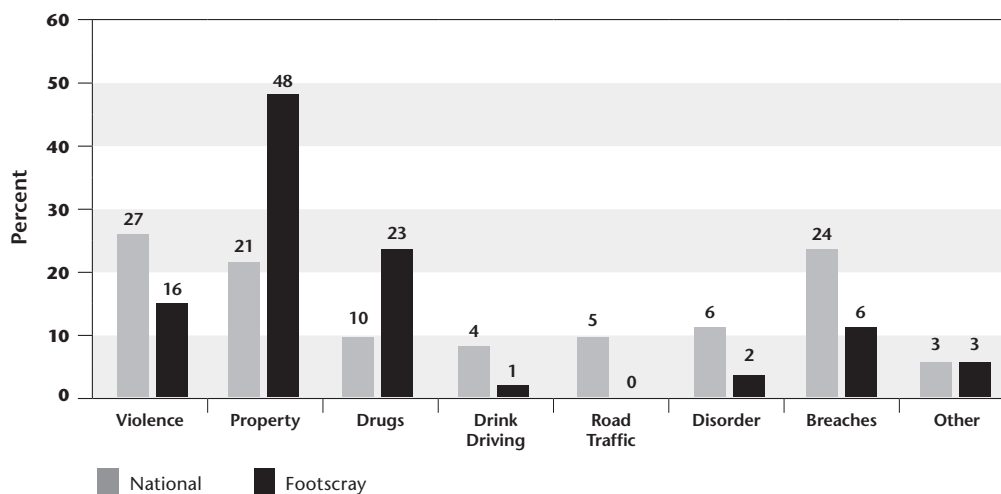
Source: AIC DUMA collection 1999–2012 (computer file).

In 2012, 2,552 detainees nationally and 204 detainees from Footscray tested positive to methamphetamine. Property offences (47%) constitute the highest proportion of charges recorded against methamphetamine-using detainees interviewed at Footscray whereas violent offences (28%) constitute the highest proportion of offences among the national sample of methamphetamine using detainees. Property offence charges were the most prevalent charge recorded for the national detainee sample across the 2006-2012 period (26%). The decrease in prevalence of property charges in the national methamphetamine using sample, from the 2006-2012 to the 2012 period, may suggest that one or more Australian states, other than Victoria, recorded decreased levels of property offending for methamphetamine users over this period. In 2012, the difference in prevalence between drug (22%) and violent offence (18%) charges among methamphetamine-using Footscray detainees has narrowed, from the 10 percent difference observed in the 2006-2012 data.

Comparison between offending patterns for methamphetamine users and heroin users

To assess whether the pattern of offending for methamphetamine users differs from that of other illicit drug users, a comparison of charges was conducted between detainees who tested positive to methamphetamine and those that tested positive to heroin in 2012 for both Footscray and national samples. The percentage of criminal charges alleged against detainees testing positive to heroin at Footscray Police Station and in the national sample that fell into each charge classification are presented in Figure 8.5.

Figure 8.5: Percentage of charges by offence classification for Footscray and National heroin using detainee samples, 2012



Notes:

The number of detainees tested varies across sites.
 A detainee could be charged with one or multiple offences.

Source: AIC DUMA collection 1999–2012 (computer file).

In 2012, 2,552 national detainees and 204 from Footscray tested positive to heroin. There was little difference in the prevalence of offence types for heroin and methamphetamine-using detainees. Nationally, the highest proportion of charges against heroin-using detainees were violent offences (27% compared to 28% for methamphetamine), followed by breach (24% for both drugs) and property offences (21% as compared to 20% for methamphetamine). Similarly, for Footscray, there was little difference in the prevalence of offence type for heroin and methamphetamine users. Property offences were the most common offence type recorded for both heroin (48%) and methamphetamine (47%) using detainees, followed by violent offences (16% for heroin and 18% for methamphetamine) and drug offences (23% for heroin and 22% for methamphetamine). In conclusion, results from the DUMA program demonstrate that, nationally, methamphetamine users were charged with a high proportion of property and violent offences. For Footscray, property and drug offences were the most common charges recorded for methamphetamine users, closely followed by violent offence charges. Variations in patterns of offending for methamphetamine users across time or between national and Victorian samples may reflect differences in offending patterns between the samples. Alternatively, it may be a sign of differences in local drug market conditions, local police practices or the targeting of particular forms of criminal offending in the local community.

ATS-related criminal activity statistics (Victoria Police)

Victoria Police provided the Committee with statistics on ATS-related criminal activity including offences by crime type and results from random roadside drug testing operations. The latter were presented above in the discussion of road trauma, drugs and driving.

Using Victoria Police Crime Statistics and modelling based on the DUMA data which provides an assessment of the proportion of crime attributable to the use of particular drug types, Victoria Police indicated that in Victoria in 2012-13, 6.9 percent of total offences could be attributed to ATS use.³⁹⁷ Table 8.3 shows the the percentage of offences in different crime categories that were attributable to amphetamines.

Table 8.3: Percentage of different types of offences that were attributable to ATS in 2012-13.

Offence type	Percentage
Arson	15.38
Burglary (residence)	13.8
Theft (shops/steal)	11.29
Robbery	10.3
Property damage	9.68
Assault	6.98

Source: Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

In relation to homicide, a different methodology compared to DUMA was used by Victoria Police to estimate the percentage of homicides that involved ATS. A detailed investigation by Victoria Police of individual cases, as opposed to extrapolation, found that in 2012-13, ATS/crystal methamphetamine was present in 21.2 percent of homicide investigations (22 out of 104 investigations), and until November 2013, this percentage had risen to 34.5 percent (10 out of 29 investigations).³⁹⁸

Table 8.4 shows the number of offences for the years 2008 to 2013 that were attributable to ATS, for dependent and non-dependent users. It is apparent that the greatest variation between dependent and non-dependent users related to robbery offences. All offenders who committed arson were dependent ATS users and amongst those who perpetrated property damage, a substantial number were dependent as well. Generally, the proportion of dependent to non-dependent ATS-attributable offenders remained constant between 2008 and 2013.

³⁹⁷ Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

³⁹⁸ Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

Table 8.4: Number of different types of offences that are attributable to ATS (by year), 2008–2013

Year	Robbery		Assault		Arson	
	Dependent	Non-Dependent	Dependent	Non-Dependent	Dependent	Non-Dependent
2008	367.4	3.7	2252.9	211.8	537.2	0.0
2009	351.3	3.5	2416.0	227.1	497.9	0.0
2010	340.1	3.4	2481.3	233.2	458.6	0.0
2011	372.0	3.7	2689.6	252.8	439.9	0.0
2012	342.9	3.5	3150.6	296.2	486.6	0.0
2013	297.1	3.0	3259.0	306.4	477.5	0.0

Year	Burglary		Theft		Property Damage	
	Dependent	Non-Dependent	Dependent	Non-Dependent	Dependent	Non-Dependent
2008	6640.8	899.9	10515.6	1056.8	5190.9	284.2
2009	6060.8	821.3	9335.9	938.2	5278.1	289.0
2010	5940.2	804.9	8928.8	897.3	4789.9	262.3
2011	5816.1	788.1	8922.8	896.7	4642.6	254.2
2012	6305.1	854.4	9581.6	962.9	4613.8	252.6
2013	5970.3	809.0	8669.3	871.2	4375.2	239.5

Note: Data provided by DHI (Drug Harm Index) factors for amphetamines. A breakdown by gender or age was unavailable.

Source: Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

Academic research

Use of violence by criminal syndicates involved in methamphetamine supply in Australia

A study by Ritter, Bright and Gong (2012) based on anecdotal accounts from Australian law enforcement officers, stated that there is evidence of violent acts, such as physical violence, abductions and threats, being committed at the retail level of the methamphetamine market. At lower levels of the market, violence appears to be primarily used as a means to elicit payment for outstanding drug debts. Little evidence was provided of the presence, or lack thereof, of violence in upper levels of the market (Ritter, Bright & Gong 2012). International studies have also reported that violence is present at lower market levels, such as retail levels, where it is used as a means of gaining respect (Curtis & Wendel 2007; Matrix Knowledge Group 2007). Engagement in violence at higher levels of the drug market may not be as common due to being viewed as counter-productive to the business enterprise (Curtis & Wendel 2007; Matrix Knowledge Group 2007).

Comparison between methamphetamine and heroin users' experiences of victimisation and engagement in violence

In a Sydney-based sample of heroin and methamphetamine users, increased frequency of use of methamphetamine was associated with a rise in risk of violent offending in the previous 12 months (Torok et al. 2008). Over 80 percent of methamphetamine users (n=118) interviewed by Torok and colleagues reported engagement in violent offending in their lifetime, with 51 percent of users reporting violent offending in the previous 12 months.

Methamphetamine users (50%; n=118) reported significantly higher engagement in violent crime in the previous 12 months than did heroin users (40%; n=161). If engagement in the illicit drug market solely drives the rise in violent offending then this difference between substance users would not be expected. The majority of violent crimes were reported to have been committed against drug-using acquaintances (59%). Furthermore, when heroin and methamphetamine user reports of having experienced violent victimisation were examined, engagement in the illicit drug market was identified as a risk factor for experiencing victimisation. Methamphetamine use was not identified as a risk factor for experiencing victimisation (Torok et al. 2008).

Methamphetamine use and criminal offending: Australian methamphetamine using sample

In its submission the Burnet Institute discussed the findings of the UnMet study, a study involving a sample of 255 methamphetamine users who were recruited during 2010 and were followed up one year later during 2011:

... over half of the UnMet sample had previously been in contact with the criminal justice system at recruitment, 41% reported arrest in the previous year and 38% reported ever having been in prison. Over half (55%) of the UnMet sample reported engaging in drug dealing and/or property crime (35%) in the month prior to recruitment, however only a very small minority (three percent) reported committing a violent offence in that time.³⁹⁹

The submission also explained that the Burnet Institute had recently examined variables associated with criminal offending in a sample of people who inject drugs (PWID). The sample was recruited as part of the Illicit Drug Reporting System (IDRS) in the 2002–2010 period. Crystal methamphetamine injection in the previous six months was not associated with past-month self-reported violent crime or property crime, and had only a small but statistically significant association with recent drug dealing.⁴⁰⁰

Ecstasy and Related Drugs Reporting System (EDRS) Data

As noted in Chapter 5, the Ecstasy and Related Drug Reporting System (EDRS) entails surveys of regular ecstasy users (REU), surveys with key experts who have contact with REUs due to the nature of their work, and an analysis of existing national and state-based data sources that contain information on ecstasy and related drugs, including methamphetamine and crystal methamphetamine. It provides data on drug market characteristics of availability, place of use and purity and associated harms based on the survey responses (Sindicich & Burns 2014).

The survey conducted in 2013 found that 34 percent of the national sample reported engaging in some form of criminal activity in the month prior to interview (Table 8.5). In Victoria, 26 percent reported engaging in some form of criminal activity in the month prior to interview. Sindicich & Burns reported the following national data:

A fifth (21%) of the national sample reported that they had dealt drugs in the last month and, of these, two-thirds (67%) reported doing so less than once per week, 9% once per week, 13% more than once per week but less than daily, and 11% reported dealing on a daily basis. Seventeen percent of the national sample reported that they had committed a property crime in the last month and, of those, the majority (70%) reported doing so less than once per week, 15% once per week, 10% more than once per week but less than daily, and 4% reported property crime on a daily basis. Three percent (n=17) reported committing a violent crime in the past month. Three percent (n=17) reported having committed fraud in the month prior to interview (Sindicich & Burns 2014, p.131).

399 Professor Paul Dietze, Deputy Director, Centre for Population Health, Burnet Institute, Submission, 21 October 2013.

400 Professor Paul Dietze, Deputy Director, Centre for Population Health, Burnet Institute, Submission, 21 October 2013.

Table 8.5: Criminal activity among regular psychostimulant users (RPU), 2013

National (%)	National									
	2012 N=607	2013 N=686	NSW n=100	ACT n=77	VIC n=100	TAS n=76	SA n=100	WA n=100	NT n=45	QLD n=88
In the last month										
Any crime	38	34	34	46	26	34	32	42	13	34
Drug Dealing	26	21	18	17	18	21	22	25	7	31
Property crime	17	17	22	35	12	18	7	25	7	8
Fraud	3	3	0	9	2	3	3	2	2	2
Violent crime	5	3	3	4	0	3	4	3	2	1

Source: Sindicich & Burns (2014, p.131).

Methamphetamine use and violent offending: United States Parolee sample

Cartier, Farabee and Prendergast (2006) reported in a United States sample of state prison parolees (N=641) that methamphetamine use was a significant predictor of self-reported violent criminal behaviour and criminal offending in the 12 month post-release period. However, methamphetamine use was not a significant predictor of incarceration for a violent crime within 12-months of release. Violent offences were classified in this study as murder, manslaughter, robbery, or assault. The violent, or non-violent, nature in which other offence categories were committed was not assessed. This may explain why methamphetamine use predicted self-reported violent criminal behaviour but not return to custody for violent offences. Involvement in the drug trade through participation in sale, distribution or manufacturing of drugs was controlled for in this study.

Methamphetamine use and violence offending: International non-criminal justice samples

Baskin-Sommers and Sommers (2006) examined methamphetamine use and violence in a Los Angeles sample of young adults (N=106), aged between 18 and 25 years. The study reported that 34.9 percent of adolescents (N=37), two-thirds of whom were male, had committed violence while under the influence of methamphetamine. The 37 respondents who reported committing methamphetamine-related violence reported a total of 54 violent events. The most common form of violence reported involved domestic relationships (33 events), followed by drug-related violence (9 events) and gang-related violence (7 events). A small proportion of the violent acts were classified as random attacks (5 events). A Canadian study of at-risk youths (N=478), reported that daily methamphetamine use was not associated with perpetrating violence, with only 17.6 percent of methamphetamine users reporting assaulting someone (Martin, Palepu, Wood, Li, Montaner & Kerr, 2009). The inconsistency in the Baskin-Sommers and Sommers (2006) and Martin et al. (2009) findings may arise, in part, from the time period over which methamphetamine-related violence was considered, with ever engagement and engagement in the previous 6-month period considered respectively. Violence was defined as physical harm or attack in both studies.

The role of methamphetamine-induced psychotic symptoms in violent offending

Recent research has examined whether violent behaviour associated with methamphetamine use may be a result of methamphetamine-induced psychotic symptoms. That is, whether there is evidence that violence arising from methamphetamine use can be explained through the psychopharmacological violence model. In 2014, McKetin, Lubman, Najman, Dawe, Butterworth & Baker examined engagement in violent behaviour in a sample of

278 participants aged 16 years and older from Sydney and Brisbane, who met the DSM-IV criteria for methamphetamine dependence but not lifetime schizophrenia or mania when they entered the study. McKetin et al. (2014) examined the influence of the dosage of methamphetamine used and its relationship to violence and reported that:

There was a dose-related increase in violent behaviour when an individual was using methamphetamine compared with when they were not after adjusting for other substance use and sociodemographics... The odds of violent behaviour were further increased by psychotic symptoms...which accounted for 22-30% of violent behaviour related to methamphetamine use. Heavy alcohol consumption also increased the risk of violent behaviour (p.798).

Consistent with this, Brecht and Herberk (2013) reported in a sample of United States based dependent methamphetamine users (N=350) who were in treatment, that user perceptions of engagement in methamphetamine-related violence were stronger for those reporting the most severe methamphetamine-related problems, such as paranoia. Lapworth, Dawe, Davis, Kavanagh, Young & Saunders (2009) suggested that it was through an increase in the presence of positive psychotic symptoms that methamphetamine users experienced greater hostility and impulsivity with positive psychotic symptoms contributing to a perception of the environment as hostile and threatening (Lapworth 2011). Methamphetamine users with a high number of positive symptoms and who are high in impulsivity were identified as the most hostile. In sum, these findings suggest that violence is associated with methamphetamine use through, or in an interaction with, short and long-term psychological effects of substance use.

Two key factors that may confound the association between methamphetamine and violent offending, and which have not been adequately controlled for or addressed in a number of the studies reviewed, are individual differences, such as an individual's natural tendency towards aggression, and social, situational and contextual features.

Influence of individual differences

Individual differences in levels of aggression may contribute to variations in engagement in violent offending among methamphetamine users. In an attempt to tease apart the relative contribution of methamphetamine use and users base-line levels (i.e. natural tendency towards) of aggression, Sommers and Baskin (2006) examined instances of violent behaviour *after* initiation of methamphetamine use with convictions for violent crime and self-reported violent behaviour *before* initiation. They found that previous substance-related violence and childhood fighting were significant predictors of methamphetamine-related violence. This finding suggests that the risk of engagement in methamphetamine-related violence is elevated for those with a history of violence or aggression. However, 36.4 percent of respondents who had committed methamphetamine-related violence (n=55) reported no prior commission of violent offences, suggesting that prior aggression alone does not fully account for risk of engagement in methamphetamine-related violence.

Individual differences are also observed in the short and long-term effects of intoxication and withdrawal for a given frequency of use and methamphetamine dose. Substance potency, method of ingestion and substance dependence alter metabolism rates for individual users and thus the physical and psychological effects (Scott, Woods, Matt, Meyer, Heaton, Atkinson & Grant, 2007). The cumulative physiological and psychological effects associated with intoxication and dependence on multiple substances also remain unclear. Noting that a substantial proportion of methamphetamine users are poly-drug users this may provide a source of variation in aggression levels displayed among methamphetamine users (see Chapter 10).

Influence of social, situational and contextual features

The intoxication effects and behavioural outcomes of drug use are proposed to be influenced by both the characteristics of the individual, such as personality, tendency towards aggression and presence of mental illness, and features of the environment (Sommers & Baskin 2006; Gizzi & Gerkin 2010; Embry, Hankins, Biglan & Boyles 2009).

Dr Rebecca McKetin's comments to the Inquiry in February 2014 explain how social, situational and contextual features may interact with effects of methamphetamine use to result in an increase in aggression and violent behaviour.⁴⁰¹

I am going to preface what I say by saying that obviously there are contextual factors that provoke violence; it is not like someone is going to jump up and suddenly start banging their head on the wall. Having said that, that is actually what happens in some cases. The drug does seem to have a physiological effect, and because it stimulates the person, if there is a violent situation they have more energy to respond and they feel more aggressive, more confident, more arrogant, if you like, more cocky and less inhibited.

There is also an issue with chronic use of the drug in that it deregulates the brain chemicals that are involved with controlling our emotions. Even though we do not have a good handle on the physiology underlying methamphetamine-related violence, it seems to be that chronic users have a decrement in serotonin. It has been shown that that happens in their frontal lobes, and that then is correlated with the level of violence that you see in that population. So you have chronic changes in the brain from the drug, and then you have the drug on top of that, which is increasing dopamine — that is, the stimulating, active drug. If you then add that to the context, where you might have someone who is carrying a drug and they are frightened of losing it or they might be having a terse interaction with someone over a deal that has gone wrong, they are in an environment where there are weapons and there is a lot of hostility and they are also the type of person — a lot of people who are heavily involved with drug use have a predilection towards violent behaviour in any case — all of these factors come together.

Then you have the paranoia, which is just the icing on the cake, so you have somebody who not only is quite hyped up and has chronic changes in their brain from using the drug that mean they are unable to regulate their emotions — they have all of the contextual factors there — but then they also have this delusional belief going on that you are out to get them; they are disinhibited. All of these things come together.⁴⁰²

Evidence presented to the Committee in hearings noted that the presence of alcohol in particular appeared to increase the risk of volatile interactions.⁴⁰³ A number of paramedic, ambulance, police and emergency department personnel, in their submissions to the Inquiry, voiced concern that alcohol was a dangerous and potent drug in terms of causing violent and aggressive behaviour.⁴⁰⁴

401 Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

402 Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

403 Associate Professor Tony Walker, General Manager, Regional Services, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013; Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

404 For example, Associate Professor Tony Walker, General Manager, Regional Services, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013.

Conclusion

The evidence suggests a degree of support for the assertion that there is an increased risk of violence associated with methamphetamine use. This elevated risk of violence and aggression may, in many cases, not rise to a level sufficient to constitute violent offending. However, methamphetamine use does appear to be associated with criminal offending more generally, in particular property and drug-related offences.

A number of studies suggest that the association between methamphetamine use and violence may be mediated or moderated by the presence of psychotic symptoms. That is, methamphetamine use may lead to psychotic symptoms, which in turn, elevate risk of violent behaviour. Alternatively, short and long-term effects of methamphetamine use may interact with psychotic symptoms to produce an increased risk of violent behaviour. If established, such associations would account for why persons in close proximity to methamphetamine users, and users themselves, report methamphetamine-related aggression and violent behaviour but why a rise in violence is not consistently observed. This may prove a fruitful area for further research.

The influence of social, situational and contextual features may also partially account for differences in the reports of front-line personnel and health-care personnel, who are not involved in emergency care, about the frequency of aggression in interactions with methamphetamine users. It may be the case that provocation from others, or elements of the physical environment, may elicit a reaction of heightened aggression from individuals experiencing symptoms of acute methamphetamine intoxication (Brecht & Herberk 2013; McKetin, McLaren, Riddell & Robins 2006).

PART D

The Patterns, Culture and Profiles of Methamphetamine Use

9. The Patterns of Methamphetamine Use

Introduction

Drug use is influenced by many factors in addition to the pharmacological properties of the drug. The patterns of methamphetamine use comprise the rituals, 'culture' and 'natural history' of the drug, including such matters as how the drug is administered and the trajectory of drug use over time. This for example might include the possible transition period from first time or occasional use to dependent use. Patterns of drug use may also vary depending on the profile of the user. However, there is no single profile of a methamphetamine user. The reasons a person may use ice and the way in which the drug is used will vary according to a number of factors including the person's gender, ethnicity, age and socioeconomic background. Moreover, the setting or social context in which the drug is used; the culture or ritual associated with the drug's use; and the meaning ascribed to the drug's use by the user are also extremely important aspects of the patterns of methamphetamine use (Ryder, Salmon & Walker 2001).

Patterns of methamphetamine use

Depending on the context in which the use takes place, there are considerable variations in the patterns of methamphetamine use between individuals. Patterns of drug use are also remarkably diverse throughout Australia, including between metropolitan and rural and regional areas (McKetin et al. 2012a).

Lee et al. have outlined six discrete patterns of methamphetamine use each with their own reasons as to why people may use the drug. These are referred to in Table 9.1:

Table 9.1: Patterns of methamphetamine use

<p><i>Experimental use</i></p> <p>Experimental methamphetamine use generally occurs in late adolescence/early adulthood and is typically short lived. Experimental use is motivated by curiosity to experience new feelings/moods or as a result of influence from peers.</p> <p><i>Recreational use</i></p> <p>Recreational methamphetamine use usually occurs in a social setting. The amount and duration of use may vary depending on the occasion. Recreational use is perceived as enjoyable with few negative consequences or effects on social functioning. Methamphetamine is frequently used on a recreational basis, where users limit their use to the weekend or special occasions.</p> <p><i>Circumstantial/Situational use</i></p> <p>Circumstantial (or situational) methamphetamine use occurs when specific tasks have to be performed, which may require special degrees of alertness or endurance. Examples of this include long distance driving or shift work. Circumstantial methamphetamine use may also serve a specific function, such as suppressing appetite and promoting weight loss.</p> <p><i>Intermittent or binge use</i></p> <p>Intermittent or 'binge' use, occurs when methamphetamine are used intensively for a long period of time, anywhere from two to ten days, with significant breaks in between these intense periods of use.</p> <p><i>Regular use</i></p> <p>Regular use is characterised by frequent, habitual use and is often accompanied by a physical and/or psychological dependence syndrome. For regular users, methamphetamine plays a significant role in their day-to-day life and may impair or impact on health, psychological or occupational functioning. Approximately 3% of methamphetamine users will use on a regular basis. This is often in the context of polydrug use, where methamphetamine may be used in combination with other drugs such as alcohol, cannabis or other psychostimulant drugs including ecstasy.</p> <p><i>Polydrug use</i></p> <p>Polydrug use is very common amongst methamphetamine users, with alcohol, cannabis and other psychostimulant drugs (such as ecstasy) being the most frequently used drugs in combination with methamphetamine. Users may do this to enhance or prolong the effects of methamphetamine, or to alleviate unpleasant side effects.</p>
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Source Lee et al. 2007, p.4.

The importance of context

In discussing the patterns of methamphetamine use, an understanding of the context in which it takes place is important '[a]s it shapes the way in which methamphetamine are understood and experienced' (Dwyer et al. 2012, p.56). Lee et al., for example, have described context as crucial in understanding each of the drug use patterns outlined in Table 9.1. An appreciation of context also explains *why* different populations may use methamphetamine; the consequences of use including drug-related harms; and why some people (but not others) may move from one pattern of use to another, for example occasional to chronic or dependent use (Ryder, Salmon & Walker 2001).

One of the most formative and influential theorists to discuss the importance of understanding drug use from a patterns and social context perspective was Norman Zinberg (1979, 1984). Zinberg noted that policy development in the field of drugs had to take into account the contextual variables of 'drug, set and setting'. The concept of 'drug', 'set' and 'setting' is of primary importance in determining why different user groups may administer a particular substance.

Zinberg's approach is summarised by d'Abbs and MacLean:

By these [concepts] Zinberg means: the pharmacological-toxicological properties of the substance (drug); the attributes of persons using the substance, such as personality and physical health (set); and aspects of the social and physical environment in which consumption occurs (setting). No intervention strategy is likely to ameliorate [substance abuse] and the problems associated with it unless it addresses each of these factors, and the interrelated effects engendered by them.⁴⁰⁵ This does not mean that a single program must attempt to bring about change in all three domains, even if it could do so. However, it does mean that any intervention strategy, of which particular programs will form a part, must begin by identifying the factors in each of these domains that shape the usage patterns and consequences [of substance abuse and drug taking] (d'Abbs & MacLean 2000, p.v).

The properties of methamphetamine (the 'drug') have largely been discussed in Chapter 3; this chapter deals with both the profiles of various users (the set) and the context in which they may use (the setting). An appreciation of this discussion is also important for the development of policy and strategy. For example, understanding that a person in the workplace (setting) uses methamphetamine (the drug) as an aid to assist his energy or work performance (set), enables interventions to be developed addressed at drug abuse in the workplace.

Settings, culture and ritual

Some users of methamphetamine may use by themselves.⁴⁰⁶ However, research suggests that at least in the early stages of use, the drug is often consumed within group settings.

For example, in McKetin, Kelly and McLaren's study of Sydney methamphetamine users a 'typical' methamphetamine use occasion:

[c]onsisted of taking a point of ice or base or half a gram of powder. Methamphetamine users took the drug at home in the company of their friends, partners and/or acquaintances. They would often take the drug before going out to socialise, but many would also take the drug simply to enjoy its effects and would carry on with their usual activities or pastimes. It was uncommon for methamphetamine users to take the drug specifically to work or study (2006, p.xvi).

Recent data from the Australian Institute of Health and Welfare also indicates that the use of methamphetamine often takes place in the context of social activity. Table 9.2 for instance shows the locations at which recent users of methamphetamine took the drug. In 2013 over 55% of the users surveyed had methamphetamine at a party and 64% had taken it at a friend's house, with 36% taking it in a pub, club or licensed premises and 30.5% taking it at a rave. There had been a decline in the percentage of people who used methamphetamine in their own home, from 49% in 2004 to 38% in 2013, which suggests that using methamphetamine is more likely to be a social activity than a solitary one.

405 Although d'Abbs and MacLean are discussing Zinberg's theories in the context of volatile substance abuse, their views are equally applicable to other forms of licit and illicit drug taking.

406 This may particularly be the case for older users or users who are relatively well advanced in their drug taking 'history'. Use patterns also tend to become 'less social' and more frequent with the progression to dependence (McKetin et al. 2013b, p.693).

Table 9.2: Places at which recent users usually use meth/amphetamine, 2004 to 2013

	Victoria				Australia			
	2004	2007	2010	2013	2004	2007	2010	2013
In my own home	48.5	49.9	41.9	37.7	47.2	53.9	47.1	46.5
Friend's house	54.9	46.3	50.3	63.4	53.0	51.9	53.5	59.0
At a party	42.0	57.6	54.0	55.3	49.6	52.5	50.4	46.9
At a rave/dance party	53.4	46.3	35.6	30.5	46.1	39.0	35.3	26.8#
At licensed premises (e.g. pubs/clubs)	45.9	53.0	45.4	35.9	45.5	39.6	39.6	24.5#
In a car	21.6	26.0	20.3	19.3*	18.3	21.0	16.1	15.6
Somewhere else	23.2	11.6*	8.9*	19.7*	18.0	19.3	12.1	12.1

Note:

* RSE>25% but <50%, estimate should be interpreted with caution

Statistically significant change between 2010 and 2013.

Source: Mr Geoff Neideck, Head, Housing Homelessness and Drugs Group, Australian Institute of Health and Welfare, correspondence, 21 July 2014.

This 'social' pattern of methamphetamine use can be very different from other drugs. The use of the drug, including the sharing of the drug with friends, may take place over a much longer period of time than for drugs such as heroin. As Dr Roger Volk told the Committee:

An episode of ice use looks so different from an episode of heroin use or alcohol use, which can be self-limiting, self-defining. An ice episode use can go on for days. Someone will stay awake for days, and then they will crash and then they will sleep for three days.⁴⁰⁷

The euphoria or 'rush' associated with methamphetamine, particularly in the company of others, has been reported as being a particularly attractive aspect of using the drug. As one respondent explained:

...I eventually had my first smoke [of methamphetamine]. And I was blown away... The euphoria I was feeling, feelings of wellbeing and of just being invincible. This feeling of closeness to everyone, and relating to people and talking, and having fun and dancing, and just a deep appreciation of everything in life. It was very weird and like I had a high self-esteem and I loved life and everything about it and exploring new things (McKetin, Kelly & McLaren 2006, p.85)

This type of experience, which Dr Roger Volk has called the 'drama of use' is in many instances far more intense (and ritualistic) than for comparable drugs such as heroin.⁴⁰⁸

For some cohorts of users, particularly older injecting users, taking methamphetamine may be as much about 'the ritual of the needle' as it is about the drug itself. For example, Angelo Pricolo from the Pharmacy Guild of Victoria told the Inquiry:

The older drug users are used to using speed, which was a less potent version, in a powder variety. That was more often than not injected. You still have a population that will inject that drug because that is what they are used to. And then of course there is a huge group who are just addicted to the needle and they will inject water. I have had eye drops stolen from the pharmacy and when I have talked to the guys

407 Dr Roger Volk, Forensic and Other Drugs Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

408 Dr Roger Volk, Forensic and Other Drugs Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

and said, 'What are you doing?', they have said, 'You don't understand. It's the needle. I'll inject water, if I have to. It's the needle'. So we are dealing with a group of people who have very particular needs.⁴⁰⁹

Smoking and sharing

Whilst these older users may inject methamphetamine, sometimes as an extension of an earlier heroin drug injecting history (McKetin et al. 2013b), younger people may view smoking as a 'superior' form of ingestion compared to injection; particularly as it is a mode of administration suited to group activity (McKetin et al. 2013b).⁴¹⁰ Its immediate effects and the fact that it can be smoked in a sharing and ritualistic manner make it attractive to friends using it in a recreational manner. For example, evidence has been given to the Committee that in some circles of friends a preferred mode of taking the drug is to sprinkle it on cannabis and then smoke it.⁴¹¹

Another reason young people or 'novice' drug users may prefer smoking as route of administration is that it does not have the fear associated with needle sharing and the associated risk of disease transmission (Groves & Marmo 2009; McKetin et al. 2013b). For 'drug snobs',⁴¹² it is also not a method which is associated with 'junkies' or hard core users.⁴¹³ Smoking, particularly in the opinion of young people, is not 'stigmatising' like injecting.⁴¹⁴ As Ms Kerry Donaldson from the Youth Support and Advocacy Service (YSAS) in Bendigo told the Committee:

[w]hat I am finding is that ice using groups are splitting [between occasional and problematic users]... because people who do not use ice in a problematic way cannot stand the behaviours of the ice addicts. The young people are saying, 'I am not going to hang out with them [dependent] users anymore, because they are irrational, they are schizzing all over the place, they are unpredictable and they are violent'. So the ice users are isolated again even within the drug-using culture, which is interesting.⁴¹⁵

YSAS also believed that because methamphetamine is most commonly smoked rather than injected, young people will be more easily initiated into using it. 'The likelihood is increased when young people either associate with others for whom smoking methamphetamine is common or for those who believe it is common among other young people'.⁴¹⁶

The academic literature has suggested that the use of amphetamine type stimulants (ATS) has become almost *normalised* in youth culture.⁴¹⁷ This has certainly been the case for so-

409 Mr Angelo Pricolo, Chair, Strategic Harm Minimisation in Pharmacy (SHarP) Advisory Group, Pharmacy Guild of Australia — Victoria, Public Hearing, Melbourne, 3 February 2014.

410 For example, a senior police officer in Mildura told the Committee that in his long experience of interacting with drug users throughout his career, heroin use is a more solitary or isolated activity compared to the 'sharing' nature of methamphetamine use.

See Superintendent Paul Naylor, Superintendent, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013.

On the sharing rituals of methamphetamine, particularly amongst young people, see also Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

411 Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

412 See Groves and Marmo 2009.

413 Earlier British research found that young people who orally ingested or smoked amphetamines distanced themselves from heroin users not only because of the 'dirty' nature of heroin but also because they associated heroin with injection. In other words, the negative perceptions were to do with both the content of the drug and the way in which it was used. One reinforced the other. Injecting use was also perceived as leading to addiction, rather than any properties associated with the drug itself (McElrath & McEvoy 2001).

414 Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

415 Ms Kerry Donaldson, Manager, Community Programs, Youth Support + Advocacy Service, Bendigo, Public Hearing, Bendigo, 25 October 2013.

416 Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS, Submission, 21 October 2013.

417 See also the discussion of the normalisation of drug taking in the context of youth culture in Chapter 13.

called ‘party drugs’ such as ecstasy in recent years. Evidence suggests, however, that it may also be increasingly occurring with methamphetamine, particularly when smoked.

Smoking methamphetamine has emerged as a popular youth trend... Departure from injecting and ‘pill popping’ has therefore further normalised methamphetamine within youth culture and provided a more accessible form that is readily available to young people as well as the gay community (Groves & Marmo 2009, p.420).

Similar observations were made by other witnesses. For example, Mr Zach Mason, a youth worker with Junction Support Services in Wodonga, stated in his evidence:

We do not have a lot of clients that inject, they all smoke. It is kind of a transgression where injecting is seen as being a junkie or it is seen as doing something very serious, whereas it is a smooth transition from a cigarette or a joint to then go on and smoke one of these ice pipes.⁴¹⁸

Such comments suggest that because of this process of ‘normalisation’, some (young) people may view the smoking mode of administration as somewhat benign.⁴¹⁹ But according to evidence to this Inquiry one pattern of use can easily lead to another more dangerous mode.⁴²⁰

There appears to be two distinct cohorts of ice users in our community comprising of the heavy injecting poly-drug user who inject ice and the non-injecting drug users who smoke ice. The smoking of ‘ice’ among young recreational drug users would be the trend that warrants urgent attention. The smoking of ‘ice’ has the potential to introduce a young, less drug involved type of person into a more risky pattern of drug use.⁴²¹

Whilst smoking methamphetamine may be an increasingly normalised part of the drug taking experience, especially when used in group settings, this does not mean it is harmless behaviour. Caraniche, a psychology consulting firm specialising in drug and alcohol treatment services, argued that education programs on methamphetamine need to ‘[d]ispel the myth that smoking methamphetamine is safe and that use is not problematic until it is intravenous, a common misconception among users in the early stages’.⁴²²

Changing patterns: Transitions in methamphetamine use

Notwithstanding this apparent division between (younger) smokers of methamphetamine and (older) injectors of the drug, many health workers who gave evidence to the Committee expressed concern that the pattern of smoking methamphetamine may facilitate a relatively speedy transition to injecting drug use.

For example, representatives of Youth Projects stated they were seeing young people taking methamphetamine at an increasingly early age. Such people were at risk of moving to ‘hard core injecting use’ at a relatively early age. This is very different to the patterns of heroin use they had hitherto seen whereby injecting and prolonged use did not start until

418 Mr Zach Mason, Youth Worker, Junction Support Services, Public Hearing, Wodonga, 24 February 2014.

419 For a discussion of the ‘normalisation’ of drug use, see discussion Chapter 13.

420 Some commentators have argued that whilst smoking may have inherent dangers of itself it is at least marginally a safer form of administration than injection. As such, some witnesses have argued the banning of smoke bongs or pipes is short-sighted as it may lead to greater use of injecting methamphetamine. See for example, Mr Simon Ruth, Director of Services, Victorian AIDS Council, Public Hearing, Melbourne, 14 October 2013. The merits or otherwise of this argument are discussed in Chapter 26 pertaining to harm reduction interventions.

421 Ms Elwyn Witney, Head of Counselling, Swan Hill District Health, Submission, 6 October 2013.

Interestingly, Lee et al. have stated that methamphetamine is the first drug ever injected by a majority of injecting drug users (2007, p.58).

422 Ms Jacinta Pollard, Managing Director, Caraniche, Submission, 21 October 2013.

See Chapter 6 for a discussion of the harms associated with smoking methamphetamine.

at least the mid-20s.⁴²³ Moreover, once people make a transition to more 'efficient' routes of administration, such as injecting, it is unlikely that they will revert to a less efficient pattern of taking the drug (McKetin, Kelly & McLaren 2006, p.80).

Witnesses have spoken of these 'patterns of transition' that may start with social or occasional use often amongst friends, and end in relatively entrenched and ultimately dependent behaviours. This was highlighted by Ms Philippa Northam of Junction Support Services:

How does the addiction start? Our clients have told us that ice use can begin as a social thing and that passing the pipe at a party is pretty commonplace these days. The report that while ice is often labelled as a party drug, they feel that relates more to the euphoric effect. They say that because you cannot legally smoke or inject ice, it is less associated with clubs and much more with parties and within the home. In this way it is becoming much more embedded in our social fabric as children are often exposed at home and obviously also their peers are exposed to ice use. Once hooked, the users that we spoke to said they build a community around their drug use. For example, they would make friends with the dealer's girlfriend in order to ensure they have a consistent supply.⁴²⁴

Concerns have also been expressed about a potential for the occasional use of methamphetamine to trend relatively quickly to dependent use. For example, Ms Cheryl Sobczyk from Bendigo Community Health Services commented that for many of the problematic methamphetamine users coming to her service the transition from occasional to dependent use was noticeable:

It appears recreational use does move into more dependent use sooner and quicker than with some of the other drugs people could use recreationally for a lot longer. Even with heroin use, I have known people who have used heroin recreationally for years and years. We are not seeing that same trend with ice... We are seeing an increased number of younger professionals, or younger tradespeople, coming through our service whom we had not actually seen before — so people who have been initiated [quickly] into this particular drug. These particular clients coming through our services are a new cohort of people we had not previously been seeing — not at the younger age. Quite often if people become longer term and dependent on drugs, they may access treatment when they are much older, but we are seeing people who have been initiated into using ice actually accessing treatment a little bit earlier.⁴²⁵

These patterns of transition are clearly of concern to people working in the field. The research literature, however, is less clear as to exactly why and how methamphetamine users may transit from occasional to dependent use (McKetin, Kelly & McLaren 2006, p.199).⁴²⁶

However, it is clear that patterns of use and the 'natural history' of methamphetamine use may vary depending on the population or profile group of those using the drug (McKetin et al. 2013b). These diverse profile groups of drug takers are discussed further in Chapters 11–14.

423 Ms Melanie Raymond, Chairperson, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

See also Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Public Hearing, Shepparton, 25 February 2014; Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014; Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol and Drug Association, Public Hearing, Melbourne, 14 October 2013; Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013. See chapter 9 for further discussion of the transition from non-injecting to injecting forms of the drug.

424 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Public Hearing, Wodonga, 24 February 2014.

425 Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013.

426 Indeed, academics have claimed that further and better research is required on the patterns of use for methamphetamine users. See Chapter 30 in the context of research needs.

Conclusion

Patterns and profiles of drug use, especially a drug such as methamphetamine, need to be understood within their social contexts and cultures and not merely be reduced to the drug's pharmacology. As Dwyer et al. note:

ATS effects are produced through the interactions of pharmacology, subjectivity, micro-contexts (eg. social relationships, symbolic meanings) and macro-contexts (broader social, cultural, political, economic and historical contexts) (2012, p.56).

The patterns of methamphetamine use are constantly changing. Evidence given to the Inquiry, for example, suggests that at least in Australia the social demographic of methamphetamine users is getting younger.⁴²⁷ Most methamphetamine use is seen among young adults and tends to consist of occasional non-injecting use that ceases as people mature in later adulthood (McKetin et al. 2013b, p.692). However, it is also true that in many cases the patterns of methamphetamine use will change over the life course with use patterns tending to become 'less social' and more frequent with, in some cases, a progression to dependence (McKetin et al. 2013b, p.693). Patterns of use may also vary according to the profile of the user and the context in which they use. There is, however, little comprehensive research being undertaken on the profiles of those who use methamphetamine, particularly with regard to women, Aboriginal people and people from culturally and linguistically diverse communities.⁴²⁸

Finally, methamphetamine needs to be understood in the social and cultural contexts in which it is used. As Dwyer et al. state:

[Methamphetamine] has been used therapeutically, productively, recreationally and problematically, by a range of social groups, across a variety of social settings, in multiple ways and for multiple purposes (2012, p.67).

Given the changing patterns of use and their social contexts, it is essential that there is further exploration of the pathways, trajectories and changing dynamics of methamphetamine use amongst discrete groups of users.

427 See for example, Ms Melanie Raymond, Chairperson, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

428 See discussion on research gaps with regard to methamphetamine in Chapter 30 of this Report.

10. Poly-Drug Use: Compounding the Issues

Introduction

Research into drug use patterns indicates that many users engage in the use of both licit and illicit drugs, rather than only using one drug type. Early research by Williams and Parker on methamphetamine and 'club drug' use in recreational settings found a strong correlation between drinking, smoking and illicit recreational drug use.⁴²⁹ However, the authors warn that poly-drug use is rarely sufficiently factored into research studies and policy analysis, which tend to focus on specific drug types:

[d]ue to the traditional separation of tobacco, alcohol and illegal drug use in terms of markets, policy and research foci there is little enquiry about combination or consecutive substance taking episodes. So official household surveys and even the national drug treatment data base do not allow poly-drug repertoires to be adequately recorded. Yet when we do enquire about poly drug use, we find high rates and when we profile drug users in treatment its presence is endemic... Given the warnings from the literature on drugs transitions across the adolescent–adult life course and the inter-relationship between tobacco, alcohol and illicit drug use this is a worrying omission with public health implications (Williams & Parker 2001, p.399).

A number of more recent research studies, whilst acknowledging this research focus on individual drug types, have indicated that many people, both recreational and dependent users, take methamphetamine as part of a suite of drugs they use. For example, McKetin, McLaren & Kelly's (2005) study of Sydney methamphetamine users found very high levels of poly-drug use amongst their respondents, with users having a median of 10 drug classes consumed in their lifetime and seven drug classes within the past year prior to the survey. Cannabis was the other primary drug of choice with 76 percent of methamphetamine users having smoked cannabis in the past month and 42 percent of users having smoked it daily.

Alcohol and tobacco use were also very common. Moreover, at least one in five users of methamphetamine in the study also used opioids such as a heroin on a daily basis and a similar number were on opioid substitution therapy (McKetin, McLaren & Kelly 2005).

Other studies have also demonstrated that methamphetamine users tend to be extensive poly-drug users, both of other stimulant substances (e.g. cocaine) and substances producing sedative effects, such as opioids and tranquilizers, which are often used to self-medicate against adverse effects of amphetamines (Herbeck et al. 2013). In a separate cross-sectional survey of 750 individuals conducted in three Australian capital cities in 2006, Kinner and Degenhardt (2008) found that:

Crystal methamphetamine users were distinguished from other methamphetamine users by their more extensive patterns of poly-drug use. As a group they were more frequent methamphetamine users, and were more likely to have initiated use earlier. Non-smoking crystal methamphetamine users were more likely to report injecting and heroin use. By contrast, recent crystal methamphetamine smokers were less likely to have injected recently but more likely to have used heroin and range of 'party drugs' including cocaine, ketamine and GHB (Kinner & Degenhardt 2008, p.297).

Poly-drug use can also be influenced by contextual factors such as access to certain drugs and environments that promote the use of multiple drugs. Research conducted on crystal

429 Although not heroin which, as discussed in Chapter 9, is seen by at least recreational and 'party drug' users as a 'dirty' drug.

methamphetamine use among a sample of 45 poly-drug users in Sydney's dance party subculture sought to determine user characteristics, patterns of use and associated harms from poly-drug use. It found that 'the most common drugs used by amphetamine users were cannabis (100%), alcohol (99%), hallucinogens (93%), tobacco (93%), benzodiazepines (73%), amyl nitrite (70%), cocaine (62%), and heroin (55%)' and the median duration of speed use in the preceding 6 months was 12 days, compared with a median of 2 days crystal meth use among the present sample (Degenhardt & Topp, 2003, p. 21).

As emphasised by Williams and Parker (2001), failure to recognise the prevalence and patterns of poly-drug use can have significant consequences for public health, law enforcement and community safety programs. In particular, the development of programs and policies within the traditional framework of a single-drug strategy can prove counterproductive if the use of one drug type is inextricably linked to the use of other drugs within the local drug market. The extent that methamphetamine users concomitantly use alcohol and cannabis at high rates may have significant implications for drug treatment interventions and programs targeting methamphetamine use. Similarly, the extent that other stimulant drugs, including new synthetic and designer psychoactive substances, are potential substitutes for methamphetamine has implications for the supply reduction and drug market interdiction activities of police.

Using a number of key Australian data sources, this chapter examines what is currently known about the prevalence and patterns of poly-drug use among methamphetamine users in Victoria and across Australia. It describes what is currently known from research and practice about the reasons for poly-drug use and the implications this has for treatment and intervention planning. The medical and physical effects of poly-drug use are then explored to assess short and long-term harms. Finally, the experiences of service providers who come into contact with poly-drug users through their work will be discussed.

The prevalence of poly-drug use

Several major national datasets and research projects have sought to quantify the prevalence of poly-drug use among methamphetamine users. Perhaps the most notable of these is the detailed survey of Sydney-based methamphetamine users conducted in 2005 by McKetin, McLaren and Kelly (2005). This research project was funded by the National Drug Law Enforcement Research Fund (NDLERF) and found that more than three-quarters of methamphetamine users had recently used other illicit drugs. These included, among others, cannabis (76%), ecstasy (38%), heroin (29%) and benzodiazepines (36%).

Although the largest and most comprehensive study of methamphetamine users in Australia, the research by McKetin, McLaren and Kelly was conducted only in Sydney and only with those described as regular psychostimulant users (RPU). Analysis of other data sources can, however, provide insight into the extent to which these findings may pertain to the broader community of methamphetamine users in Victoria.

Use amongst the general community

The National Drug Strategy Household Survey (NDSHS) is a large population survey that assesses people's knowledge of and attitudes towards drugs and their history of alcohol and other drug consumption. Managed by the Australian Institute of Health and Welfare (AIHW), this national survey provides cross-sectional data on alcohol, tobacco and other drug use in Australia every three years — the most recent being administered in 2013 (AIHW 2014).⁴³⁰ It is the only survey conducted in Australia which collects information on drug use patterns in the general population.

430 At the time of tabling this report, only preliminary findings of the 2013 survey were available, relating mainly to lifetime and most recent use of drugs, with some data on type of drug, frequency of use for some demographic variables. Other information was prepared for the Committee and has been included with the permission of the Australian Institute of Health and Welfare (AIHW).

Table 10.1 describes the prevalence and patterns of poly-drug use among recent (past-12 month) illicit drug users across Australia. Overall, these data illustrate that the overwhelming majority of recent users of methamphetamine (92%) had used at least one other illicit drug type in the past 12 months. The most commonly cited drug used in combination with methamphetamine was cannabis, reported by 72.7 percent of recent methamphetamine users. This was followed by ecstasy (53%), cocaine (39.5%) and pharmaceuticals for non-medical purposes (34.7%).

It is important to remember that, since these data cross-tabulate the self-reported recent use of each drug type irrespective of the frequency, no distinction is made between primary and secondary drug types within a poly-drug use framework. It is not clear, for example, to what extent these data are generally representative of regular or principal methamphetamine users as distinct from those who may have used methamphetamine only once or twice in the past 12 months.

Notwithstanding this limitation, these data also reveal a number of other key findings. In particular, the results presented above reflect the degree of poly-drug use by those who self-reported the use of methamphetamine; however, the problem of poly-drug use is not specific to methamphetamine users. For example, as illustrated earlier, methamphetamine-cannabis users represented 72.7 percent of all recent cannabis users. As a proportion, this same group of methamphetamine-cannabis users represented 15.4 percent of all those who had recently used cannabis (being a much larger sample of the population). For other drug types, the data in Table 10.1 illustrate that recent methamphetamine use was reported by as many as 60.4 percent of all recent users of new and emerging psychoactive substances, 40.6 percent of recent ecstasy users, 43.2 percent of hallucinogen users, 38.6 percent of recent cocaine users and 15.6 percent of recent users of pharmaceuticals.

Table 10.1: Poly-drug uses, recent drug users aged 14 years or older, Australia, 2013 (percent)

Other drugs recently used	Recent users of								
	Cannabis	Ecstasy	Meth/ Amphet Amines	Cocaine	Halluc- inogens	Inhalants	Synthetic Cannab- inoids	New & emerging psycho-active substances	Pharma- ceuticals
Cannabis	n.a.	76.8	72.7	69.7	87.1	58.4	91.4	87.2	29.5
Ecstasy ^(b)	20.0	n.a.	53.0	55.8	63.7	46.8	33.8	72.9	13.7
Meth/ amphetamines ^(c)	15.4	42.0	n.a.	38.6	43.2	36.6	37.3	60.4	15.6
Cocaine	15.1	44.9	39.5	n.a.	37.8	30.9	19.3	46.8	12.3
Hallucinogens	11.1	31.5	26.4	21.4	n.a.	32.5	25.5	49.4	9.2
Inhalants	4.6	14.6	13.9	11.3	20.0	n.a.	*10.0	38.2	5.7
Synthetic Cannabinoids	11.1	16.1	22.2	10.9	24.5	*15.6	n.a.	40.7	7.5
New and emerging psychoactive substances	3.5	11.3	11.8	8.5	15.6	*19.6	13.5	n.a.	4.0
Pharmaceuticals ^(c)	13.4	24.9	34.7	25.8	33.5	33.7	27.9	44.2	n.a.
Did not use any other illicit	54.7	8.3	8.2	13.1	*2.2	27.5	*4.5	—	62.1

Notes:

a) Used at least once in the previous 12 months.

b) Included 'designer drugs' before 2004.

c) For non-medical purposes.

Source: AIHW 2014, unpublished.

To complement these published data, a series of more detailed national and Victorian statistics on poly-drug use were provided by the AIHW to the Committee. Specifically, poly-drug use estimates have been provided for Victoria for each of the four most recent waves of the NDSHS collection (2004, 2007, 2010 and 2013). In addition, national data for the same series have also been provided to aid comparative analysis. Table 10.2 illustrates a number of key similarities and differences.

Table 10.2: Proportion of recent meth/amphetamine users who also reported using other drugs in the last 12 months, Victoria and Australia, 2004 to 2013

Substance type	Victoria				National			
	2004	2007	2010	2013	2004	2007	2010	2013
Cannabis	77.2	81.8	72.4	63.6	82.5	77.4	73.1	72.7
Ecstasy	70.6	77.3	58.3#	60.1	61.1	68.1	59.2#	53.0
Hallucinogens	18.9	5.4**	34.5#	26.8	15.8	15.4	28.3#	26.4
Inhalants	5.3*	4.6**	6.0*	19.9*#	6.7	5.4	8.6	13.9#
Injected drugs	11.0*	16.2*	8.5*	8.1*	12.2	16.3	15.2	11.3
Pain killers/analgesics	13.3*	13.1*	16.9*	N/A.	13.0	18.6	21.0	N/A
Tranquilisers or sleeping pills	13.2*	21.4*	23.5	N/A.	11.7	20.0	20.7	N/A
Analgesics, tranquilisers, steroids, methadone, opiates used in the previous 12 months	N/A	26.7	31.3	38.7	N/A	29.7	31.1	34.7

Notes:

Recent user is a person who reported using meth/amphetamines in the last 12 months

*RSE > 25% but < 50%, estimate should be interpreted with caution

**RSE > 50% estimates is considered unreliable for general use

Statistically significant changes between 2007 and 2010 or 2010 and 2013.

N/A: not available.

Source: AIHW submission April 2014 and AIHW unpublished.

For example, the proportion of recent methamphetamine users in Victoria in 2013 who were also using hallucinogens was roughly equal to the national average (26.8% cf. 26.4%). The same was true for recent users of analgesics, tranquilisers, steroids, methadone and opiates in the previous 12 months (38.7% cf. 34.7%). Methamphetamine users in Victoria differed from the national average in terms of their use of the other drugs specified in Table 10.2 with the largest difference between Victoria and national data being in respect of cannabis (63.6% cf. 72.7%). This represents a change from the results in 2010 where methamphetamine users who also used cannabis were of similar proportions in Victoria and nationally (72.4% cf. 72.7%).

Historical estimates provided by the AIHW also enable some consideration of trends in poly-drug use by methamphetamine users. Inspection of the data in Table 10.2, for example, shows that in Victoria the extent to which recent methamphetamine users also used ecstasy had declined significantly between 2007 (77.3%) and 2010 (58.3%) as well as between 2010 (58.3%) and 2013 (60.1%), whereas the poly-use of inhalants increased significantly between 2010 (6%) and 2013 (19.9%) — although these estimates should be treated with caution in view of the small number of respondents involved. It is worth noting that while these trends are consistent with those seen nationally the degree of change was in both cases more pronounced in Victoria. Finally, although not statistically significant, the data also show that the poly-use of hallucinogens, analgesics, tranquilisers, steroids, methadone and opiates increased between 2007 and 2013 both in Victoria and nationally.

The NDSHS data examined so far have revealed the co-occurrence of methamphetamine and other drug use over a period of 12 months. Analysis of the data describes only the extent to which recent methamphetamine users had used one or more other illicit drug types in the same 12-month period. The data do not describe the extent to which methamphetamine users consume multiple drugs within the same episode of use. Concurrent use in this context may have significantly different implications for policy and practice.

To examine the degree of concurrent poly-drug use, additional data were supplied by the AIHW and these are reported in Table 10.3. Here, recent methamphetamine users were asked to indicate which other drug types are typically consumed at the same time as using methamphetamine. In 2013, the results showed that in Victoria the concurrent use of alcohol was reported by 88.4 percent of recent methamphetamine users, slightly higher than the national average of 86.0 percent. For other drug types, concurrent use of cannabis was reported by 40.6 percent of methamphetamine users and ecstasy 37.0 percent of methamphetamine users. Much smaller proportions of recent methamphetamine users reported concurrent use of cocaine (15.4%) and pharmaceuticals (17.5%) in Victoria in 2013.

Table 10.3: Drugs used at the same time when using meth/amphetamines, 2004 to 2013

	Victoria				Australia			
	2004	2007	2010	2013	2004	2007	2010	2013
Alcohol	62.4	86.7	89.8	88.4	64.7	84.5	88.2	86.0
Cannabis	71.2	65.9	53.9	40.6	74.4	65.6	54.1	49.8
Cocaine	17.1	27.1	19.8	15.4	10.5	20.5	18.3	14.6
Ecstasy	48.4	61.1	50.9	37.0	40.1	55.4	44.1	29.8#
Pharmaceuticals	N/A	N/A	14.1	17.5	N/A	N/A	14.2	15.5

Notes:

Recent user is a person who reported using meth/amphetamine in the past 12 months

*RSE>25% but <50% estimate should be interpreted with caution

#Statistically significant changes between 2010 and 2013

N/A: not available.

Source: AIHW submission April 2014 and AIHW unpublished.

In trend terms, the proportion of recent methamphetamine users reporting the concurrent use of alcohol has been increasing in Victoria, up from 62.7 percent in 2004 to 88.4 percent in 2013. The prevalence of concurrent cannabis use, on the other hand, has been consistently declining across the latest three waves of collection, down from 65.9 percent in 2007 to 40.6 percent in 2013. Trends in the concurrent use of cocaine and ecstasy have fluctuated over the series, although it is interesting to note that for both drug types the prevalence declined in the most recent wave of data collection.

It is important to note that this high prevalence of concurrent drug use is by no means unique to the users of methamphetamine. In fact, many studies of other drug users across different contexts in Australia have also revealed high rates of poly-drug participation (see Sweeney & Payne 2006). In this context, it is important to recognise that poly-drug use is the norm rather than the exception and that policies targeting a specific drug type, such as methamphetamine in this case, must account for poly-drug use as a general behavioural trait of a majority of users, rather than a specific activity of a minority.

Australian Secondary Students Alcohol and Drug Survey 2011

Considering that young people are unlikely to be adequately represented in national population-level surveys, a number of data collection programs have emerged that offer alternative estimates of illicit drug use, including amphetamine use, by young people. As detailed in Chapter 5 (Prevalence and Harms), the Australian Secondary Students Alcohol and Drug (ASSAD) Survey emerged with a specific focus on the licit and illicit drug use experiences of secondary school students aged between 12 and 17 years.⁴³¹

Table 10.4: Percentage of secondary students who had used tranquilisers, cannabis, amphetamines, hallucinogens or ecstasy in the past 12 months who had used other substances on the same occasion, Australia, 2011

Substance used on same occasion	Victoria		National			
	Amphetamines (%)	Amphetamines (%)	Tranquilisers (%)	Cannabis (%)	Hallucinogens (%)	Ecstasy (%)
(n) [^]	60	549	2451	2994	579	482
Alcohol	58	56.5	15.7	61.4	46.4	62.4
Tobacco	46	40.1	12.4	47	40.7	47.0
Cannabis	36	33.4	10.5	N/A ^{^^}	37	33.9
Hallucinogens	7	10.5	2.6	7.1	N/A ^{^^}	12.6
Amphetamines	N/A ^{^^}	N/A ^{^^}	3.1	4.9	9.1	13.8
Ecstasy	9	14.3	2.5	5.3	9.0	N/A ^{^^}
Analgesics	7	8.5	22.6	6.3	8.0	9.2
Tranquilisers	1	4.8	N/A ^{^^}	2.6	5.2	7.6
No other substance used	28.0	29.4	61.3	26.7	32.3	21.9

Notes:

[^] Number of students surveyed using a substance in previous year.

^{^^} N/A+ not applicable

Percentages may not equal 100% as multiple responses were allowed.

Source: White & Bariola 2012, p.88; Victorian ASSAD 2011, p.288.

Ecstasy and Related Drug Reporting System (EDRS) 2013

The Ecstasy and Related Drug Reporting System (EDRS) provides a snapshot of the ecstasy and related drugs (ERD) market across Australia (Sindicich & Burns 2014). A detailed description of the EDRS data is published each year and comprises both national and jurisdictional findings.⁴³² Unlike the NDSHS or ASSAD, the EDRS provides a more detailed examination of poly-drug use among targeted samples of drug users who are unlikely to be captured in household or school-based methodologies.

431 A total of 4,797 students in Years 7 to 12 took part in the survey, which represents a participation rate of 76% of the total number of students selected for the survey (i.e. 80 students from 45 lower secondary schools and 100 students from 27 upper secondary schools (Bariola & White 2012, p. 4).

432 However, it should be noted that the information on poly-drug use in the national report is more detailed than for individual jurisdictions. The most recent national and Victorian surveys available for reporting were conducted in 2013 using face-to-face interviews with current regular psychostimulant users (RPU) and telephone and face-to-face interviews with key experts.

According to the most recently available data (2013), the EDRS estimated that almost half of the national participants (49 %) who were methamphetamine users had recently (in the past six months) used at least one other illicit drug type (Table 10.5). The lifetime prevalence of drug use related to methamphetamine was estimated at 70 percent. By methamphetamine type, recent poly-drug use was more commonly reported among those using powdered methamphetamine (37 %) than those using crystal methamphetamine (24%) or base (6 %). Similarly, the lifetime prevalence of other drug use was highest among those who had used powdered methamphetamine (63%), followed by the users of crystal methamphetamine (35%) and base (20%).

Compared across successive years, the ERDS paints an interesting portrait of poly-drug use among methamphetamine users. Specifically, between 2003 and 2009, the prevalence of recent poly-drug use among methamphetamine users had consistently declined — falling from a high of 84 percent in 2003 to 54 percent in 2009. In the three years of data collection since 2009, the trend in recent poly-drug use has reversed, increasing from 54 percent to 61 percent in 2012. Most notably, this apparent upward shift in recent poly-drug use has been mostly experienced among the sub-sample of users classified as ice users. However, most recent data from 2013 revealed a decline of 12% (61% in 2012 to 49% in 2013) in recent poly-drug use among methamphetamine users.

Furthermore, the national EDRS report also stated that concurrent poly-drug use was also common among recreational drug users in general, with 77 percent reporting that they had been under the influence of one or more other drugs (stimulants or depressants) in addition to the ‘main’ drug at the time of last overdose (Sindicich & Burns 2013). These were typically alcohol (50%) and cannabis (19%), with smaller numbers reporting ketamine, cocaine, LSD and benzodiazepines (3%) (Sindicich & Burns 2014).

Table 10.5: Lifetime and recent (last six months) poly-drug use of regular psychostimulant users (RPU) from the national sample who also reported methamphetamine use, 2003–2013 (%)

%	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Methamphetamine (powdered speed)											
Ever used other drugs	87	85	89	86	82	77	74	76	77	76	63
Recently used other drugs	73	68	74	64	57	46	45	47	49	48	37
Methamphetamine (base)											
Ever used other drugs	51	53	52	52	45	39	33	30	36	32	20
Recently used other drugs	36	39	38	34	26	18	15	13	16	15	6
Crystal methamphetamine (ice/crystal)											
Ever used other drugs	63	63	60	65	54	47	36	38	43	48	35
Recently used other drugs	52	45	38	49	33	24	15	17	26	29	24
Methamphetamine (any form)[^]											
Ever used other drugs	92	91	94	93	89	83	79	81	83	84	70
Recently used other drugs	84	83	84	82	71	59	54	56	60	61	49

Note: [^] Refers to participants who nominated one or more of the following drugs: speed, base and/or ice/crystal.

Source: Adapted from National EDRS 2013, table 5, p.6.

A comparative examination of the national and Victorian EDRS data for 2013 is presented in Table 10.6. Overall, the data indicate that recent and lifetime poly-drug use was higher among Victorian methamphetamine users than was seen nationally. For example, 71 percent of methamphetamine users in Victoria had recently used at least one other drug type in the past six months, compared with just 49 percent of the national sample. Similarly, for ice users in particular, the prevalence of recent poly-drug use in Victoria (45%) was one and a half times that seen (as an average) across Australia (24%).

With respect to the frequency of all forms of methamphetamine use among poly-drug users, those from Victoria reported higher proportions in comparison to the national average. The median days of use was also larger in the Victorian sample, which reported 8 median days of use in comparison to 4 days reported nationally.

Table 10.6: Comparison between national and Victorian lifetime and recent (last six months) poly-drug use of RPU, 2013

%	National n= 686	Victoria n=100
Methamphetamine (powdered speed)		
Ever used other drugs	63	86
Recently used other drugs	37	58
Median days of use	3	4
Use (n,range)	(1-180)	(1-80)
Methamphetamine (base)		
Ever used other drugs	20	30
Recently used other drugs	6	8
Median days of use	2	3 [^]
Use (n,range)	(1-48)	(1-48)
Crystal methamphetamine (ice/crystal)		
Ever used other drugs	35	62
Recently used other drugs	24	45
Median days of use	4	10
Use (n,range)	(1-180)	(1-170)
Methamphetamine (any form)[^]		
Ever used other drugs	70	91
Recently used other drugs	49	71
Median days of use	4	8
Use (n,range)	(1-180)	(1-172)

Note:

[^]Small numbers interpret with caution.

Median days have been rounded to whole numbers.

Source: Adapted from National EDRS 2013, table 4, p.2.

Finally, Papanastasiou, Dietze & Lloyd (2014) also indicated that poly-drug use was normal among RPU and, in their opinion, problematic.

Illicit Drug Reporting System (IDRS) 2013

As noted earlier, the Illicit Drug Reporting System (IDRS) uses a similar methodology to EDRS, however it provides additional information on prevalence of methamphetamine use among injecting drug users who also use illicit drugs other than ecstasy. It aims to identify emerging trends in the local and national illicit drug markets based on survey results from those users as well as key experts working in the field.⁴³³ The latest IDRS report presents information on the use and market characteristics of crystal methamphetamine available in different states and territories. The most recent IDRS survey which is available for reporting was conducted in 2013 nationally⁴³⁴, including in Victoria.⁴³⁵

The information relating to poly-drug use in the national IDRS report is limited and primarily based on the interpretation of findings described in Table 10.7. The report acknowledged that poly-drug use over the last six months was common in the sample, with little difference between the jurisdictions. It stated that substantial proportions of the sample reported recent use of three of the four main drug types monitored by the IDRS, that is, heroin (60%); cannabis (72%); and methamphetamine (any form; 66%) (Stafford & Burns 2014, p.11).

Table 10.7: Drug use among the national sample in the six months preceding interview, 2013

Type of drug	Percent Used
Tobacco	91
Cannabis	72
Any amphetamine	66
Any benzodiazepines	64
Alcohol	59
Any heroin (inc.homebake)	60
Heroin	60
Ice/crystal	55
Benzodiazepines (not prescr.)	47
Any methadone	48
Any morphine	38
Speed powder	34
Benzodiazepines (prescr.)	40
Any oxycodone	36
Morphine (not prescr.)	35
Oxycodone (not prescr.)	32
Methadone (prescr.)	34
Methadone (not prescr.)	20
Any buprenorphine	16
Cocaine	16
Base	13

433 The 2013 IDRS incorporates a quantitative survey of people who inject drugs and semi-structured interviews with key informants.

434 There were 887 participants interviewed as part of the national survey with a mean age of 40 years (range 18 — 66 years) and 66% were male (Stafford & Burns 2014, p.6).

435 There were 150 people who inject drugs (PWID) interviewed in Victoria and the mean age of the sample was 40 years and almost three-quarters were male (Cogger, Dietze & Lloyd 2014, p.6).

Note: 'Any heroin' includes heroin and home bake heroin. 'Any methamphetamine' includes speed and powder, base, 'ice/crystal and liquid amphetamine. 'Any methadone' includes licit (prescr.) and illicit (non prescr.) methadone liquid and Physeptone®. 'Any morphine', any 'buprenorphine', 'any oxycodone', 'any form pharmaceutical stimulants'. 'Other opioids' refers to opioids not elsewhere classified. 'Use' refers to any form of administration and does not necessarily imply injection.

Source: Adapted from 2013 National IDRS report, figure 1, p.12.

In comparison, the Victorian IDRS report provided even less information on poly-drug use based on self-reported responses. However, some key experts particularly emphasised poly-drug use practices among methamphetamine users. One expert from the City of Dandenong provided anecdotal reports of rising numbers of heroin/methamphetamine poly-drug use presentations to the Drug Court, a trend not previously observed (Cogger, Dietze & Lloyd 2014, p.16).

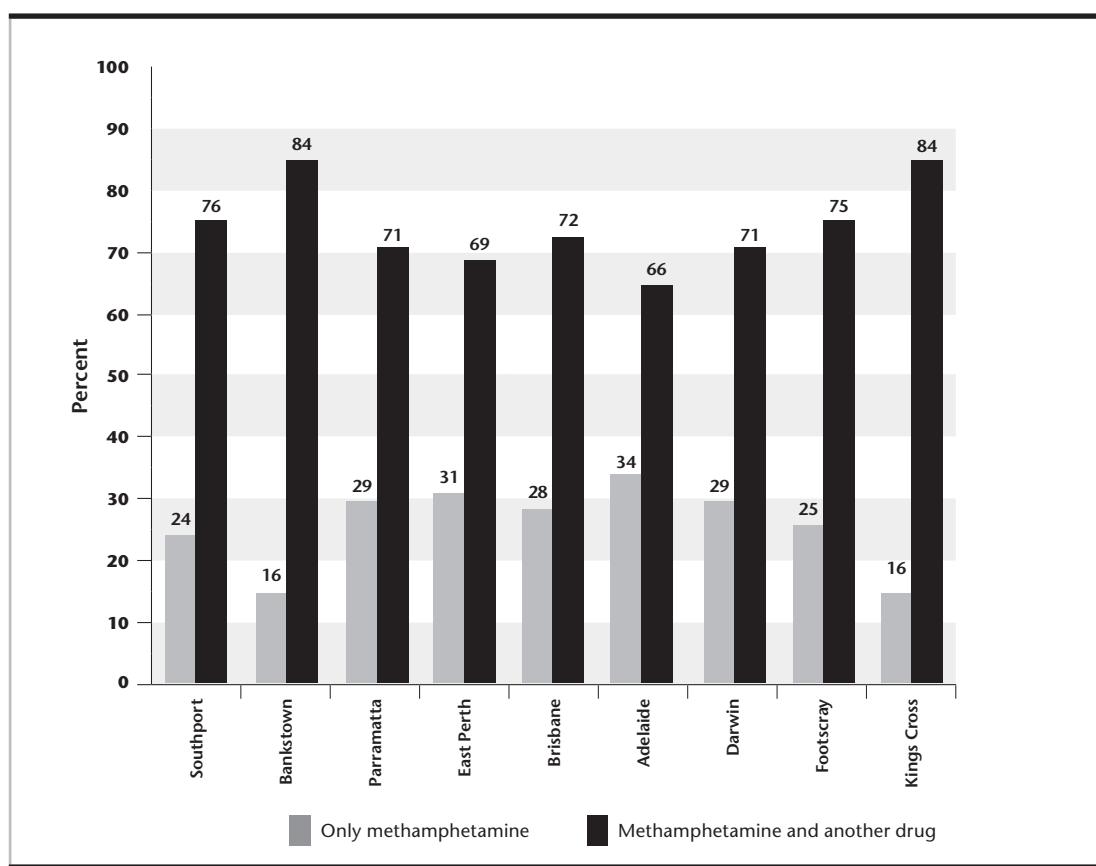
Drug Use Monitoring Australia

Unlike the previous sources of information mentioned, the Drug Use Monitoring Australia (DUMA) program provides data on the prevalence and perceptions of drug use among another important key sentinel population, i.e. police detainees. DUMA is designed to utilise a dual methodology which incorporates both self-reported information and voluntary urinalysis of detainees. The most comprehensive study of poly-drug use among detainees in the DUMA sample was conducted in 2011, where it was found that one-third of detainees reported using two or more drugs in the 30 days prior to being detained. Cannabis was the primary drug used by 48 percent of detainees, followed by heroin (19%) and amphetamines (17%) (Sweeney & Payne 2011). It also found that cannabis, alcohol and benzodiazepines were the main drugs used by detainees who had poly-drug use habits.

Although the analysis by Sweeney and Payne (2011) identified the complex nature of poly-drug use among the DUMA sample, to assist the present inquiry a series of additional analyses have been conducted by the Australian Institute of Criminology (AIC) on data collected in 2012. Specifically, urinalysis test results have been collated from all nine DUMA data collection sites in 2012. In this national sample, 361 detainees tested positive for methamphetamine. Among them, 263 only used methamphetamine and 98 were found to have used at least one other drug.

Figure 10.1 illustrates the proportion of detainees from all sites who tested positive for methamphetamine and another drug in 2012. In Footscray in Victoria, the results showed as many as three in every four detainees (75%) methamphetamine using detainees had also used at least one other illicit drug (including cannabis, ecstasy, heroin, cocaine and other opiates).

Figure 10.1: Proportion of detainees from the all sites who tested positive for methamphetamine and another drug in 2012



Note:

The number of detainees who were tested varies across sites and participation in providing urine analysis is voluntary. Source: AIC DUMA collection 1999-2012 (computer file).

Alternative data sources

In addition to the information described above, some statistical evidence was also presented to the Committee during the hearings and through submissions. One of these submissions described an Australian longitudinal study — ‘The UnMet Study’ — undertaken by the Burnet Institute in Melbourne. The research examined 255 people who used methamphetamine, recruited during 2010 and followed up one year later. It found that all of the sample respondents reported use of other drugs in the previous six months and that:

- 75% reported use of other drugs with methamphetamine in the previous six months, most commonly cannabis (61%), alcohol (57%) and ecstasy (17%);
- 87% reported using other drugs to counter the ‘comedown’ effects subsequent to methamphetamine use, most commonly cannabis (62%), licit or illicit benzodiazepines (54%) and heroin (34%).⁴³⁶

According to Professor Paul Dietze of the Burnet Institute, the results of this study show that:

These patterns of polysubstance use highlight the need to address the use and harms of using other substances in addition to methamphetamine use when dealing with clients presenting with methamphetamine related issues. Indeed, problematic use of other substances (e.g., heroin, cannabis) was cited as a barrier to treatment utilisation among some members of the UnMet cohort...⁴³⁷

436 Quinn, B, Stoope, M, Papanastasiou, C & Dietze, P 2013, ‘Methamphetamine use in Melbourne, Australia—Baseline characteristics of a prospective methamphetamine using cohort and correlates of methamphetamine dependence’, *Journal of Substance Use*, vol. 18, no. 5, pp.349-362 cited in submission from Professor Paul Dietze, Deputy Director, Centre for Population Health, Burnet Institute, 21 October 2013.

437 Professor Paul Dietze, Deputy Director, Centre for Population Health, Burnet Institute, Submission, 21 October 2013.

Research cited in a submission by the Austin Health's toxicology service,⁴³⁸ noted that poly-drug use is common amongst methamphetamine users, particularly those who frequent 'clubs, raves, parties, festivals and pubs':

Over 1/3 (42%) of methamphetamine users report daily use of cannabis and an associated high proportion of cannabis related complications. The majority smoke tobacco and drink alcohol, with a small proportion classified as drinking dangerously high quantities of alcohol. A substantial number of methamphetamine users have a history of heroin use, including people who are enrolled in opioid maintenance therapy.⁴³⁹

The propensity to use methamphetamine as a party drug at raves and nightclubs in combination with alcohol is quite a different pattern from traditional use of ecstasy at dance parties and raves etc. This combination is far more potentially dangerous than merely consuming the drugs with water. Peter Miller from the School of Psychology at Deakin University told the Inquiry that such users are more likely to experience alcohol-related injuries.⁴⁴⁰

Finally, in their submission to the Committee, Victoria Police described the extent of poly-drug use by amphetamine type stimulants (ATS) users apprehended for possession offences, confirming that the majority of those having contact with the criminal justice system for amphetamine-related offences were also apprehended for offences related to other substances, accordingly:

Poly-drug use is common amongst ATS users. Recent analysis indicates that a large proportion (just over half) of offenders processed for ATS, were processed for at least one other drug type within 12 months, most commonly cannabis.⁴⁴¹

The experience of agencies

Notwithstanding their methodological limitations, these aforementioned data sources tell an interesting and consistent story about poly-drug use among methamphetamine users. Specifically, all data sources indicate that the vast majority of methamphetamine users also use other drugs, and the concurrent use of alcohol and cannabis is common. Further, the national population (NDSHS) and sentinel population (EDRS) surveys suggest that poly-drug use is more common among methamphetamine users in Victoria than in some other jurisdictions across Australia.

The extent to which these national and jurisdictional data have currency is not known, since for some sources (in particular the NDSHS and ASSAD) the most recently available data were collected as far back as 2010 or 2011. However, the more recent experience and evidence presented to the Inquiry suggests that the general conclusions drawn above are equally applicable in 2014. In particular, submissions were provided to the Committee from across a broad spectrum of public health, community service and criminal justice stakeholders. Among them was an overwhelming consensus that in Victoria at present, 'multiple or poly-drug use is the norm'.⁴⁴² For example, several agencies provided evidence about a three-way split in drug use between methamphetamine, alcohol and cannabis.

438 McKetin, R 2006, 'Patterns and drug use in Australia', Asian Multi-City Epidemiology Working Group, Taipei.

439 Dr Fergus Kerr, Medical Director Medicine and Emergency CSU, Director of Emergency Medicine, Medical Clinical Lead in Patient Flow, Austin Health, Submission, 14 October 2013.

440 Associate Professor Peter Miller, Principal Research Fellow, School of Psychology, Deakin University, Public Hearing, Ballarat, 18 November 2013.

441 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

442 Dr Matthew Frei, Head of Clinical Services, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

Most commonly with alcohol and cannabis. Superintendent Jock Menzel from Gippsland nicely summed up the prevalence of this form of poly-drug use when he told the Inquiry 'You don't find ice without cannabis [or alcohol]'. See Superintendent Malcolm (Jock) Menzel, Divisional Commander, Eastern Region Division 5 — Morwell, Victoria Police, Public Hearing, Traralgon, 28 January 2014.

The list of people who noted the ubiquity in the use of these drugs with the use of methamphetamine is far too long to present here.

People working with the homeless have also found that alcohol used in association with methamphetamine is a common combination.⁴⁴³ For clients seen in mental health settings, the use of a single type of drug is also rare.⁴⁴⁴ Finally, pregnant women who use methamphetamine seen by the Women's Alcohol and Drug Service (WADS) are also likely to be tobacco smokers, drinkers and users of other illicit drugs:

In 2013 around a quarter of the women cared for at WADS reported using ice as part of a pattern of poly-drug use. Typically, ice is used alongside alcohol and tobacco irregularly over weeks or months, or intensively for a period, followed by a period with cannabis, opiates and prescription drug use.⁴⁴⁵

According to some witnesses to the Inquiry this increase in poly-drug use, at least in the number and combination of drugs that are being used, is a worrying trend. As Mr Paul Cranage told the Inquiry:

Certainly there is more poly-drug use while using ice. Clients state that they use drugs to come down off their high, so they are using the cannabis, heroin or benzos as a way of bringing themselves down. There certainly is a lot of poly-drug use, as opposed to a few years ago when we would find that a lot of young people might be just using, say, cannabis and not necessarily using any other drugs...this is certainly something that has increased, causing a high risk of overdose due to the extreme highs and the extreme lows when they are using different types of drugs. There is certainly more risk and we certainly look at how do we provide education around that very issue, around safety concerns.⁴⁴⁶

Although the information identified from the ASSAD survey suggests that poly-drug use is perhaps less common among young methamphetamine users, the experience of stakeholders suggests that poly-drug use remains a significant concern for young methamphetamine users in Victoria. In this context Mr Anthony Grimm, Co-ordinator of the Chatterbox Outreach Program, noted:

In the last 12 months the program has seen over 2,000 young people. It has made approximately 50 to 60 referrals for case management. From 2,000 to 50 to 60, there is a great deal there. However, the program conducts a lot of brief intervention including immediate crisis support. I think it is important to mention that most of the young people that program is seeing on the bus are not using only methamphetamine. They are poly-drug users. It is very rare that it will see a young person who is using just one type of drug.⁴⁴⁷

Other service providers also discussed similar issues concerning the prevalence of poly-drug use among young people in Victoria. Ms Bell, Senior Manager of Adolescent Specialist Support Programs, stated:

Currently we have four residential settings with 16 young people residing in placements, with 5 in one unit, which is extremely complex at the moment. The young people there are all substance users; they are poly-substance users. They tend to have a progression from alcohol to marijuana, and it tends to go in ebbs and flows of what is available and what they can financially afford. We have been through phases of glue sniffing and petrol. Marijuana tends to be probably the consistent one — marijuana and alcohol. Then that is topped up by the use of amphetamines, such as ice, or some of them have gone on to use heroin. A large percentage at the moment is poly-users around alcohol and marijuana, and we have a small group who we know are consistently using ice.⁴⁴⁸

443 See for example Mr John Blewonski, Chief Executive Officer, VincentCare Victoria, Submission, 21 October 2013.

444 Mr Wayne Daly, Nurse Unit Manager, Alexander Bayne Centre, Psychiatric Services, Bendigo Health, Public Hearing, Bendigo, 25 October 2013.

445 Ms Teresa Lynch, Manager, The Royal Women's Hospital, Submission, 11 March 2014.

446 Mr Paul Cranage, Alcohol and Other Drug Program Manager, Uniting Care Ballarat, Public Hearing, Ballarat, 18 November 2013.

447 Mr Anthony Grimm, Co-ordinator The Chatterbox Street Outreach Program, White Lion, Public Hearing, Melbourne, 24 March 2014.

448 Ms Marg Bell, Senior Manager, Adolescent Specialist Support Programs, Shepparton, Berry Street, Public Hearing, Shepparton, 25 February 2014.

Without exception, the experience of key informants and stakeholders in Victoria supports the statistical evidence suggesting that poly-drug use is highly prevalent among both adult and young methamphetamine users. Importantly, while these stakeholder experiences do not specifically indicate that poly-drug use has further increased in recent years, they do provide an overwhelming sense that the problem of poly-drug use has not improved and that efforts to tackle methamphetamine abuse must be developed within a framework that recognises problematic poly-drug use as a central consideration. This issue was specifically highlighted by Dr Rebecca McKetin who described the difficulties associated with poly-drug habits and their consequences for drug treatment:

We are talking about treatment, and I am not saying we should not develop treatment options, we do need to do that; but when you are talking about poly-drug use in these questions, one of the problems we are seeing at the moment is that stimulant users — whether it is amphetamines, but I think mostly it is methamphetamine, amphetamine or ecstasy and cocaine — drink quite heavily. They go out and binge drink because the stimulant effects allow them to drink more than you would otherwise. They sober the person up, if you like. They offset the sedative effects of alcohol.

When we talk to stimulant users, they are reporting incredibly high levels of alcohol consumption when they go out binge drinking. This is not your kind of chronic person who would turn up to treatment. This is your 20-something-year-old male on a big night out, and that has got an important risk for alcohol-related violence, because the methamphetamine increases the risk of violence and so does the alcohol, and you have the two together. In that context you would have, not necessarily treatments, but maybe some other kind of harms reduction approach because you are targeting a different population.⁴⁴⁹

The reasons for poly-drug use

Poly-drug use occurs in various contexts. Recreational illicit drug users may prefer to use more than one substance in order to balance the effects of stimulants and depressants and minimise negative reactions. For example, it is possible that methamphetamine users may choose to consume alcohol and cannabis, which are both depressants, to counter the strong stimulant effect of the methamphetamine. On the other hand, some dependent users may choose to use more than one drug with similar psychopharmacological properties to experience a greater effect as they attempt to counterbalance an increasing tolerance to their drug of choice.

Poly-drug use habits can also be influenced by the type of user (recreational or dependent), the experience they are seeking, individual preferences, knowledge of different substances and their effects, and by which substances are available to the user at any given time. In conversation with the Committee, Mr Wilson of the Youth Outreach, Alcohol, Tobacco and Other Drugs Team described the nature of poly-drug users based on his experience of being part of an outreach program:

We do see the odd recreational users, no doubt, but most of the people we see are dependent drug users, and they are poly-drug users. They are not only users of ice, or they may have graduated to ice because ice was all they could get. We have even seen people swapping from heroin, for example, to ice because there is no heroin available. Heroin availability in this region goes up and down; it fluctuates, like most drugs do, but definitely ice would be more available than something like heroin.⁴⁵⁰

Knowing whether these users will return to using heroin if it becomes available, and to what extent movements between drug types are influenced by variations in price and purity, would be valuable for a greater understanding of the nature of poly-drug use. Nonetheless, Mr Wilson's comments are particularly informative for the observation that some users of

449 Dr Rebecca McKetin, Fellow in Mental Health Research, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

450 Mr Bill Wilson, Youth Outreach, Alcohol, Tobacco and Other Drugs Team, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014.

heroin, a depressant, will switch to stimulants like ice. Given the very different effects of these two classes of drug, it appears likely that some users are seeking an experience or meeting a need that comes from using substances in general, rather than the effects of a particular substance.

Key researchers from Needle and Syringe Programs (NSPs) in Victoria noted that concurrent opioid and benzodiazepine use was a common poly-drug use strategy designed to ameliorate the methamphetamine 'comedown' (Cogger, Dietze & Lloyd 2013). For some people poly-drug use may serve a particular behavioural function, for example the decision to use a stimulant substance such as methamphetamine may be predicated on the desire and intention to consume greater-than-normal quantities of alcohol, ordinarily a depressant. Young recreational users of methamphetamine in particular can find the combination of alcohol and stimulants useful in allowing them to drink more without feeling sleepy. Some stakeholders have described this as creating 'wide awake drunks' — 'people who have all the disinhibition of alcohol but who are not sleeping it off', thus increasing the potential for violent and disorderly conduct.⁴⁵¹ For others, poly-drug use 'is simply a matter of availability, that is, what is on offer'.⁴⁵² For example clubbers, ravers and dance party enthusiasts are thought to be increasingly turning to crystal methamphetamine as a party drug when MDMA or ecstasy is not available.⁴⁵³

Using a unique ethnographic technique, a study conducted in the United States explored the self-reported violence among rural methamphetamine users. It found that some of the participants commonly reported using particular substances to conclude methamphetamine 'binges' whereas others use substances to 'mellow out' after using drugs such as powder or crack cocaine (Sexton, Carlso, Leukefeld & Booth 2009). In Victoria, the reasons for poly-drug use appear consistent, with the Swan Hill District Health Counselling Department (SHDCD) describing the poly-drug use of their clients, including poly-drug users who use crystal methamphetamine or 'ice', as combining alcohol, cannabis, benzodiazepines and other amphetamines, which may include ecstasy, to enhance effects and/or relieve withdrawal symptoms.⁴⁵⁴

Witnesses to the Inquiry, particularly from alcohol and drug treatment agencies or health services, noted that the most common form of poly-drug use (other than alcohol or cannabis) is the use of benzodiazepines, other prescription drugs⁴⁵⁵ and/or opiates to counteract the come down effects of methamphetamine withdrawal. This is particularly to mitigate depression and enhance sleep.⁴⁵⁶ A representative of the Victorian Pharmacy Guild explained that some pharmacists were increasingly observing this practice of using prescription opioids

451 Dr Matthew Frei, Head of Clinical Services, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013. See also comments of Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

The simultaneous use of alcohol with stimulants also poses significant problems for the ambulance services, particularly in the context of aggression and non-cooperation, whilst alcohol affected patients are in many cases much more easily settled. See Mr Allan Eade, Intensive Care Paramedic, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013; Mr Mark Allen, Team Manager, Morwell Mobile Intensive Care Ambulance (MICA) Unit and Single Response Unit (SRU), Ambulance Victoria, Public Hearing, Traralgon, 28 January 2014 and the discussion in Chapter 8.

Conversely, as profiled in the Introduction to this Report, notwithstanding high levels of multiple drug use, alcohol of itself remains the number one problematic drug for ambulance officers, police, emergency and AOD workers.

452 Superintendent Paul O'Halloran, Superintendent and Divisional Commander Eastern Region Division 4, Victorian Police, Submission, 24 February 2014.

453 Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013.

454 Ms Elwyn Witney, Head of Counselling, Swan Hill District Health, Submission, 6 October 2013.

455 See comments of Mr Michael Whelan, MICA Team Manager, Ambulance Victoria, Public Hearing, Shepparton, 25 February 2014.

456 See for example: Ms Jacinta Pollard, Managing Director, Caraniche, Submission, 21 October 2013; Ms Melanie Raymond, Youth Projects, Submission, 22 October 2013; Ms Kit-e Kline, Drug and Alcohol Worker, Wathaurong Aboriginal Co-operative, Submission, 22 October 2013; Mr Raymond Blessing, Chief Executive Officer, TaskForce, Submission, 24 October 2013; Mr Terry Robinson, Coordinator, Barwon Youth, Public Hearing, Geelong, 28 October 2013.

to assist during the phase of withdrawal.⁴⁵⁷ Dr David Eddey of Barwon Health also told the Committee that the use of prescription drugs such as Xanax (alprazolam) or opioids could have serious impacts on a person's health when used in association with methamphetamine.⁴⁵⁸ Problems could also eventuate when doctors prescribe these drugs without being aware of other substances such as crystal methamphetamine that patients may have been taking concurrently:

Patients may present drug seeking for these prescription drugs and we are aware that users find GPs who may prescribe benzodiazepines for the treatment of 'anxiety' and then use social media and other networks to inform other users of the GP and their apparent willingness to prescribe alprazolam and diazepam in particular.⁴⁵⁹

Mr Alan Fisher from Albury Wodonga Health encapsulated the problems for clinicians and treatment providers in addressing this particular type of poly-drug use:

Having amphetamine dependence on its own is relatively unusual without another drug. Typically they will be prescription drugs, such as alprazolam — Xanax — cannabis, alcohol or other central nervous system depressants; that is to say that often people will have a run on speed but then when they want to come down off the drug they will use a depressant to help ease that passage down, rather than struggling and hanging on with white knuckles. That introduces another set of complications because users will become dependent on more than one drug. It is more usual to have another drug problem with amphetamine than not. That, once again, makes it difficult and challenging to treat and to get people into appropriate treatment services. It also complicates their presentation and their psychological and psychiatric conditions. As we know, people are playing a seesaw, stimulated and going up — a central nervous system stimulant — but then using a depressant to come down. People are drifting between two worlds a lot of the time.⁴⁶⁰

Interestingly, in the specific population that is being seen by the Drug Court of Victoria in Dandenong, half the clients who have been using methamphetamine also have serious heroin-related problems or dependence.⁴⁶¹ This concurrent usage of heroin and crystal methamphetamine counters much of the evidence given to the Inquiry by other witnesses, which suggests these drugs are used at different times.

Notwithstanding the potentially strong behavioural incentives for poly-drug use, it is equally important to recognise the strong role played by external factors such as drug supply, price and purity. A study of 101 drug users from Sydney, for example, demonstrated that:

While demand for both methamphetamine and heroin was found to be price elastic, elasticity estimates were influenced by the nature of participants' drug dependence. The group least responsive to changes in methamphetamine price were those only dependent on methamphetamine, while the group most responsive were only dependent on heroin. Cross price elasticity showed limited substitution into other drugs as the price of methamphetamine increased. In contrast, for heroin, there was significant substitution into pharmaceutical opioids and to a lesser extent, benzodiazepines and methamphetamine. However, for the most part, the decreases in methamphetamine or heroin consumption outweighed any substitution into other drugs (Chalmers, Bradford & Jones 2010, p. 381).

457 Mr Angelo Pricolo, Chair, Strategic Harm Minimisation in Pharmacy (SHaP) Advisory Group, Pharmacy Guild of Australia — Victoria, Public Hearing, Melbourne, 3 February 2014.

458 Dr David Eddey, Director of Emergency Medicine, Barwon Health, Public Hearing, Geelong, 28 October 2013.

459 Dr David Eddey, Director, Department of Emergency Medicine, Dr Nic Reid, Emergency Medicine Staff Specialist, and Dr Cath Peake, Clinical Coordinator, Drugs and Alcohol Services, Barwon Health, Submission, 24 October 2013.

460 Mr Alan Fisher, Clinical Leader, Drug and Alcohol Community Treatment Services, Albury Wodonga Health, Public Hearing, Wodonga, 24 February 2014.

See also comments of Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014. Ms Stoneman told the Inquiry that you get a significant problem of benzodiazepine dependence as a result of using the drug to wean yourself off methamphetamine — 'an onion effect around different substances used and different dependencies occurring'.

461 Mr Tony Parsons, Magistrate, Drug Court of Victoria, Public Hearing, Melbourne, 9 December 2013.

Medical and physical effects of poly-drug use

The physical effects of methamphetamine use, both when used alone and in combination with other drugs have been described in Chapter 6. It is important to reiterate, however, that the use of a 'cocktail' of drugs can exponentially increase risks to the user.⁴⁶² Whilst methamphetamine of itself may be less likely to result in fatal consequences compared to opioid drugs when used alone, in combination with alcohol and/or other drugs the risks increase (Degenhardt & Hall 2012). For example, the combination of methamphetamine and alcohol can be particularly harmful given the capacity of amphetamine type stimulants to mask the effects of alcohol; this may be particularly dangerous in the context of driving a motor vehicle (Topp 2012, p.82).⁴⁶³ Whilst the combination of alcohol and methamphetamine do not produce a new and more dangerous psychoactive substance, as can happen with cocaine, there are harmful consequences beyond those resulting from methamphetamine alone, such as elevated heart rate and blood pressure (Darke et al. 2008). The risk of accidents and injury are similarly increased when ATS are used in conjunction with benzodiazepines and other forms of prescription drugs (Ali, Meena & Gowing 2012).

The complexities of poly-drug use and the potentially harmful consequences of drug combinations from different classes of drugs were also outlined in a submission from Peninsula Health's Drug and Alcohol Program (PenDAP):

The experience of the PenDAP clinicians is that the most common drug used comorbid to methamphetamine is alcohol. There is a concerning trend observed however regarding increased comorbid use of Gamma-Hydroxybutyric acid (GHB) and its analogues (e.g., gamma-butyrolactone, 1,4-Butanediol, etc.). This combination has been reported by clients to reciprocally increase effects of euphoria. Methamphetamine has also been reported by clients to reverse the CNS depression caused by GHB. Such poly-drug use has significant health risks. Finally, clients have reported using benzodiazepines (e.g., alprazolam and diazepam), atypical antipsychotics (e.g., quetiapine and olanzapine), and opiates to buffer the negative emotional effects and insomnia associated with "crashing" from a methamphetamine binge.⁴⁶⁴

Similarly the Australian Drug Foundation noted the myriad ways in which licit, illicit drugs and alcohol can interact in potentially lethal combinations:

Concurrent use of cannabis and methamphetamine has been shown to increase psychotic symptoms in some individuals, particularly those with schizophrenia (Jenner & Lee, 2008). The combination of heroin and methamphetamine can cause respiratory depression which may induce cardiac failure, particularly among people where cardiac disease is present (Darke, et al., 2008). Methamphetamine can also increase the risk of heroin overdose, as the effects of heroin might be muted by the methamphetamine effects and so more heroin could be used than intended (Jenner & Lee, 2008). The combination of methamphetamine and cocaine has shown to substantially increase the cardiotoxic effects of both drugs (Darke, et al., 2008). People often smoke more tobacco when using methamphetamine and so nicotine-related health risks are increased (Jenner & Lee, 2008)... Methamphetamine can also disguise the intoxication effects of alcohol, which may increase the risk of alcohol poisoning or accidents due to a false sense of feeling sober and in control.⁴⁶⁵

462 Witnesses to the Inquiry from the Victorian Alcohol and other Drugs Association (VAADA) observed that Victorian Coroner's Court data shows a strong nexus between methamphetamine, alcohol, benzodiazepine and other drug use where these cocktails of drugs and their various effects contribute to the death.

See Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol and Drug Association, Public Hearing, Melbourne, 14 October 2013.

463 See also comments of Mr Bill Wilson, Youth Outreach, Alcohol, Tobacco and Other Drugs Team, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014. Mr Wilson noted that in addition to the problems associated with traditional poly-drug use an added complication is the use of the new synthetic drugs in association with methamphetamine many of which have not been regulated.

464 Dr Sherene Devanesen, Chief Executive, Peninsula Health, Submission, 21 October 2013.

465 Mr John Rogerson, Chief Executive Officer, Australian Drug Foundation, Submission, 28 October 2013.

The combination of one or more drugs either concurrently or soon after initial ingestion clearly may also have consequences beyond medical complications; for example stimulants and alcohol could exacerbate the potential for violence, as discussed in Chapter 8.

The adverse physical and psychological effects of poly-drug use can also be demonstrated by the type of treatment users seek from service providers. The submission presented by the Maribyrnong City Council raised some concerns in that regard:

Polydrug use is likely to increase the risk of more serious harm and unpredictable effects to a person. Not being able to isolate the effects of specific drugs not only increases the risk to an individual but also makes it problematic to identify the most appropriate service/treatment response given that the impact of one particular drug may be compounded by the use of another illicit drug or alcohol. The nature of such drug use requires a multidisciplinary approach to support, management and treatment that needs to be informed by evidence based clinical practice.⁴⁶⁶

Conclusion

The evidence appears to be clear — methamphetamine users are predominantly poly-drug users who not only use other drugs at different times, but use other drugs concurrently with methamphetamine to achieve specific behavioural outcomes. This trend appears consistently across all national data collection instruments, it is confirmed in police arrest and apprehension data, and it reflects the experience of criminal justice, health and community services practitioners across Victoria. Whether the practice of poly-drug use among methamphetamine users is higher in Victoria than in other states, or whether it is becoming more prevalent remains to be seen, however on both counts the EDRS and the NDSHS suggest this might be worth ongoing analysis and monitoring.

Just exactly why methamphetamine users use multiple drug types remains a matter of ongoing investigation, however, from the evidence examined in this Inquiry it is unlikely that a single all-encompassing explanation will be identified. Instead, there appears to be a complex explanatory framework comprised of several key themes, but neither of which will necessarily explain all poly-drug use activities by a methamphetamine user on all occasions of use. These explanations can be broadly classified into four groups:

- a) *Other drugs as facilitators of methamphetamine* — where the use of other drug types provide psychopharmacological benefits which assist, aid or enhance the methamphetamine experience. This is particularly so for those who use anti-psychotic drugs to ameliorate the negative side effects of heavy stimulant consumption and facilitate prolonged methamphetamine binges.
- b) *Methamphetamine as a facilitator of other drug use* — where methamphetamine use may provide psychopharmacological benefits which assist, aid or enhance the use of other drug types. This is particularly the case for those who frontline workers have identified as using methamphetamine as a method of maximising and prolonging periods of alcohol or cannabis consumption.
- c) *Other drugs as substitutes for methamphetamine* — where both methamphetamine and other drugs may act as short or long-term substitutes during periods when the availability and purity of each drug fluctuates. This may be particularly the case in rural and regional locations where the supply of methamphetamine is more variable.
- d) *Methamphetamine and other drug use are common to a generalised drug using behavioural repertoire* — that while some drug users have short-term preferences for methamphetamine as their preferred drug, the behavioural consequences of a generalised drug addiction mean that it is the effect of drug use that is sought irrespective of drug type.

⁴⁶⁶ Mr Arden Joseph, Director, Community Wellbeing, Maribyrnong City Council, Submission, 21 October 2013.

Irrespective of why poly-drug use occurs, its occurrence among methamphetamine users has a number of important consequences for policy makers and frontline practitioners. From a simple medical and health services perspective, poly-drug use brings with it a number of potentially serious health consequences which can have both long and short-term effects on individuals and the community. The suggestion that young club-going Victorians use methamphetamine to reduce drowsiness and facilitate increased alcohol consumption is particularly troubling. From a law enforcement perspective, managing intoxicated offenders both on the street and in custody can be complicated if the mix of substances used by a particular individual is unknown.⁴⁶⁷ Finally, identifying appropriate diversion and referral-to-treatment options, not to mention the likely success of such treatment, can be complicated if and when methamphetamine use is indicated but is not necessarily the only drug being used. This issue is discussed in Chapter 28 pertaining to treatment issues.

In any case, the considerably high prevalence of poly-drug use among methamphetamine users necessarily demands a rethink of the ways in which methamphetamine use is measured in research, described in policy, and operationalised in treatment and prevention practice. This is because, as Anex argues:

Methamphetamine is often presented as a significant problem in its own right. However, focusing on methamphetamine use alone misses the point that poly-drug use is the norm among many people using drugs, and methamphetamine is typically used with a range of other drugs, including alcohol (McKetin, Najman et al. 2012). The range of drugs used with methamphetamine and the contexts and environments in which they are used, as well as the individual who uses the drug, all contribute to the ways in which methamphetamine is experienced and the impacts it has.⁴⁶⁸

467 Mr Arden Joseph, Director, Community Wellbeing, Maribyrnong City Council, Submission, 21 October 2013.

This information was provided to the Submission by Health Works, a specialist AOD service operating as part of the Western Region Health Centre.

468 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

11. Methamphetamine use in Rural and Regional Victoria

Introduction

Australia is one of the most urbanised countries in the world, with over two-thirds (69%) of the population living in major cities. It also has one of the lowest population densities outside of its major cities.⁴⁶⁹ This concentration of the population in urban centres is also true of Victoria. In 2013, 73.6% of the total Victorian population lived in metropolitan Melbourne and 26.2% in regional Victoria.⁴⁷⁰ Census data gives the following snapshot of population data for Victoria.

Between the 2006 and 2011 censuses, 82.5 percent of Victoria's population growth was in metropolitan Melbourne (the 31 metropolitan local government areas), 10.0 percent was in Victoria's ten regional cities, and 7.6 percent was in the remainder of regional Victoria (the 38 regional and rural local government areas). Between 2006 and 2011, all regional cities experienced population growth. In relation to growth rates, with the exception of Ballarat (1.9 percent), the regional cities had growth rates below the Victorian average of 1.7 percent per annum between 2006 and 2011. The large regional cities of Greater Geelong (1.3 percent) and Greater Bendigo (1.5 percent), along with Wodonga (1.5 percent) and Greater Shepparton (1.2 percent), had higher growth rates than the average for regional Victoria generally (1.1 percent).⁴⁷¹

Given these population figures, it would be expected that the use of methamphetamine is likely to be significantly higher in urban areas of Victoria, particularly Melbourne. However, concern has been raised in the media and by police, rural drug and alcohol agency workers and local residents about methamphetamine use becoming a major problem in rural and regional Victoria. To gain an understanding of the prevalence and impact methamphetamine is having in rural communities the Committee travelled extensively throughout regional Victoria holding public hearings and receiving evidence as to the nature and extent of the problem.⁴⁷²

The diversity of regional Victoria

There is a tendency to view rural Victoria as homogenous, but the reality is very different. Dr Roger Brough, from the former Australian Rural Centre for Addictive Behaviours (ARCAB), a witness to the Drugs and Crime Prevention Committee's Inquiry into Amphetamine Use and 'Party Drug' Use in Victoria in 2004, stated:

The thing that I think is not always appreciated is that rural Victoria is not a homogenous culture and group of people. There are different issues, cultures and mixes of population groups. There are different drug problems in different areas. The epidemiology differs from one part of Victoria to another. There are a number of factors. So when we read reports of metropolitan data and reports of rural data, they

469 <http://www.aifs.gov.au/institute/pubs/factsheets/2011/fs201103.html>.

470 <http://www.dpcd.vic.gov.au/home/publications-and-research/urban-and-regional-research/census-2011/quick-facts>.

471 <http://www.dpcd.vic.gov.au/home/publications-and-research/urban-and-regional-research/census-2011/quick-facts>.

472 For a list of the regional locations that the Committee visited, see Appendix 4.

do not make a lot of sense and they do not really give you a lot of information about what is going on in rural Victoria because all the results are aggregated. There needs to be some way of disaggregating data to make it relevant and appropriate to particular areas.⁴⁷³

Similar comments were made to that Inquiry by Aboriginal community representatives. As discussed in Chapter 12, not all Aboriginal communities are the same, so too there are significant differences between rural and metropolitan Aboriginal populations:

There is a difference between urban and rural communities. Even though it is rural here, there is a difference between the Warragul community and Drouin community and Morwell community as well. I live near Echuca, in Shepparton. They are 40 minutes apart and I live on a little mission between those two called Cumeragunja. Within 45 minutes there are five different communities and those communities are entirely different.⁴⁷⁴

Methamphetamine use in rural and regional Victoria — A new problem?⁴⁷⁵

It is difficult to gauge the extent of methamphetamine use in rural and regional Victoria due to the lack of comprehensive data on the numbers of people using the drug in rural locations. Certainly the perception from witnesses who gave evidence to the Inquiry is that methamphetamine use is high in rural and regional areas of the state and is having a profoundly serious effect on these communities.⁴⁷⁶ As a feedback report on a rural forum into crystal methamphetamine stated: ‘The smaller the community, the greater the psychological impact’ (Anex 2014, p.3).

Some witnesses have claimed that the appearance of methamphetamine in rural locations has been a relatively recent phenomenon a claim that has been reinforced by media reporting on this subject.⁴⁷⁷ In the past, according to such witnesses, alcohol and to some extent cannabis were the real ‘drug issues’ in rural towns and communities. Illicit drugs such as heroin were relatively rare — thus the appearance of ‘hard drugs’ such as crystal methamphetamine in their communities was particularly disconcerting.⁴⁷⁸ It should be noted, however, that whilst methamphetamine use in rural Victoria has been presented to the Committee as a ‘new’ occurrence, a report into amphetamine and party drug use by the Parliamentary Drugs and Crime Prevention Committee 10 years ago noted concerns by

473 Dr Rodger Brough, Australian Rural Centre for Addictive Behaviours, in conversation with the Drugs and Crime Prevention Committee, *Inquiry into Amphetamine and ‘Party Drug’ Use in Victoria*, Melbourne, 6 October 2003. Dr Brough, an expert in rural alcohol and other drug (AOD) issues, also gave evidence to the current Inquiry.

See Dr Rodger Brough, Drug and Alcohol Physician, South West Healthcare, Public Hearing, Warrnambool, 3 March 2014.

474 Mr Ron Marshall, Latrobe Community Health Services, evidence given to the Drugs and Crime Prevention Committee, *Inquiry into Amphetamine and ‘Party Drug’ Use in Victoria*, Public Hearing (Moe), 23 October 2003.

475 The terms ‘metropolitan’, ‘rural’ and ‘regional’ are used as much as possible throughout this chapter in accordance with the Rural, Remote and Metropolitan Area (RRMA) classification system. ‘Metropolitan’ and ‘urban’ here refer to capitals and other large cities, and ‘regional’ to rural and remote towns and cities. See <http://www.aihw.gov.au/rural-health-rrma-classification>.

476 Submissions from individual regional districts give demographic data pertaining to those communities which provide useful background information for placing the problems associated with methamphetamine use in a rural context. These included submissions from the Sunraysia and Murray Regions; the Goulburn Valley; Central Victoria; Albury–Wodonga; Gippsland; Geelong; and South-West Victoria.

Numerous witnesses also gave oral evidence at Public Hearings throughout the state that also provided useful background knowledge.

477 See for example:

Mr Clive Alsop, Regional Co-Ordinating Magistrate Gippsland, Magistrates’ Court of Victoria, Submission, 28 October 2013; Mr Rob McGlashan, Executive Officer, Northern Mallee Primary Care Partnership, Submission, 21 October 2013; Mr Hamish Fletcher, Chief Executive Officer, Primary Care Connect, Submission, 18 October 2013.

478 See Superintendent Daryl Clifton, Victoria Police, Public Hearing, Bendigo, 25 October 2013; Superintendent Andrew Allen, Divisional Commander, Ballarat Division, Western Region, Victoria Police, Public Hearing, Ballarat, 18 November 2013; Ms Mary Bassi, Manager, Primary Health, Sunraysia Community Health Services, Public Hearing, Mildura, 5 December 2013; Mr Alan Fisher, Clinical Leader, Drug and Alcohol Community Treatment Services, Albury–Wodonga Health, Public Hearing, Wodonga, 24 February 2014; Detective Acting Inspector Paul Maher, Goulburn Valley Division 3, Victoria Police, Public Hearing, Shepparton, 25 February 2014.

regional health workers that methamphetamine were being used in rural Victoria at that time.⁴⁷⁹

What remains unclear is whether the level of methamphetamine use and the consequences that flow from that has changed to any significant degree in the past 10 years. Unfortunately there is only limited formal evidence to substantiate the current levels of methamphetamine use in regional Victoria.⁴⁸⁰

Some data is provided every three months through the Early Identification of Drug Harms Project (EIDHP), run by Turning Point Alcohol and Drug Centre, to the Victorian Health Department. These accounts do suggest a high and increasing amount of methamphetamine use is occurring in rural and regional Victoria.⁴⁸¹ In addition, drug treatment data compiled by the Department of Health suggests there are more courses of treatment that are amphetamine-related being delivered in rural than metro areas. 'In the two quarters for 2013–2014 there are some 183 courses of treatment that have been delivered in rural areas, compared to 96 in the metro areas'.⁴⁸²

Methamphetamine use in rural Victoria — Community concerns

In addition to this (limited) official data, accounts from a variety of witnesses suggest that the use of methamphetamine in regional Victoria is serious and increasing. This may be particularly the case in the Sunraysia (Mildura), Goulburn (Shepparton), Gippsland, Albury–Wodonga and South-West (Warrnambool) regions.

Anex, the peak body that supports injecting drug users, in conjunction with the Victorian Department of Justice, has been conducting a series of community forums on methamphetamine use in most regional areas of the state.⁴⁸³ Regional communities have been reporting to Anex a huge upsurge in methamphetamine use and many serious consequences that flow from this including family breakdown and violence, crime⁴⁸⁴ and child neglect. Anex states:

It has been reported to Anex in the course of our work in regional and rural areas that the use of methamphetamine, particularly ice, is having an impact at a community level. While illicit drugs can be more difficult to source in country areas (particularly heroin) according to workers' reports to Anex and other sources such as the Early Identification of Drug Harms Project [EIDHP] reports, this is not the case with methamphetamine, which is easily accessed in these areas. Community workers have reported that the use of this drug has become socially acceptable, even to the point where some rural workers are using the drug in the course of their day to day work, particularly when they are involved in labouring work.⁴⁸⁵

Notwithstanding the difficulty in gauging accurate prevalence figures for methamphetamine use in rural communities, it is certainly true according to some witnesses to the Inquiry that the problem appears to be highly visible because of the small size of rural towns and communities:

479 See Drugs and Crime Prevention Committee, *Inquiry into Amphetamine and 'Party Drug' Use in Victoria*, Parliament of Victoria 2004.

480 See Chapter 5 for discussion of the limited data available on methamphetamine use in rural and regional Victoria.

481 Ms Judith Abbott, Acting Director, Community Programs and Prevention Branch, Mental Health, Drugs and Regions Division, Department of Health, Public Hearing, Melbourne, 31 March 2014.

In undertaking the EIDHP, Turning Point makes contact with approximately 45 health and AOD agencies across the state to ascertain advice and relatively contemporaneous qualitative information and advice about what is happening in the field, with regard to drug use, including the emergence of new trends.

482 Ms Judith Abbott, Acting Director, Community Programs and Prevention Branch, Mental Health, Drugs and Regions Division, Department of Health, Public Hearing, Melbourne, 31 March 2014. See also the discussion in Chapter 29.

483 See Chapter 24 for a discussion of these forums.

484 A submission from the Victoria Police noted a distinct upsurge in rural crime related to methamphetamine including trafficking, drug manufacture, acquisitive crime such as theft and burglary, assaults and even homicide. See Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

485 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

When you are looking at the rural areas it is more visible because the communities are closer together. It is more visible for people to see what is going on in those communities, whereas even though when you are looking in the city you do not see it as much, there is still a lot of usage in the city... it is just that it is more spread out in the city area; it is not in one area. That is my view of why it is more visible in the rural areas.⁴⁸⁶

It may also be that the issue is felt more acutely in rural areas of Victoria because of fewer law enforcement, treatment and alcohol and other drug (AOD) services available.⁴⁸⁷

Drug educator Mr Paul Dillon had a slightly different perception on this sense of perceived crisis with regard to methamphetamine in rural communities. Without underestimating the extent of the problem, he told the Committee there was also a danger in overstating the situation:

In a regional centre, if you have a handful of people who have this problem — I am using ‘handful’; I am not saying it is four or five people — it is very, very easy to see. They get a lot of attention, and what happens is they cause a great many problems. The people I have spoken to in Victoria who are having issues with methamphetamine are those front-line workers, whether they be from health or law enforcement, who are having great problems with these people.

When I say to them, ‘How many are we talking about? Are we talking about hundreds, thousands?’ usually, when you actually boil it down, it is a core group causing a great many problems, but the problems look much, much larger. In a regional centre, a few people...cause a great drain upon what is happening. I think sometimes with these stories — and I have seen many of them over the years; we are certainly not minimising it and certainly not trying to take away from any of these people who are trying to deal with it, whether it be the families or the workers who come in contact with them. They do not have the capacity to deal with them and this group will cause a great problem.⁴⁸⁸

Numerous media accounts appear to be questionable and do not shed any light on this situation. For example, a report on methamphetamine use in rural Victoria quoted a witness, herself an ex-user, claiming that virtually the whole town of Neerim South in Gippsland is addicted to the drug,⁴⁸⁹ however the Committee received evidence from police witnesses that methamphetamine is not a problem in this rural location.⁴⁹⁰

Another point that needs to be made is that in rural and regional areas of the state, as in Melbourne, the drugs of most concern according to both official indicia (economic, health and social costs data) and evidence from witnesses to the Inquiry, are the licit substances of alcohol and tobacco.⁴⁹¹

Profiles of methamphetamine users and their reasons for use

As in metropolitan areas of the state, it cannot be said that there is one ‘typical’ profile of a methamphetamine user in rural and regional Victoria. Like their counterparts in Melbourne,

486 Mr Gilbert Freeman, Counsellor, Ngwala Willumbong Co-operative Ltd, Public Hearing, Melbourne, 24 March 2014.

487 See Mr Mike Sabin MP, Member for Northland, New Zealand Parliament, Comments at Rangatira Forum, Melbourne. 6 June 2014.

488 Mr Paul Dillon, Director and Founder, Drug and Alcohol Research and Training Australia, Public Hearing, Melbourne, 3 February 2014.

489 See ‘The other faces of meth’ *The Age*, 23 November, 2013. See also the blog posted by Victorian journalist Neil Mitchell — *Ice town: Victorian region’s ‘terrifying’ scourge*, 28 November 2013 at <http://www.3aw.com.au/blogs/breaking-news-blog/ice-town-victorian-regions-terrifying-scourge/20131128->.

490 See evidence of Superintendent Malcolm (Jock) Menzel, Divisional Commander, Eastern Region Division 5 — Morwell, Victoria Police, Public Hearing, Traralgon, 28 January 2014. Superintendent Menzel told the Committee that the article was in his view ‘confronting’ and could not be verified according to his research or investigations.

491 See for example: Mr Mark Allen, Team Manager, Morwell Mobile Intensive Care Ambulance (MICA) Unit and Single Response Unit (SRU), Ambulance Victoria, Public Hearing, Traralgon, 28 January 2014; Dr Tony Chan, Emergency Department Director, Latrobe Regional Hospital, Public Hearing, Traralgon, 28 January 2014; Ms Dianne Barker, Acting Senior Manager, ICMS and Residential Care, St Luke’s Anglicare, Bendigo, Public Hearing, Bendigo, 25 October 2013; Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013; Mr Mike Fuery, Paramedic, Ambulance Victoria, Public Hearing, Wodonga, 24 February 2014.

people may use for situational or functional reasons, for enjoyment or because they are dependent on the drug. Indeed, the profile of methamphetamine users in rural areas is extremely varied, as reported in a submission by the Northern Mallee Community Partnership:

The demographic profile of a methamphetamine use identified in rural areas is hugely diverse and unique in drug taking culture of users. Covering a broad range of cultural backgrounds, low-medium-high socio economic backgrounds, and not limited to a specific age range.

In summary, inexpensive, easily made and in demand, methamphetamine is used by housewives, students, club-goers, truckers and a growing number of others.⁴⁹²

Methamphetamine may also be used in both recreational and dependent ways by young people in regional towns and rural locations. Given the relatively high levels of Aboriginal people living in rural and regional areas, particularly towns such as Shepparton and Mildura, it is not surprising that a significant percentage of methamphetamine users would come from these communities.⁴⁹³

Similarly, the reasons why people in rural and regional communities may use methamphetamine (and/or other drugs) are probably not all that different from the reasons why it is used in metropolitan communities.⁴⁹⁴ There may, however, be some reasons for methamphetamine use that are particularly associated with living in a rural area. These may include social and economic disadvantage, higher levels of unemployment, boredom, low school retention⁴⁹⁵ and surprisingly greater access to the drug, particularly when it is manufactured and distributed locally. A submission from the Goulburn Valley Community Legal Centre (GVCLC) provides a case study in why methamphetamine use may occur in one rural town (Shepparton):

The Goulburn Valley area has a relatively high number of citizens who are continuously unemployed or obtain only seasonal work and therefore rely on welfare payments. Contributing factors include generational poverty, the loss of local manufacturing and food processing industries, the increased use of cheap itinerant labour for seasonal work, and the ongoing effects of the recent prolonged drought.

Shepparton in particular has been identified as containing an above average population of citizens who are suffering high levels of socio-economic disadvantage. GVCLCs clients are primarily drawn from those same members of the community. Their situation is compounded by a range of associated issues such as unstable and unaffordable housing, poor education, low employment prospects, financial distress, relationship breakdown, and their consequent separation from the mainstream. Poor mental health is the almost inevitable consequence of living in such circumstances and the abuse of alcohol, other legal drugs and illicit substances [including methamphetamine] the perceived panacea for it.⁴⁹⁶

Similar problems that explain methamphetamine use exist in the south-west of the state. Francis Broeckman of Brophy Family and Youth Services in Warrnambool told the Committee in this regard:

Some of the differences in the rural and regional setting are around isolation, boredom, unemployment, lack of opportunities. Difficulty to change peer groups I think is one of the key areas. They get locked into a peer group and then wherever they go, they are found.⁴⁹⁷

492 Mr Rob McGlashan, Executive Officer, Northern Mallee Primary Care Partnership, Submission, 21 October 2013.

493 See Chapters 12 and 13 for further discussion of methamphetamine use by young people and Aboriginal Victorians respectively.

494 See discussion in Chapter 14.

495 On this issue, see Ms Robyn Reeves, Chief Executive Officer, Ballarat Community Health Centre, Public Hearing, Ballarat, 18 November 2013; and Ms Fiona Harley, Deputy Executive Director, Mallee Family Care, Public Hearing, Mildura, 5 December 2013. See also discussion Chapter 22.

496 Ms Kaz Gurney, Managing Lawyer, Goulburn Valley Community Legal Centre, Public Hearing, Shepparton, 25 February 2014.

497 Mr Francis Broeckman, Chief Executive Officer, Brophy Family and Youth Services, Public Hearing, Warrnambool, 3 March 2014.

Access and availability of methamphetamine

Witnesses have informed the Committee that methamphetamine is relatively easy to access in rural and regional areas. For example, people in rural centres are said to be accessing methamphetamine in a number of ways: from local manufacturers/dealers or by travelling to Melbourne and other larger regional centres to purchase the drug:

There is no doubt it has pervaded into every area of local community, small towns. In the past it seemed to be that smaller country towns did not have the so-called hard drug issue, but there is no doubt that with ice it is in local communities everywhere. From what I am seeing it does not appear to be a complicated network set-up. It more appears to be that we have separate groups that will usually go to the metropolitan area, buy what they need for the week and bring it back. They will have their own network; they do not appear to be interconnected as such.⁴⁹⁸

Another important issue pertaining to the supply of methamphetamine is the use of central transit routes in various parts of the state. For example, evidence has been given that in an area such as Warrnambool or Portland, interstate highways can readily bring in the drugs from locations such as Mt Gambier in South Australia and Geelong.⁴⁹⁹ Cross-border transit of drugs between border towns such as Mildura or Wodonga also facilitates ease of access and supply.⁵⁰⁰

Fear or lack of knowledge about the drug

Many regional and rural communities feel overwhelmed by ice and unequipped to deal with this drug. Fear is also exacerbated in small rural communities because of the lack of anonymity in these places. Family members in particular may feel shame knowing that their loved one's drug use may be public knowledge.⁵⁰¹ A feedback report on ice forums in rural Victoria stated that many families in rural and regional areas will not seek help 'due to a sense of shame and the stigma attached to drug use and mental illness' (Anex 2014, p.14). Alternatively, this lack of anonymity may result in users either not seeking treatment or as discussed below, leaving their communities to access that treatment. Moreover, as discussed in Chapter 24, many people in rural and regional communities have reported that they desperately need better information about ice and its effects. This is certainly what the peak body Anex is finding across the state:

At Anex training sessions, forums and workshops we are consistently advised by attendees that they need ongoing ice education as staff turnover means loss of knowledge and corporate memory about what resources there are to draw on.

From presenting to regional communities, it has become apparent that services in these areas need better networking and cross-service/sector planning to:

- Better identify drug use patterns to enable predictions for service demand (including better connections with what is going on in school communities, local sports clubs and entertainment venues and certain workplaces)
- Deal with the issues associated with methamphetamine use and to improve referral pathways into treatment (including child protection, police, mental health services, family violence services, AOD treatment services).⁵⁰²

498 Detective Senior Sergeant Paul Maher, Detective Acting Inspector, Goulburn Valley Division 3, Victoria Police, Public Hearing, Shepparton, 25 February 2014.

499 Superintendent Don Downes, Western Region, Division 2, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

500 Superintendent Paul O'Halloran, Superintendent and Divisional Commander Eastern Region Division 4, Victoria Police, Public Hearing, Wodonga, 24 February 2014.

501 See Ms Bev McIlroy, Manager, Glenelg Southern Grampians Drug Treatment Service (QUAMBY), Public Hearing, Warrnambool, 3 March 2014.

502 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

This concern in rural communities was expressed to the Committee by Mr John Ryan from Anex when he gave evidence to the Committee:

A lot of our work has actually been in country Victoria because it is country Victoria that has most noticed the significant increase. Part of the value of living in the country is that people have better local networks. They know what is going on in their town, and therefore they are more quick to catch on to a significant issue. Because they do not yet have the skills and knowledge to be able to understand how to manage the issue adequately, there is therefore a lot of fear and anxiety. I am confident that can be worked through.⁵⁰³

Treatment and service provision

Clearly the demographics of rural and regional populations are different from those of the cities. It follows that the factors bearing on illicit drug use and communities' capacity to respond to this problem are different from those encountered in metropolitan contexts. This is particularly true with regard to the provision of treatment services.⁵⁰⁴

Partnerships to address methamphetamine use in rural and regional communities

As previous discussions indicate, various service providers acknowledge the prevalence of methamphetamine use and its consequences in rural and regional Victoria. Concerns have been raised about a lack of information on the drug and its effects. Resource constraints also limit the ability of individual service providers to respond to the issue. Consequently the Committee examined partnership approaches in rural communities. The two partnership strategies — one based in the Wimmera and one in the Sunraysia/Mallee region — that were presented to the Committee as models that could easily be replicated in other areas of the state are discussed in detail in the following sections.⁵⁰⁵ Such approaches consist of a variety of stakeholders in conjunction with the community coming together to plan, develop and implement strategies to address substance abuse.

The Wimmera Drug Action Taskforce

The Wimmera region is based in north-west central Victoria with Horsham as the regional city. The Wimmera Drug Action Taskforce (WDAT) is an inter-agency partnership, with a catchment area covering the four Local Government Areas of Horsham Rural City, Hindmarsh, Yarriambiack and West Wimmera.

The WDAT consists of representatives from health and community services organisations, councils, emergency services, schools and other community groups. It does not receive any dedicated funding and members either volunteer or are supported by their employers.

The mission statement of the Taskforce is:

'to reduce the harms caused by alcohol and other drugs to our communities through integrated, evidence-based prevention and early intervention'. WDAT initiatives utilise a number of strategies from community awareness/education through to workforce development.⁵⁰⁶

Since forming in 2010, the WDAT has engaged in an extensive, 'whole-of-community' partnership approach to implement the Wimmera Local Drug Action Plan. This plan aims to address a variety of issues pertaining to substance abuse such as pharmaceutical misuse,

503 Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

504 See discussion Chapter 27.

505 This is not to state that there are no other similar and equally worthwhile partnership programs in other areas of the state. The two models profiled here were presented to the Committee for consideration as best practice examples in submissions by the respective management teams of the partnerships.

506 Dr Nyree Hutchins, Clinical Psychologist and Chair, Wimmera Drug Action Taskforce, Submission, 12 June 2014.

youth alcohol and other drug misuse, sports and drug misuse and importantly in the context of the Wimmera area, methamphetamine use.

The Wimmera Ice Action Plan (WIAP)

Toward the latter part of 2011 Grampians Community Health, and AOD treatment providers began seeing an increase in ice-related intakes and presented this information to WDAT. Subsequently, in 2012, WDAT identified ice as a priority issue and sent a range of local professionals to receive training by Anex on the drug. WDAT also brought the issue to the attention of the public through local media, both print and radio.

In 2013 the WDAT continued to raise community awareness on ice through the media and by hosting professional development seminars and community forums. In September 2013 an ice specific working group of WDAT was organised to develop the region-wide holistic Wimmera Ice Action Plan (WIAP), covering all aspects from prevention through to treatment. An intensive two-month media campaign was implemented, culminating in a professional development seminar attended by over 100 professionals, and a community forum which attracted over 240 people. In addition, a family support group was formed to inform and assist families whose members may be using ice. WDAT is continuing the implementation of the WIAP with further community forums planned throughout the region in late 2014.

The key approaches of the WIAP are its focus on prevention as a means of addressing methamphetamine use. Equally important is its use of a partnership model to target different levels of intervention and different groups of methamphetamine users.

A prevention model

A submission to the Inquiry from WDAT outlines how a multi-level Local Drug Action Plan for the Wimmera has allowed the Taskforce to target projects at different levels of prevention.⁵⁰⁷ These have included:

Primary Prevention: including the implementation of primary school alcohol and other drug education programs in schools; Community education including via local media and running education forums on methamphetamine.

Secondary Prevention (targeting at-risk groups): including Sports Health and Wellbeing (SHAW) program; Alcohol and other Drug Education modules for sports clubs.

Tertiary Prevention (early intervention): Family Support groups, promotion of social inclusion through Community education events and media liaison, promoting and facilitating ongoing educational opportunities to upskill health, mental health and community work professionals in identifying and working with Alcohol and other Drug use problems (including focussing on methamphetamine use).⁵⁰⁸

Each of these approaches may target methamphetamine specifically where it is appropriate to do so. For example, this may not be the case with primary school children.⁵⁰⁹

Working in partnership

The WDAT has stated that ‘cultivating local partnerships have been integral to WDAT’s ability to implement the Local Drug Action Plan and ‘Ice’ Action Plan’, particularly for the rural communities in their catchment area.⁵¹⁰

The partnerships that WDAT have entered into to address methamphetamine and other drug use in the regional towns and rural areas of the Wimmera have been diverse and

507 Further details of WDAT’s prevention and education programs are covered in Chapter 22.

508 Dr Nyree Hutchins, Clinical Psychologist and Chair, Wimmera Drug Action Taskforce, Submission, 12 June 2014.

509 See also Chapter 23 as to why specific instruction on methamphetamine use may not be appropriate for primary school age children.

510 Dr Nyree Hutchins, Clinical Psychologist and Chair, Wimmera Drug Action Taskforce, Submission, 12 June 2014.

comprehensive.⁵¹¹ They have also resulted in beneficial outcomes according to WDAT's submission to the Inquiry:

- Partnerships with local government (shire councils), local health services and community agencies have allowed projects to be locally-focussed, facilitated community 'buy-in' and improved the long-term sustainability of these initiatives.
- Partnerships with local media outlets have enabled our education and awareness programs to reach a geographically and socio-economically diverse audience.
- Partnerships with local schools and education-support agencies allowed us to develop, pilot and deliver our successful Knowledge is Power (KIP) primary school alcohol and other drug education program.
- Partnerships with local sporting bodies have also allowed the development and integration of a drug education module that is regularly presented to sporting clubs.
- Partnerships with emergency services, particularly police, has improved collaboration between agencies focussing on differing areas of the methamphetamine problem (demand reduction & supply reduction). This has had many benefits, including improved data for informing tertiary prevention strategies, and improved consistency in community education messaging.⁵¹²

WDAT's partnership program, whilst comprehensive and ambitious in its outreach, has not been without its challenges. In short, 'full implementation of Wimmera Local Drug Action and Ice Action Plans throughout our region has been hampered by a lack of financial resources'.⁵¹³

Nonetheless, WDAT views their partnership approach as a successful model for addressing methamphetamine use in the Wimmera region. Whilst not formally evaluated, WDAT's best-practice, innovative work has been acknowledged and supported by state-wide bodies such as the Victorian Alcohol and Drug Association (VAADA).⁵¹⁴

Its partnership approach has been recognised as an innovative means of cross-sector collaboration to address methamphetamine and other drug use issues through a prevention framework.⁵¹⁵ WDAT's submission to the Inquiry claims that their 'locally focussed, collaborative approach is highly recommended as an effective means of addressing the full spectrum of challenges of methamphetamine use across regional communities'.⁵¹⁶

The Northern Mallee Community Partnership

The Northern Mallee Community Partnership (NMCP) is based in the rural city of Mildura, the main town in the Sunraysia/Mallee region of Northern Victoria. The Partnership unites more than 40 government and local organisations to address issues important to the local community. In particular, the Partnership provides a forum for discussion of local issues, particularly among health, welfare and law enforcement agencies in the Mildura region.⁵¹⁷

Background to Project Ice

In late 2012 and early 2013 a perceived rise in the issue of ice in the Mallee region was a recurrent discussion at meetings of the NMCP. In particular, police, health and welfare groups in the Mallee region noted rising use of ice among their clients and problems

511 See Submission of Dr Nyree Hutchins, Clinical Psychologist and Chair, Wimmera Drug Action Taskforce, Submission, 12 June 2014. for a full list of partnership members.

512 Dr Nyree Hutchins, Clinical Psychologist and Chair, Wimmera Drug Action Taskforce, Submission, 12 June 2014.

513 Dr Nyree Hutchins, Clinical Psychologist and Chair, Wimmera Drug Action Taskforce, Submission, 12 June 2014.

514 See letter from Sam Biondo, CEO, VAADA, 16 May 2014 attached to Dr Nyree Hutchins, Clinical Psychologist and Chair, Wimmera Drug Action Taskforce, Submission, 12 June 2014.

515 Including the endorsement of the Youth Drugs, Alcohol Advice Service (YoDAA). See Dr Nyree Hutchins, Clinical Psychologist and Chair, Wimmera Drug Action Taskforce, Submission, 12 June 2014.

516 Dr Nyree Hutchins, Clinical Psychologist and Chair, Wimmera Drug Action Taskforce, Submission, 12 June 2014.

517 For a complete list of NMCP member agencies see www.nmcp.org.au.

surrounding the drug. Anecdotally, members reported that ice had rapidly become the second-most common illicit drug in Mildura, with some agencies describing it to be at ‘epidemic’ proportions.⁵¹⁸

Mildura, as with many other rural cities, has relatively high levels of socioeconomic disadvantage including high unemployment, low school retention rates and poverty which can act as ‘breeding grounds’ for substance abuse and associated crime.⁵¹⁹ Of particular concern was the spread of crystal methamphetamine to the Aboriginal community in Mildura and surrounding area.⁵²⁰

Anecdotal evidence has also been presented to the Committee that local farmers with substantial debt were turning to crystal methamphetamine as a way of coping with financial and other pressures. As Rob McGlashan, the Executive Officer of the NMCP, told the Committee:

One thing that is particularly unusual for our region is that we have seen a downturn in the economy, there is no doubt about that. Primary producers have been suffering now for a number of years through drought, the downturn in the economy itself and the price of the dollar and so forth. We have obviously a local financial counselling service available for farmers which is across Victoria, but ours has come to us and said, ‘We are seeing an increase in farmers that are coming in for financial counselling, declaring that they are using ice’, and the financial counsellors do not know how to respond to that. So they have just requested some information sessions on what the drug is and so forth.

That is a very particular demographic that should not and traditionally would not be taking drugs — alcohol maybe, but farmers do not normally indulge in that sort of drug taking. So it is an interesting one and probably summarises the effect, that the drug is taking a hold locally.⁵²¹

Methamphetamine-related crime in the Mallee was also of particular concern to the region’s police. A submission from the NMCP to the Committee stated:

Victorian police data indicates a near doubling of the drug crime rate in Mildura in the past two years. The rising use of methamphetamine, or ice, is now accounting for about 90% of drug-related arrests. According to Inspector Simon Clemence ‘... it is without doubt the single biggest drug problem in our community’.⁵²²

The formation of Project Ice

The mounting concerns expressed by members of the NMCP on the crystal methamphetamine issue resulted in a decision early in 2013

[t]o establish a specific and targeted campaign to increase awareness and build community resilience to the drug’s influence. The group envisaged a six-month campaign to “saturate” the local community

518 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013.

519 Martin Hawson, General Manager, Community and Culture, at Mildura Rural City Council put the issue of methamphetamine use in a demographic context when he gave evidence to the Committee noting that Mildura was in the lower socioeconomic categories for a number of indices:

‘From a socioeconomic perspective, the index of relative socioeconomic disadvantage, we are ranked 12th in terms of disadvantage. Our unemployment rate is 7.6 percent, with fluctuations obviously taken into account; the Victorian measures are running at about 5.4 percent. Social housing as a percentage of the total dwellings is 6 percent, whereas the Victorian measure is 3.8 percent. Families headed by one parent, 18.2 percent, whereas the Victorian measure is 15.5 percent. The low-income families with children is running at 2.7 percent, whereas the Victorian measure is 1.8 percent.’

Mr Martin Hawson, General Manager, Community and Culture, Mildura Rural City Council, Public Hearing, Mildura, 5 December 2013.

520 These problems are particularly noticeable given the relatively high levels of Aboriginals living in Mildura and surrounding districts compared to the rest of the state. For example, in 2011, Mildura Rural City had 1,836 Indigenous persons who were usual residents and this represented 3.6% of the total local government area population, compared to the Victorian average of 0.7%. Robinvale, a smaller town to the east of Mildura, had 295 Indigenous persons who were usual residents and this represented 7.9% of the usual resident population.

521 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

522 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013.

with information regarding ice — community forums, media coverage, posters and advertising.^{523 524}

As a result the project group implemented a proactive regional response to the local issues pertaining to crystal methamphetamine in the town and wider region — an all-of-community action partnership known as ‘Project Ice’. In the words of a submission to the Inquiry by the NMCP — ‘In Mildura, the people have chosen to fight back’.⁵²⁵

Rob McGlashan the Executive Officer of the NMCP gave evidence to the Committee when it visited Mildura. He wished to stress that:

Project Ice Mildura is not just a group of vigilante community members who have got together, but it is actually a formal approach under a very formal model as part of the Northern Mallee Community Partnership. It is a community engagement framework with an executive committee which is made up of the different community sectors including police, health, education and welfare, and there is a partnership office which we do have some resources there to implement what we call our wicked problems locally.⁵²⁶

Michelle Withers who also works with the NMCP told the Committee that the reason Project Ice came about can be likened to a ‘cliff analogy’:

If you look at this analogy, you will see the pointy end of the stick, as we talk about it, is there at the bottom. When people have come over the cliff, they are there at the tertiary end, so you are looking at your ambulance, the hospital et cetera.

When you move up, you go through your prevention phases until you see that at the top of the cliff you have the community. What we have seen here, and the reason for this analogy, is to show you that what our Project Ice is about is a proactive campaign. We are not waiting until people are falling off the cliff and in crisis. We have all become exposed to the fact that ice is an issue in our community. We do not have the hard data but we are all aware that it is a growing problem, so what Project Ice is doing is an education and prevention campaign to address the people who are not near the edge of the cliff.

You are looking at people who know nothing about drugs. You are looking at people who are perhaps interested in finding out what is going on, perhaps at risk of recreational use. What we are wanting to do is inform the community about what this is so that when they are exposed they have some quality credible knowledge. That is why we have put that analogy in. We are not talking about waiting until they get to crisis. Project Ice is about speaking to the community before it becomes critical.⁵²⁷

Community education initiatives

The service providers involved with Project Ice brought together resources to fund an awareness campaign for the local district, and to ensure a strong and consistent message was delivered to the community. The group also developed a comprehensive community campaign and a communications plan for ongoing community awareness and information:

We have embarked on a community education blitz, to inform our community on what the drug is, how it is made, how it works on the body, why it is so addictive, signs to look for, short term and long term effects. We are doing this from limited resources.⁵²⁸

523 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

524 It established a drugs project group, bringing together Sunraysia Community Health, the Northern Mallee Primary Care Partnership, Mildura Rural City Council, Mildura Police, Mallee District Aboriginal Services, Mildura Base Hospital, Mental Health Services, the Department of Education, the Northern Mallee Local Learning and Employment Network and the Department of Justice.

525 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013.

526 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

527 Ms Michelle Withers, Integrated Services Coordinator, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

528 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013.

To deliver these community education initiatives key community members were trained as facilitators. The NMCP has been pleased with the results of these forums noting that by October 2013, 300 people had attended the community information sessions held including over 140 service providers. According to Ms Michelle Withers, one of the key aspects of making Project Ice a success in delivering its 'message' was excellent relations with local media who understood rural and regional issues and concerns.

Project Ice has, according to the NMCP, acted as a conduit for the public to provide intelligence to the local police with regard to the issue of methamphetamine-related crime:

The people of Mildura are now aware and concerned about the 'ICE' problem. People are now increasingly prepared to speak up and assist with police intelligence. As a result of both an increased intense police focus and community information, drug-related arrests have increased dramatically. In 2010/2011 police received 57 intelligence reports in relation to drug crime. Last year this increased to 418.

By combining as a group of health, welfare and enforcement agencies [in conjunction with the public] we are sending a clear message that as a community we are informed and aware and will not tolerate 'ICE'.⁵²⁹

The Project has distributed campaign posters and developed advertising strategies to complement the community information that is being delivered in forums and seminars. The campaign message has a short and sharp focus namely — 'It's not if, but when someone you know will be exposed to ice ... get the facts'.⁵³⁰

The Project has also played a key role in terms of providing education sessions to secondary school students. The NMCP has expressed concerns that this is a role that in part has been developed because the formal school system is not providing sufficient drug education:

Education in schools has to be the number one key priority. While we are informed by Department of Education and Early Childhood Development employees that every school child receives a minimum of 10 hours of drug education per year, our research with both students and schools is that this just doesn't happen. Students attending our ICE information sessions state they have no previous education of methamphetamine. Schools simply report that they are not trained or confident to implement drug education. This needs to be addressed.⁵³¹

The future?

There have been limitations as to what Project Ice has been able to achieve within the relatively short period of its operation. It has limited resources and expertise in developing the type of grass roots campaigns it would ideally like to roll out. In particular, it would assist them if they had:

Communications advice, guidance and resources based on market research and empirical evidence to assist developing (or to implement directly) local awareness and education campaigns. Most previous campaigns are now outdated so offer little assistance.⁵³²

Nonetheless, on balance, according to the NMCP, Project Ice has been a 'success'. It has raised awareness of the methamphetamine issue in Mildura and surrounding districts. It has also developed inclusive and rural focused strategies to address it.⁵³³

529 Ms Michelle Withers, Integrated Services Coordinator, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

530 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013.

531 See Chapter 23 for an account of drug education in schools.

532 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013.

533 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013.

A model that suits the rural and regional community

In rural communities particularly it is recognised that a lack of resources and specialised service provision means it makes sense for local service providers to work in partnership to make those resources stretch further and to ensure information sharing is facilitated.

Initiatives such as Project Ice, the Wimmera Ice Action Plan, and the newly formed Greater Geelong Collective Community Effort on Substance Abuse, discussed in Chapter 24, are ways in which local people in rural and regional areas, many of whom will know their local service providers, can participate in issues that concern them and be involved in grass roots strategies to address the problems confronting their local communities. As a feedback report into community ice forums held in rural Victoria explained, ‘Rural and regional communities are resilient and come together to address major issues such as this’ (Anex 2014, p.4).

Conclusion

Methamphetamine use can have different effects on a variety of users and the communities from which they come. The relative lack of research literature specific to methamphetamine use in rural and regional communities has meant much of what has been presented here has been taken from the experiences of rural and regional representatives throughout Victoria. Whilst some of these accounts are anecdotal evidence, they are nonetheless valuable for that. It is unfortunate, however, that this evidence is not to any significant degree substantiated by formal or comprehensive research.

Some of the most relevant and enlightening information has been supplied by rural and regional community health and AOD providers. These services have frequently made the point that their records and knowledge of drug use patterns in specific regions is limited to some degree to clients who formally *access* the respective service system. The evidence, therefore, does not account for individuals too remote to access an appropriate service or who choose, even if their drug use is problematic, not to access formal treatment or support.

The problems associated with methamphetamine use are similar in both metropolitan and rural regions of Victoria. Nonetheless, methamphetamine use still needs to be addressed from a specific rural context where appropriate. This is particularly the case with regard to service provision, especially treatment, which many witnesses have told the Committee is biased in favour of Melbourne.⁵³⁴

This point was strongly emphasised by Ms Bev McIlroyd from the Glenelg Southern Grampians Drug Treatment Service:

I want to clearly make the point that as rural drug treatment services, rural issues and rural responses and rural impacts need to be taken seriously. I cannot say that strongly enough. What we see here, there is little relationship to what people see in the city. I understand figures, I understand numbers and I understand dollars, however, each person deserves the right to have their issues addressed no matter where they are.⁵³⁵

The variability and complexities of drug use throughout the populations profiled in this and the previous chapter clearly requires acknowledgment, further research and strategies that are informed by people with appropriate training and knowledge — of both methamphetamine use as well as the diverse cultural and environmental contexts in which it is used.

⁵³⁴ See discussion in Chapter 29.

⁵³⁵ Ms Bev McIlroyd, Manager, Glenelg Southern Grampians Drug Treatment Service (QUAMBY), Public Hearing, Warrnambool, 3 March 2014.

12. Methamphetamine Use and its Effect on Aboriginal communities⁵³⁶

Introduction

A significant amount of evidence has been given to this Inquiry that methamphetamine use is a serious and growing concern in Aboriginal communities throughout Victoria resulting in medical and social harms for Aboriginal individuals, families and extended communities.⁵³⁷ The Aboriginal health sector in particular 'is openly concerned about methamphetamine impacts on their community members'.⁵³⁸ The peak body Anex, for example, has undertaken extensive training around methamphetamine use for Aboriginal services and conducted many community forums with Aboriginal Victorians. Through this work, Anex has received 'numerous reports that there are high levels of use of methamphetamine in these communities, and through discussions with Aboriginal services we are hearing of significant methamphetamine-related problems'.⁵³⁹

Despite the concerns expressed by Aboriginal community representatives in both metropolitan and rural regions of Victoria, with regard to methamphetamine use it should be understood that there is a heterogeneity in Aboriginal populations that needs to be taken into account in any understanding of substance abuse.⁵⁴⁰ Many witnesses have told the Committee that it is important to acknowledge that whilst Aboriginal people as a whole may share a legacy of past colonisation and dispossession⁵⁴¹ and in some cases a traumatic present, there are also many differences between and within Aboriginal communities. A remote settlement of older Aboriginal people will not necessarily have the same problems or needs as those of young urban Kooris. A 'one size fits all' approach will be no more suitable for Aboriginal Victorians than it would be for non-Aboriginals.⁵⁴²

536 This Report deliberately uses the terms Aboriginals or Aboriginal Australians or variations thereof. In 2009 the National Aboriginal Community Controlled Health Organisation (NAACHO), its members and affiliates voted unanimously for 'Indigenous' to be used only in an international context and Aboriginal in the domestic context. The Committee respects this decision and follows its usage accordingly.

537 See for example, Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Submission, 17 October 2013; Dr Karen Adams, Researcher, Victorian Aboriginal Community Controlled Health Organisation, Submission, 18 October 2013; Mr Rudolf Kirby, Chief Executive Officer, Mildura District Aboriginal Services, Submission, 21 October 2013; Ms Kit-e Kline, Drug & Alcohol Worker, Wathaurong Aboriginal Co-operative, Submission, 22 October 2013; Mr Bernie Geary OAM, Principal Commissioner, and Mr Andrew Jackomos PSM, Commissioner for Aboriginal Children and Young People, Commission for Children and Young People, Submission, 25 October 2013. Numerous witnesses from Aboriginal organisations who gave evidence to the Committee at public hearings also testified to these concerns that methamphetamine use was a serious and growing concern in many Aboriginal communities throughout Victoria.

538 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

539 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

540 Thus differences between urban and rural Aboriginals or even communities within one urban area such as Melbourne may need to be taken into account. Moreover, specific population groups within Aboriginal communities may have different needs that should be addressed. Such groups may include people with co-morbidity problems, men who have sex with men, prisoners, sex workers and the homeless. See Australian National Council on Drugs (ANCD) 2011 for further discussion on the heterogeneous nature of Aboriginal populations.

541 See discussion below.

542 See Mr Christofer Beal, Coordinator, Tanderra AOD Services, Bairnsdale, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

Aboriginal Victorians — A snapshot

A discussion of the use and problems associated with methamphetamine by Aboriginals in Victoria needs to be understood within the context of some basic background data. This is particularly important in understanding some of the social and structural issues that, at least in part, may contribute to relatively high levels of substance abuse amongst Aboriginal Victorians.

The 2011 Australian census showed there were 37,990 Aboriginal and Torres Strait Islander people living in Victoria. Of these, 18,675 (or 49.2%) were male and 19,315 (or 50.8%) were female. The median age was 22 years compared to 38 years for the general population. Victoria's Aboriginal population has therefore grown by 26% since the 2006 census and is growing by 4.7% annually.⁵⁴³ The percentage growth of Victoria's Aboriginal and Torres Strait Islander population was only exceeded by the Australian Capital Territory. By 2021 the Victorian Aboriginal population is expected to reach approximately 50,006 people.

At the time of the 2011 census, 46.3% of Victoria's Aboriginal and Torres Strait Islander population lived in metropolitan Melbourne (17,573 persons) compared with 53.7% in regional Victoria (20,415 persons). This compares with the total Victorian population of which 73.6% lived in metropolitan Melbourne and 26.2% in regional Victoria.⁵⁴⁴

A submission from the Victorian Aboriginal Legal Service (VALS) noted that:

The geographic distribution and age profile of Victoria's Aboriginal population increases their propensity to be involved in the use of illicit substances such as ice, and paints a worrying picture for the future, particularly when combined with the well documented reasons why Aboriginal people are already more likely to be over-represented in the justice system [such as];

- High levels of poverty;
- Poor education outcomes;
- High rates of unemployment;
- High levels of drug and alcohol abuse;
- Over-crowded housing and high rates of homelessness;
- Over-representation in the child protection system;
- High levels of family dysfunction; and
- A loss of connection to community and culture.⁵⁴⁵

Younger Aboriginal people in particular continue to be seriously over-represented in the justice system and according to VALS, are more likely to face a greater risk of a lifetime of offending associated with illicit drug use:

Aboriginal young people are three times as likely to be processed by police and in 2011-12 they comprised 15% of those receiving a Youth Justice Centre Order compared to their population share of about 1%. Aboriginal people more generally are 20 times as likely to return to prison under sentence within two years of release... The higher than average growth of the Aboriginal population and lower median age mean that the numbers coming into contact with the justice system are likely to grow.⁵⁴⁶

In relation to methamphetamine use, a submission from the Victorian Aboriginal Community Controlled Health Organisation (VAACHO) also linked the profiles of Aboriginal Victorians to their use of the drug. Of particular concern was their claim that 1 in 10 young Aboriginal people use methamphetamine compared to 1 in 20 young non-Aboriginal people. It also stated that:

543 http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/quickstat/2.

544 <http://www.dpcd.vic.gov.au/home/publications-and-research/urban-and-regional-research/census-2011/quick-facts>.

545 Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Submission, 17 October 2013.

546 Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Submission, 17 October 2013.

- Of young Aboriginal people who use methamphetamine 1 in 2 use daily or weekly compared to 1 in 10 non Aboriginal people
- Numbers of Aboriginal people in Victorian prisons have doubled in the last 10 years, almost all have drug dependence and this worsens after imprisonment
- Aboriginal families with methamphetamine dependent members request improved support and skills in dealing with methamphetamine dependence
- [There is] Little evidence of effectiveness of methamphetamine health education and prevention programs that work with Aboriginal people
- [There is] Little evidence about effectiveness of methamphetamine treatment with Aboriginal people.⁵⁴⁷

These various observations are examined in greater detail throughout this chapter.

The extent of the problem in Aboriginal communities

Concerns expressed with regard to methamphetamine use in Aboriginal communities are not to any significant degree matched with academic research evidence. While there is a significant amount of literature about drug use such as alcohol and volatile substances among Aboriginal people there is relatively little research material regarding methamphetamine use in this population. A relatively recent important study is the *Injecting Drug Use and associated harms amongst Aboriginal Australians* (2011) undertaken for the Australian National Council on Drugs (ANCD). Whilst this study examines the use of injectable drug use generally rather than methamphetamine specifically, it is important for its discussion on the problems associated with gauging the extent of substance abuse in Aboriginal communities, including methamphetamine and other injectable drug use.

Indeed, various academic sources acknowledge that getting an accurate picture of the prevalence of methamphetamine use, and indeed any drug use, within the Aboriginal population is very difficult, as with the mainstream population. For example, the ANCD Report on Aboriginal injecting drug use noted that there is a clear gap in accurate data in relation to both the extent and the harms associated with illicit drug use by Aboriginal Australians:

In particular, there is a lack of accurate and representative data on patterns and prevalence of Aboriginal [injecting] drug use that can be compared nationally...There are significant knowledge gaps and issues in: the methods used to collect Aboriginal recreational and injecting drug use data; data sources; the focal point of data collection; and the purpose of data collection...Australia does not have a comprehensive system to determine the level of drug use in Aboriginal communities... Furthermore, an inclusive approach to posing research questions and their intended outcomes by enabling participation of Aboriginal communities in research design is critical to determining relevance and meaning when dealing with data and its use (ANCD 2011, p.xiii).

The ANCD Report noted that whilst a separate study was undertaken by the Australian Institute of Health and Welfare as a supplement to the National Drug Strategy Household Survey (NDSHS) in 1994, this has not been repeated in later applications of the NDSHS. Whilst the 1994 supplement resulted in valuable information at the time, this information is clearly now out-dated. Subsequent general surveys of drug use in Australia (and Victoria) do not yield sufficient data to allow for comprehensive analysis of Aboriginal use of illicit drugs generally or methamphetamine specifically (ANCD 2011, p.16).

The limitations in gauging the extent of drug use and associated harms in Aboriginal communities have also been raised in evidence to the Inquiry. A submission from Northern Mallee Primary Care Partnership for example states:

⁵⁴⁷ Dr Karen Adams, Researcher, Victorian Aboriginal Community Controlled Health Organisation, Submission, 18 October 2013.

There are currently significant issues in collecting and interpreting health and wellbeing data for Indigenous populations. [There is] very limited availability of local or regional health and wellbeing data for Indigenous population. Some health and other agencies have different processes for collecting data and the question of Indigenous status is not always asked in a consistent manner (or at all).⁵⁴⁸

It has also been suggested that one of the reasons why assessing the prevalence of illicit drug use amongst Aboriginal Australians is so difficult relates to the relatively small size of the Aboriginal population across Australia and particularly in states such as Victoria. This means 'that it is difficult to obtain a large enough sample to allow for a separate analysis of the data related to Aboriginal respondents' (Putt & Delahunty 2006 in ANCD 2011, p.17).⁵⁴⁹

An epidemic?⁵⁵⁰

Despite this lack of clarity in official data, many submissions to the Committee from both mainstream and Aboriginal alcohol and other drugs (AOD) and health services provided their own agency data on methamphetamine use by their Aboriginal clients. In most cases this data showed significant increases in methamphetamine use by Aboriginal people compared to previous years.⁵⁵¹

Such use, according to the 'Goanna Survey'⁵⁵² of young Aboriginal people in 2013, was higher compared to non-Aboriginal young people surveyed by the Australian Drug Household Survey.⁵⁵³ This discrepancy in rates of use is even more so the case for Aboriginal prisoners in Victoria with rates of substance abuse disorders, including methamphetamine dependence, being considerable higher than for non-Aboriginal prisoners.⁵⁵⁴

Evidence given to the Committee also paints a disconcerting picture as to the use of this drug in every major region of the state. For example, Mr Peter Treloar from the Ballarat and District Aboriginal Cooperative told the Committee that the consensus of Aboriginal AOD, health and other workers across the state is that crystal methamphetamine is a drug that has created 'a real blight on the Aboriginal community'.⁵⁵⁵ Mr Wayne Muir, CEO of the Victorian Aboriginal Legal Service, has called the impact on the Aboriginal community

548 Mr Rob McGlashan, Executive Officer, Northern Mallee Primary Care Partnership, Submission, 21 October 2013.

549 It is even more difficult to get a sense of any gender differences with regard to methamphetamine use amongst Aboriginal Australians. The best evidence suggests that male Aboriginals use illicit drugs consistently and significantly more than do Aboriginal females; which generally represents the position in the general population (ANCD 2011). *However*, it appears that Aboriginal females who use illicit drugs may be more prevalent than their non-Aboriginal counterparts (Iverson 2008). Some evidence also suggests that Aboriginal Australians who use illicit drugs may commence that use at an earlier age than non-Aboriginals, however again the data is not sufficiently robust to be conclusive on this point or is too old to make meaningful comparisons (ANCD 2011; Holly & Shoobridge 2003).

550 The term 'epidemic' was used by a number of witnesses to explain the crisis being caused by methamphetamine use in Aboriginal communities. See for example, Ms Lisa Briggs, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (via teleconference), Public Hearing, Canberra, 11 February 2014.

551 For example 80 percent of Aboriginal clients being seen by Primary Care Connect in Shepparton (36 out of 45) nominated crystal methamphetamine as their drug of choice. See Mr Hamish Fletcher, Chief Executive Officer, Primary Care Connect, Submission, 18 October 2013.

Solicitors from the Victorian Aboriginal Legal Service also state that a variable number of clients report regular use of crystal methamphetamine, between 20 and 70 percent, depending on the area of the state in which they live. Between 15 and 60 percent of clients were or had recently used crystal methamphetamine at the time of their offending or arrest. See Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Submission, 17 October 2013. See also the discussion in Chapter 8.

552 The Goanna survey of the substance abuse and sexual behaviours of young Aboriginal people was conducted by the Kirby Institute in partnership with VACCHO and other Aboriginal service providers. See Ward et al 2013.

553 Five percent of young non-Aboriginal people used methamphetamine on a regular basis compared to ten percent of Aboriginal young people. See Ward et al 2013.

554 See the *Koori Prisoner Mental Health and Cognitive Functioning Study* (Ogloff et al 2013) discussed in the submission of Dr Karen Adams, Researcher, Victorian Aboriginal Community Controlled Health Organisation, Submission, 18 October 2013.

555 Mr Peter Treloar, Emotional Wellbeing Nurse, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013.

'overwhelming',⁵⁵⁶ and Mr Mike Richardson, from Ngwala Willumbong Aboriginal drug rehabilitation centre, remarked that he has seen an 'explosive increase' in methamphetamine presentations.⁵⁵⁷ Dr Niall Quiry from the Victorian Aboriginal Health Service also spoke about the increase:

A very significant increase in 'ice' usage is a serious cause for concern. [it] is a growing problem... It is really flooding our workplace at the moment. When I talk to people who have been long-term drug users, they are telling me that it is quite ubiquitous. It is cheap. It is easily available. It is remarkable how many young people have either used ice on occasions or are using it regularly.⁵⁵⁸

Magistrate Clive Alsop has also described the effect of ice on the local Aboriginal population in Gippsland as being catastrophic.⁵⁵⁹

Finally, Ms Karen Heap, CEO of the Ballarat and District Aboriginal Co-operative told the Committee the experience of ice usage was of grave concern in rural and regional areas:

We are facing a rather large hurdle, I think, with ice, and it has come to my attention probably in the last two to three years that we as a community are now suffering from this horrible drug that is being distributed throughout regional Victoria...

Ice is particularly horrible because of the effects that it has on our people and the ramifications of such. We are finding that we have a lot more people coming through the door now that are requiring assistance with health and welfare... So I am very concerned. I am very concerned for our people. I am very concerned that we have a number of our community members that are now using the ice substance. We have a variety of different ages appearing to use the stuff, so I think it has become quite a party type of drug for us as Aboriginal people, which for me is very concerning.⁵⁶⁰

For many young Aboriginal people in particular, methamphetamine has replaced alcohol and cannabis as a drug of choice or is used in conjunction with these substances. Whilst the use of the term 'epidemic' can be considered by some to be an exaggeration; as the above remarks and those of many other witnesses who gave evidence to the Inquiry indicate, it is not all that far off the mark. At least, 'A very significant increase in ice usage is a serious cause for concern'.⁵⁶¹ In some communities the usage of methamphetamine has almost become normalised, particularly amongst younger peer groups.⁵⁶²

Two qualifications need to be made to the above discussion. Whilst it seems to be the case that proportionate to their population size, Aboriginal Australians disproportionately may use illicit drugs in greater numbers than non-Aboriginals, it remains true for both groups that the vast majority of drug-related harms including deaths are attributable to tobacco and alcohol use (ANCD 2011). Secondly, in any discussion of Aboriginal use of methamphetamine it must be remembered that in such drug use, as with the general population of methamphetamine users, poly-drug use remains the most significant pattern

556 Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Public Hearing, Melbourne, 17 February 2014. Representatives from the south-west of the state also gave evidence of the increasing harm the drug is doing to Aboriginal people in that region.

See Mr Allan Miller, Aboriginal Programs Manager, South West Healthcare, Public Hearing, Warrnambool, 3 March 2014.

557 Indeed Mr Richardson told the Committee that in 25 years he had 'never seen a drug take over this way'. He stated that in 2014 he has 13 of 26 presentations (50 percent) nominating ice as their first drug of choice. In 2013 or earlier 'I would be lucky to see one or two'. Mr Mike Richardson, Clinical Services Manager, Ngwala Willumbong Co-operative Ltd, Public Hearing, Melbourne, 24 March 2014.

558 Dr Niall Quiry, Senior Medical Officer, Victorian Aboriginal Health Service, Public Hearing, Melbourne, 3 February 2014.

559 Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates' Court, Public Hearing, Traralgon, 28 January 2014. Mr Alsop added that local Aboriginal community representatives had told him that it was not unusual for a methamphetamine dependent person or user to spend \$200 per day on ice or resort to trafficking to purchase the drug.

560 Ms Karen Heap, Chief Executive Officer, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013.

561 Dr Niall Quiry, Senior Medical Officer, Victorian Aboriginal Health Service, Public Hearing, Melbourne, 3 February 2014.

562 Ms Kit-e Kline, Drug and Alcohol Worker, Wathaurong Aboriginal Co-Operative, Public Hearing, Geelong, 28 October 2013.

of drug use; particularly with regard to the use of ice together with alcohol and cannabis (ANCD 2011).⁵⁶³

Access and availability of methamphetamine in Aboriginal communities

Generally witnesses from Aboriginal community organisations noted that crystal methamphetamine, whether it is sourced from Melbourne or it is manufactured in local communities, is very easy to access and for many young people both Aboriginal and non-Aboriginal it is easier to access than alcohol, as discussed in Chapter 3.⁵⁶⁴

Aboriginal people, particularly young people, seem to be accessing methamphetamine in much the same ways as members of the general community. Some people may purchase it; others who cannot afford to do so may act as low level dealers or traffickers in order to fund their own habits. Some people may turn to acquisitive crime to finance their purchases; others may rely on extended credit which results in serious debt-related problems.⁵⁶⁵ As Ms Di Griffin from the Albury-Wodonga Aboriginal Health Service told the Committee:

It seems to be everywhere. I think because there is more money to be made in dealing ice so that people are tempted to go that way rather than be selling pot. They sell ice because there is more money in it for them as well. A number of my clients buy a deal of ice and then they are able to sell on and support their own habit that way. That is an attraction for them as well.⁵⁶⁶

There has been some, albeit limited, evidence given to the Committee that Aboriginal communities may access their supplies from outlaw motor cycle gangs (OMCG) and organised crime groups. Conversely, many witnesses to the Inquiry including those from Aboriginal organisations did not believe there was much evidence of OMCG in methamphetamine supply chains. This issue is discussed in Chapter 17.

Patterns of use

The patterns of methamphetamine use amongst Aboriginal people do not differ significantly from those of non-Aboriginal users. In other words, Aboriginal people, particularly young people, may use the drug occasionally or recreationally, for functional reasons or in a dependent manner (Commonwealth Department of Health and Ageing 2008, p.87).⁵⁶⁷

There are, however, some differences in drug use patterns between Aboriginal and non-Aboriginal people that should be noted. Research on methamphetamine use by Aboriginal people undertaken by the Cultural and Indigenous Research Centre of Australia (CIRCA) for the Commonwealth Department of Health has noted that drug use for many Aboriginal people may start at an earlier age than for non-Aboriginals and that methamphetamine use in particular may have been preceded by a period of marijuana use:

563 These drugs being particularly used by Aboriginals, as in the general population, in combination to balance the highs of the ice with the lows of the withdrawal phase. See Ms Kit-e Kline, Drug & Alcohol Worker, Wathaurong Aboriginal Co-operative, Submission, 22 October 2013 and the discussion in Chapter 6.

564 See for example, Ms Kit-e Kline, Drug & Alcohol Worker, Wathaurong Aboriginal Co-operative, Submission, 22 October 2013; Mr Peter Treloar, Emotional Wellbeing Nurse, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013; Mr Joey Chatfield, Aboriginal Community Liaison Officer, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

565 See Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates' Court, Public Hearing, Traralgon, 28 January 2014; Mr Peter Treloar, Emotional Wellbeing Nurse, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013; Ms Nahtanha Davey, General Manager, Health/Family/Community, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013; Ms Miranda Madgwick, Alcohol and Drug Women's Worker, Ngwala Willumbong Co-operative Ltd, Public Hearing, Melbourne, 24 March 2014.

566 Ms Di Griffin, Aboriginal Drugs and Alcohol Counsellor, Albury-Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014.

567 See discussion in Chapter 13.

While the age when people had started using drugs varied, almost all had started before they were 19 years of age, with several starting with marijuana at around 12 years of age. Only one person had started at an older age (Commonwealth Department of Health and Ageing 2008, p.86).

This finding accords with the evidence given to the Committee. For example, some witnesses observed that a pre-existing culture of yandi/gunga (marijuana) use amongst some Aboriginal people could exacerbate the smoking of methamphetamine. Moreover, methamphetamine use as with previous marijuana use is very much a group activity in Aboriginal culture — as one Aboriginal AOD worker told the Committee, rarely would you see a (young) Aboriginal person take the drug in isolation from a group setting.⁵⁶⁸

As with the general community, poly-drug use is a very common pattern of use in Aboriginal communities. The CIRCA study found that amongst the population of Aboriginal users surveyed for their research:

A wide range of drugs [were] being used, including alcohol, cannabis, amphetamines, ice, speed, ecstasy/pills, benzodiazepines, coke. A few people from Illawarra and Western Sydney had used heroin, and all three participants from Redfern had used heroin. Several talked of using ice and alcohol together, and marijuana to “help come down”. Others talked of starting on speed and then using heroin to “bring you back down, and then the addiction set in”. Alcohol binges, some for at least two days, and methamphetamine use was also common, although the research suggests that often the pattern is for methamphetamine to become the primary drug of choice (Commonwealth Department of Health and Ageing 2008, p.86).

One respondent to the CIRCA survey outlined how the choice of drug and the patterns of use changed once methamphetamine was used:

A lot of us started drinking and smoking (marijuana), and then speed comes along and you find you can drink a lot more, and go on big binges. I used to notice that they could be up all night and drink and drink and drink, and I started asking why, and asked them to score for me, and then I started scoring myself. It’s all linked, it all fits together. You’re not getting too smashed, too drunk, you’re all right. Generally it will take over alcohol and smoking, and you’ll end up drinking less and smoking (gunga) less. Not a lot of users are big drinkers, whereas once they were (Commonwealth Department of Health and Ageing 2008, p.87).

The prevalence of poly-drug use was also spoken of by witnesses. For example, Ms Kit-e Kline, a Drug and Alcohol Worker from the Wautharong Aboriginal Co-operative in Geelong, noted how her clients could often use marijuana and prescription drugs such as benzodiazepines to ‘find some balance from experiencing the highs and lows of “ice”’.⁵⁶⁹

As with the general community, Aboriginal users varied the ways in which they took crystal methamphetamine. The CIRCA research found that the most common technique included smoking, snorting or ingesting the drug:

There were a few that injected ice, while others had very strong objections to injecting because of a fear of needles or of contracting diseases. Research suggests these drug segments see themselves quite differently, and that ‘shooters’ and ‘smokers’ are discrete groups, especially given that all participants talked of using in a social setting/with peers (Commonwealth Department of Health and Ageing 2008, p.87).

This latter point is generally true of the ‘drug snobbery’ apparent in mainstream populations of methamphetamine users; whereby injectors are viewed as addicts and inferior to, or at least different from, recreational users.⁵⁷⁰

568 Mr Tim Church, Aboriginal Drugs and Alcohol Worker, Albury-Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014.

569 Ms Kit-e Kline, Drug & Alcohol Worker, Wathaurong Aboriginal Co-operative, Submission, 22 October 2013.

570 See Chapter 9.

Finally as with the non-Aboriginal community, there is a significant risk that Aboriginal people who commence their methamphetamine use through smoking or ingesting the drug may transition to the more harmful mode of injecting (ANCD 2011).⁵⁷¹ Witnesses to the Committee have stated that this issue is of great concern to Aboriginal communities.⁵⁷²

Reasons for methamphetamine use in Aboriginal populations

Understanding *why* Aboriginal people may abuse alcohol and other drugs, including methamphetamine, is complex. There are of course some contributory factors leading to drug use that will be the same for both Aboriginal and non-Aboriginal people. Such factors may include boredom, experimentation or simply because it is 'fun'.⁵⁷³ However, it has become increasingly apparent that substance abuse in Aboriginal communities is also related to structural factors that influence the lives of Aboriginal people, including a legacy of colonisation, disassociation from culture and dispossession. As such, Aboriginal ill-health, including the consequences of drug use, is 'rooted in historical, cultural and political circumstances' (Mitchell 2007 in ANCD 2012, p.7).

The legacy of colonisation

Relatively high levels of substance abuse amongst Aboriginal Australians has, at least in part, been attributed to Australia's history of mistreatment and dispossession of its native inhabitants (Mitchell 2007). In this regard, Mr Rudolph Kirby, CEO with the Mildura District Aboriginal Services, told the Committee that it was absolutely essential that policy-makers understood and acted upon the connections between substance abuse, including methamphetamine use, criminal behaviour, poverty, and mental illness including post-traumatic stress disorder,⁵⁷⁴ and how in turn these issues related to the history of Aboriginal disadvantage:

I think a lot of [the substance abuse] ever since colonisation, is dealing with the long period of trauma and dealing with grief and loss and colonisation. I think there is a lot of grief, loss and trauma that my family and friends at my age are still struggling to come to terms with because of what happened in the past, and dealing with that grief, loss and trauma. It sits underneath the anger — the pain of knowing what happened to my aunties, uncles, grandparents and great-grandparents — the 'stolen generation' That loss still sits in there. I have sat within cross-cultural leaders training sessions with the Department of Justice in Melbourne and other places, and an individual person will ask: 'When are the Aboriginal people ever going to get over this?'. The response of one of the elders was, 'How do you think the Jewish people would feel if you asked them, "When are you going to get over the Holocaust?"'

So for us, you need to put those things into perspective, and when you take those things into consideration it has only been, realistically, in the last 20 or 30 years that Aboriginal people are trying to position themselves, whether it be with social indicators or about economic participation. It is going to take time, and that is the issue. It will not be an election response in the sense of dealing with that trauma and loss that has happened over 150-plus years. It will take time to deal with that, and the whole social infrastructure of the role of Aboriginal people.⁵⁷⁵

571 See Chapter 9.

572 See for example, Ms Kit-e Kline, Drug and Alcohol Worker, Wathaurong Aboriginal Co-Operative, Public Hearing, Geelong, 28 October 2013; Ms Karen Heap, Chief Executive Officer, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013; Ms Di Griffin, Aboriginal Drugs and Alcohol Counsellor, Albury-Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014.

573 See discussion in Chapter 13.

574 For an account of post-traumatic stress disorder and its relationship to colonisation, see Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Public Hearing, Melbourne, 17 February 2014.

575 Mr Rudolph Kirby, Chief Executive Officer, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013.

This history is directly related to past and present problems associated with alcohol, cannabis and heroin abuse experienced by Aboriginal Australians, and today is being experienced with regard to crystal methamphetamine:

If you look at why people are using ice, apart from the easy availability, if you look at the past history of Aboriginal and Torres Strait Islander peoples and what we refer to as inter-generational trauma that they have experienced and the adverse disadvantage that Aboriginal people have, ice is a drug that, to begin with, helps them to feel better about their lives because of the high that it gives, the quick high that it gives. It makes them feel good, it helps them to forget about how bad they really feel underneath. I personally believe that is why it is devastating Aboriginal communities in particular because Aboriginal people that are struggling with a lot of those issues — poverty, cannot get employment, poor education, poor health outcomes — a lot of underlying grief, loss and trauma which makes them feel terrible about their lives, ice comes along, 'Whammo, nice hit, feel great. It gives me the motivation that I'm lacking because I'm depressed'. I think that is why it is so attractive to the Aboriginal community and why the young ones in particular are really diving into it.⁵⁷⁶

Trans-generational drug use and its relationship to history

Some Aboriginal witnesses have told the Committee that this legacy of trauma and loss of identity makes itself felt through trans-generational substance abuse whereby the use of 'ice' and other drugs is becoming increasingly normalised both within immediate and extended families. Ms Kit-e Kline told the Committee that it was by no means unknown for mothers to use with sons or children with grandparents:

My belief is when people use substances it is self-medication. It is suppressing feeling and usually it is a negative feeling. From my experience of working in Aboriginal communities and studying Aboriginal culture, from the time of colonisation, as you know there were massacres, stolen generation, children were taken from their families, there was a lot of abuse that happened as well within residential homes. When a person experiences this there is no healing that has taken place, and they are having children and families themselves. This hurt, pain, grief and loss certainly has an impact — a trans-generational impact — on how they are raising their families and also their own healing. Also when you are looking at people who are taking substances it is learnt behaviour within the family home. We can see a lot of the clients I work with, they just have not started using substances, they have seen their family members use substances, and people before that have seen their family members using substances. It becomes normal within the family home, substance use. If mum is feeling stressed she might have a drink, or for dad to relax he goes out and smokes some cannabis. It becomes a way of dealing with life's stresses. We can date this back to the trauma, because it is not an individual trauma, it is a cultural trauma that happened to most Aboriginal people.⁵⁷⁷

Finally, a submission from the Commission for Children and Young People stressed the importance of acknowledging the traumatic trans-generational history of Aboriginal Victorians in developing any strategies to address methamphetamine use, particularly amongst young Kooris:

Responses to the use of ice in Koori communities need to take into account the historic and continuing disadvantage and intergenerational trauma experienced by many people within Koori communities. We know that a disconnection with communities, a disconnection with culture and a disconnection with country have been fundamental to driving Koori disadvantage and over-representation in the justice system. We also know that the problems faced by Koori communities are compounded by underlying issues of inter-generation

576 Ms Di Griffin, Aboriginal Drugs and Alcohol Counsellor, Albury-Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014.

577 Ms Kit-e Kline, Drug and Alcohol Worker, Wathaurong Aboriginal Co-Operative, Public Hearing, Geelong, 28 October 2013. See also Ms Miranda Madgick, Alcohol and Drug Women's Worker, Ngwala Willumbong Co-operative Ltd, Public Hearing, Melbourne, 24 March 2014.

trauma, family violence, racism, substance abuse, mental health, and poor education and employment outcomes. Any response to the use of ice must take into account and respond to these challenges.⁵⁷⁸

The importance of culture

Aboriginal culture is or at least traditionally has been a ‘collectivist’ or communitarian culture according to many witnesses from Aboriginal organisations.⁵⁷⁹ As previously discussed, a disassociation from traditional culture can contribute to feelings of despair that may ultimately result in self-destructive behaviours including drug abuse. Crystal methamphetamine, according to witnesses to the Inquiry, has a strong correlation to a disconnection from their Aboriginal culture and a disinclination to partake in cultural activities.⁵⁸⁰ This is exacerbated particularly for young Aboriginal men in communities where there are few of the traditional male elder models to guide and inspire the younger generation.⁵⁸¹ As the mother of a young Aboriginal man with a serious crystal methamphetamine problem told the Committee:

The elders are doing great work, but we need the males to be more readily available for them. My son says that he does not have a male role model, and everyone he gets close to either dies or leaves the area, so he cannot cope with what he is dealing with, and for him to speak to a female about it, he does not like that. That is not for him. He does not feel like a strong man. He goes and has ice, and for him that caps everything, so he does not have to think about anything; he is okay, he is high and that is it.⁵⁸²

Conversely, an embracing of culture may act as a protective factor that strengthens the resilience of young people, in particular, to ice (Western Australia Drug and Alcohol Office 2007). For example, representatives from the local Aboriginal Cooperative in Ballarat have told the Committee how important it is to put young people in particular in touch with their Aboriginal history, culture and traditions through mentoring and cultural awareness programs:⁵⁸³

A lot of the younger generation in Ballarat do not have a strong cultural connection and we are certainly trying to build on that by introducing a bit more cultural knowledge. It is similar to the Men’s Sheds sort of theory that if we can get blokes together and we can get elders to feed their cultural knowledge on to the younger people, then we can build that cultural knowledge in the community. We have only just kicked it off and it has so far proven to be quite successful — We are starting to get the feedback now from the younger ones, who are now wanting to mix a bit more with the older generation, just to find out a bit more, to learn how to do Koori art and all that sort of stuff...

If we can divert them from their life of crime, their life of drug use, into some sort of meaningful activity that connects them back to their culture, it has proved successful in other areas of Australia and I do not see why

578 Mr Bernie Geary OAM, Principal Commissioner, and Mr Andrew Jackomos PSM, Commissioner for Aboriginal Children and Young People, Commission for Children and Young People, Submission, 25 October 2013.

For further accounts of how a history of trans-generational trauma and dispossession may relate to contemporary substance abuse amongst Aboriginal Victorians, see Ms Kit-e Kline, Drug & Alcohol Worker, Wathaurong Aboriginal Co-operative, Submission, 22 October 2013; Mr Jason King, Chief Executive Officer, Victorian Aboriginal Health Service, Public Hearing, Melbourne, 3 February 2014; Dr Niall Quiry, Senior Medical Officer, Victorian Aboriginal Health Service, Public Hearing, Melbourne, 3 February 2014.

579 Mr Mark Powell, Dual Diagnosis Senior Clinician, Headspace, Public Hearing, Warrnambool, 3 March 2014.

However, given the heterogeneity of Aboriginal communities discussed earlier in this chapter, one also needs to be aware of being too reductionist in relation to an over-emphasis of the collective nature of Aboriginal society. Not all Aboriginal communities may necessarily share this attribute.

580 Ms Kit-e Kline, Drug and Alcohol Worker, Wathaurong Aboriginal Co-Operative, Public Hearing, Geelong, 28 October 2013.

581 For the importance of mentoring and role models in the context of Aboriginal young people, see Mr Mark Watt, Chief Executive Officer, White Lion, Public Hearing, Melbourne, 24 March 2014; Ms Tania Dalton, Indigenous Family Violence Regional Coordinator, Department of Human Services, Public Hearing, Warrnambool, 3 March 2014; and the discussion in Chapter 22.

582 Ms Darlene Sanders, Indigenous Engagement Officer, Mallee Family Care, Public Hearing, Mildura, 5 December 2013.

583 For further examples of how traditional Aboriginal cultural programs are used as an adjunct to conventional drug treatment therapies see comments of Mr Gilbert Freeman, Counsellor, Ngwala Willumbong Co-operative Ltd, Public Hearing, Melbourne, 24 March 2014.

it would not be successful in Victoria as well. I think it would be great if we could target the cultural side of things as part of the healing process. I think that would be a great benefit for Aboriginal communities.⁵⁸⁴

Families and extended families with strong links to their cultural heritage can also offer valuable protection in either preventing the uptake of drugs such as methamphetamine or assisting the person in stopping their use. As Mr Herb Goonen from Rumbalara in Shepparton told the Committee:

We identified that the best way to get a result was to bring the whole family together, if that family is fractured or there is not that strong community connection. If you have a really strong family connection, if you have a really strong sense of culture and everything else, those families most likely would go on to do a lot better and start to achieve.⁵⁸⁵

Given the collectivist nature of Aboriginal culture any interventions to address methamphetamine use and harms in Aboriginal communities need to work on the level not only of the individual but especially family, community and kinship.⁵⁸⁶

The impact of methamphetamine on the health and wellbeing of Aboriginal Victorians

A recent report examining injecting drug use in Aboriginal communities undertaken for the ANCD made the point that for many Aboriginal Australians the harms and consequences associated with illicit drug use, including methamphetamine, will be the same as they are for the general population. Nonetheless, the Report also acknowledged that:

Aboriginal Australians and in particular those who inject drugs, are vulnerable to poor health, including general health problems, blood borne viruses and mental health issues. Poor health, employment, education and housing are interrelated in their impact on each other and therefore can compound any difficulties associated with one or all of these dimensions. In regard to the harms associated with injecting drug use, it is clear that there are significant disparities between the health of Aboriginal Australians and that of their non-Aboriginal counterparts [including] harms to the individual, harms to the family and harms to the community (ANCD 2011, p.xii).

Harms to health

Many of the harms that Aboriginals may suffer related to their methamphetamine use, and particularly those who inject the drug, are the same as for non-Aboriginal users (cardiac health issues, blood borne viruses through injecting; psychosis etc). However, there appear to be some high risk patterns of use that may be more prevalent in the context of Aboriginal culture. These may include sharing injecting equipment, injecting in public places such as toilets and parks, and re-using drug paraphernalia. The extent to which these differences may reflect a cultural bias (ie. the Aboriginal emphasis on sharing practices) is however unclear and possibly overstated (Holly and Shoobridge 2004).

Co-morbidity amongst Aboriginal Australians

The problem of co-morbidity of drug and mental health disorders is particularly noticeable in Aboriginal Australians (Berry & Crowe 2009). The ANCD study conducted of injecting drug use in Aboriginal communities found that 'particular attention needs to be given to those Aboriginal people who inject drugs with a dual diagnosis of mental illness and drug dependency' (ANCD 2011, p.95). The report drew from an earlier study in 2006 which found that 84 percent of Aboriginal mental health admissions in the Northern Territory

584 Mr Peter Treloar, Emotional Wellbeing Nurse, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013.

585 Mr Herb Goonen, Drug and Alcohol Worker, Rumbalara Aboriginal Cooperative, Public Hearing, Shepparton, 25 February 2014.

586 Mr Mark Powell, Dual Diagnosis Senior Clinician, Headspace, Public Hearing, Warrnambool, 3 March 2014.

displayed ‘psychosis, depression and substance related disorders’ (Nagel 2006 in ANCD 2011, p.95). It concluded that a greater range of culturally appropriate and holistic mental health and drug services needed to be provided to Aboriginal people, particularly given that many Aboriginal people cited in the study injected drugs to manage their mental illness and to ‘forget’ underlying trauma pertaining to dispossession and disadvantage as Indigenous Australians (ANCD 2011, p.95).

Witnesses giving evidence to the Committee expressed their concerns that Aboriginal clients suffered greatly because of the dual issues of both substance dependence and mental illness. In particular, the fact that there were few services to address co-morbidity and that training in dual diagnosis, particularly for new staff and Indigenous workers, was insufficient, were matters of serious concern.⁵⁸⁷

The problems associated with addressing a dual diagnosis or co-morbidity diagnosis from a treatment or service provision perspective are canvassed in more detail in Chapter 28 of this Report.

Suicide

Research has shown significant correlations between substance abuse generally and suicide or attempted suicide amongst Aboriginal people. For example:

In a study of Aboriginal people who inject drugs undertaken in...South Australia, over half of the sample had attempted suicide at least on two occasions... Of those who had attempted suicide, most reported that they were intoxicated on at least one of those occasions and noted that this had played a role in facilitating the decision to action suicidal ideation (ANCD 2011, p.52).⁵⁸⁸

Such findings would seem to be particularly applicable to the use of crystal methamphetamine. Evidence has been given to the Committee that one of the destructive effects that ice is having on Aboriginal communities is a disproportionate amount of young people killing themselves or attempting suicide particularly in rural and regional areas of the state. According to a submission from the Mallee District Aboriginal Services, for example, in 2013 Mildura’s Koori community alone experienced five crystal methamphetamine related suicides within four months. The risk of suicidal ideation is particularly acute in the first eight to 10 days of methamphetamine withdrawal.⁵⁸⁹

Aboriginal drug-related suicides, according to some witnesses, can be attributed to a number of factors. These include:

- ◆ The shame and stigma associated with methamphetamine and other forms of drug abuse;
- ◆ The depressive effects of the drug itself particularly in the withdrawal stage; and
- ◆ The despair felt when users are not able to repay accumulated drug debt, especially if family members are then ‘heavied’ to pay that debt.⁵⁹⁰

587 See for example, the comments of Mr Jon Borkowski, Coordinator Alcohol and Other Drug (AOD) Services Morwell, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

588 For a discussion of the various research studies linking substance abuse, particularly injecting drug use, with suicide in Aboriginal communities, see ANCD 2011.

589 Mr Rudolf Kirby, Chief Executive Officer, Mildura District Aboriginal Services, Submission, 21 October 2013.

This account of ice-related suicides in Mildura was supported in a submission from the Commission for Children and Young People. See Mr Bernie Geary OAM, Principal Commissioner, and Mr Andrew Jackomos PSM, Commissioner for Aboriginal Children and Young People, Commission for Children and Young People, Submission, 25 October 2013.

590 See Mr Imran Mansoor, Manager, Primary Health Care, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013; Mr Rudolph Kirby, Chief Executive Officer, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013; Dr Niall Quiry, Senior Medical Officer, Victorian Aboriginal Health Service, Public Hearing, Melbourne, 3 February 2014; Mr Jason King, Chief Executive Officer, Victorian Aboriginal Health Service, Public Hearing, Melbourne, 3 February 2014 and the discussion later in this chapter.

For young Aboriginal people in particular a 'sense of fatalism' may explain, at least in part, both their methamphetamine and other substance use and any decision to take their lives:

There is a fatalistic view [of young Aboriginal men and women] of 'Who gives a shit? I am going to be dead anyway. I will worry about what happens in the next day or so, or next week. I am not planning for next month or next year (ANCD 2011, p.96).

Effect of methamphetamine abuse on Aboriginal families

A number of consequences associated with methamphetamine use could be said to particularly impact upon Aboriginal families. Perhaps even more so than in the non-Aboriginal community, the sense of shame associated with the drug's use is especially profound.

Shame and stigma

A number of studies found that Aboriginal people who were substance dependent and particularly those who injected drugs jeopardised familial relationships and were isolated from their communities due to the shame and stigma associated with such use (Franks 2006; ANCD 2011). A carry-over effect may result whereby Aboriginal people may not access services because of internalised shame and the fear that they will be discriminated against (Day et al. 2006; Van der Sterren et al. 2006). In some cases this 'shame factor' can result in methamphetamine not being spoken of in the community; with both individuals and families wanting to keep such use confidential. According to Aboriginal AOD worker Ms Kit-e Kline, for each Aboriginal person who may use methamphetamine in a group setting there may be others for whom it is a socially isolating substance that they use in secret.⁵⁹¹ As Aboriginal Youth Justice Worker, Mr Norm Stanley told the Committee:

Within Aboriginal communities, even myself from a very young age, alcohol and marijuana were almost an acceptable thing to do. There was no shame in knowing who was drinking or who was smoking or anything like that at all. When it comes to ice there certainly is that trying to hide it away. A couple of my clients are people I grew up with and they can sit straight in front of me and I know that they are heavily affected while I am talking with them or while I am trying to work with them, and I can ask the question a hundred different ways over and over ago whether they are using or whether they are affected right then and now, and, 'No, no, no, I'm not at all, bro. I'm not. ... Whereas I know but I am hoping that they will open up and tell me, 'I am, bro, and I do not know what to do about it'. That shame factor is real and it is big with the ice here, absolutely.⁵⁹²

Similar observations were made by Ms Nahtanha Davey of Mallee District Aboriginal Services, particularly in the context of Aboriginal men and youth. In extreme cases this sense of shame may result in self-harm including suicide:

We have seen this as a significant issue within our Aboriginal youth, particularly our Aboriginal men. They feel ashamed because they are so addicted to ice and they are trying to come off and do better for themselves. They are very ashamed of where they are at. They are ashamed because they have a debt that they have accrued and they are ashamed because perhaps in some cases they have been contacted by the dealer and the dealer is threatening them and their family. We have seen this more than once within our community, and tragically we have lost our members [due to suicide].⁵⁹³

It is not only men who can feel stigmatised by their methamphetamine use. Evidence was also given to the Committee of midwives who report the stress felt by mothers who gave birth to children with crystal methamphetamine addictions in the Mildura region. Many of

591 Ms Kit-e Kline, Drug & Alcohol Worker, Wathaurong Aboriginal Co-operative, Submission, 22 October 2013.

592 Mr Norm Stanley, Youth Justice Worker, Wathaurong Aboriginal Co-Operative, Public Hearing, Geelong, 28 October 2013.

593 Ms Nahtanha Davey, General Manager, Health/Family/Community, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013.

these women would not acknowledge their crystal methamphetamine use due to the deep shame and stigma associated with their methamphetamine use.⁵⁹⁴

Family trauma, disconnectedness and breakdown

Problems associated with family trauma, family breakdown and methamphetamine-related violence occur in Aboriginal communities in similar ways to that in non-Aboriginal communities. However, given the extended nature of Aboriginal kinship it could be argued individual drug use can have a particularly profound impact on both the Aboriginal families and their wider community. It is certainly true that many Aboriginal substance users regret the harm to their relationships with their immediate and extended families and community elders (Gray et al. 2001). The ANCD report into injecting drug use in Aboriginal communities described the pressures on Aboriginal families when a member was substance dependent or used heavy drugs:

Injecting drug use appears to contribute to the breakdown of the family by interfering with parental responsibilities and causing considerable distress, instability and shame... Families may also experience theft of goods by the drug user in order to support substance use... Furthermore in some cases the family economy may be dependent on drug dealing, the funds from which may also support the drug use of one or more family members... Lehmann and Francis estimate that in Melbourne for example, due to the high prevalence of drug use among Aboriginal people and the small size of the community, all Aboriginal families may be affected by injecting drug use in some way (ANCD 2011, p.54).

Methamphetamine use is also having a profound effect on Aboriginal family structure according to some witnesses to the Inquiry. This may be through children being removed from an ice using parent by welfare authorities, a user going into gaol or a mental health facility or through domestic violence. In many cases families are ill-equipped to deal with this type of family disruption. As Ms Karen Heap, Chief Executive Officer of the Ballarat and District Aboriginal Cooperative told the Committee — the violence and grief associated with the use of crystal methamphetamine can, on occasion, result in no less than the ‘destruction of the family’.⁵⁹⁵

Finally, the experience of Aboriginal families in the south west of the state is little different according to Mr Allan Miler of South West Healthcare in Warrnambool. He told the Inquiry:

In our area local Aboriginal communities have a long, strong and proud history of strong family connections and kinships, and the very fabric that makes up this process has never been challenged as much as it is when it comes to the drug ice. We are finding it increasingly breaking up family units and causing dramas and troubles that we have never seen happen before in our community. [One of my clients] a 28-year-old female from the Warrnambool area stated: ‘I’ve lost access to my child, family separation, lost connection with the ones who love me. It affects my family badly. It’s like they go through the drug habit as well but without the use. Putting up with the abuse and let-downs, false promises and the fear of not knowing where I am and if I’m safe’. ...Pretty strong words...⁵⁹⁶

Extended family as ‘caregivers’

Many immediate and extended family members have little knowledge about methamphetamine and its effects and are often bewildered at the perceived changes they see in their family members who are using the drug. As Dr Niall Quiry from the Victorian Aboriginal Health Service told the Committee:

594 See Mr Rudolph Kirby, Chief Executive Officer, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013.

595 Ms Karen Heap, Chief Executive Officer, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013.

596 Mr Allan Miller, Aboriginal Programs Manager, South West Healthcare, Public Hearing, Warrnambool, 3 March 2014.

With most drug addiction issues it is usually the user — the person with the addiction problems — who presents. Methamphetamine use is different in that we tend to get more family members presenting with the issue than we get users presenting. Both present, but the proportion is significantly different. We have mothers and aunts and brothers and sisters coming in and saying, 'This person has been a problem, and the whole family has got a problem. Can you help?'

I feel as though the family disruption is much greater than I have seen with other drugs — certainly than I have seen with speed, which is a comparable drug. As workers we really are not able to offer what families really need when young people come in and say, 'I want to get off this drug'.⁵⁹⁷

Grandparents and extended family caregivers are particularly important in the context of Aboriginal communities. As Mr Herb Goonen, AOD manager with Rumbalara Aboriginal Co-operative told the Inquiry:

We have got a number of grandparents...heaps of them. [where] the parents of the kids are either in jail or they are so strung out on meth that they are physically not capable of looking after themselves, let alone the three, four, seven kids that they have got. These grandparents might have three to six children that are doing it, that are all out there, so now these grandparents have in excess of god knows how many grandkids that are coming to their houses. It falls on other community members to sort of help out...it is definitely a very big concern for our elders.

The other problem is now we have got grandparents that are suffering a large number of abuses from grandchildren that see their parents out there doing whatever they are doing, so they are bringing it back to their grandparents and doing the standover techniques and everything else. Elder abuse is a really big concern for us, and the amount of that that refers back to methamphetamine is quite large.⁵⁹⁸

One such grandparent is Ms Darlene Sanders, an Aboriginal woman from Mildura who gave evidence to the Committee as to the effect her son's methamphetamine addiction was having on herself and the rest of her family:

My son is actually a drug addict. I have had to live with the drugs. I have had to live with the behaviour that he presents when he comes home — the unpredictable behaviour, the threatening, the violence. I have had to put a restraining order on him. He is incarcerated at the moment, but I have had to put a restraining order on him for our safety because I have my daughter and my granddaughter living at my house also. Due to him she had to leave her place, her own house — my daughter — and move back home because he would go there and he would use her place, or other addicts would be there. It was hard for her to start her own life. The reason I had to put that on him was so that we could be safe in our own home and be okay.

There were things like you would wake up in the morning and he would be in the house and you would not know what behaviour would present, so it was quite frightening at the best of times. I have had to leave my own house and stay at another person's house for safety. I get verbally abused. I have been pushed. I have been threatened. My house has been threatened, along with the people in my house.⁵⁹⁹

The effects on Ms Sanders' grandchild have been particularly damaging:

I have a 2-year-old granddaughter in my house. Unfortunately she sees photos of her uncle and says, 'Where's my uncle?' Now she knows, and when she goes past the police station she says, 'There's my uncle in there'. She will ask, 'Where's uncle? Have the police got him?', because she has already witnessed all of this, and for me that is not on. It should not be happening, but unfortunately that is the best I can do to stay alive and keep my family safe, which is not to be a part of it anymore. It is hard, but these are the steps I have to take.⁶⁰⁰

597 Dr Niall Quiry, Senior Medical Officer, Victorian Aboriginal Health Service, Public Hearing, Melbourne, 3 February 2014.

598 Mr Herb Goonen, Drug and Alcohol Worker, Rumbalara Aboriginal Cooperative, Shepparton, 25 February 2014.

599 Ms Darlene Sanders, Aboriginal Engagement Officer, Mallee Family Care, Public Hearing, Mildura, 5 December 2013.

600 Ms Darlene Sanders, Aboriginal Engagement Officer, Mallee Family Care, Public Hearing, Mildura, 5 December 2013.

Family violence

Methamphetamine use may also contribute to significant levels of family violence in Aboriginal communities. A 2011 Report on family violence within Aboriginal communities⁶⁰¹ found that Aboriginal women continue to report higher levels of physical and sexual violence during their lifetime than do non-Aboriginal women. There are also significant barriers for Aboriginal women who seek support services, with mainstream services insufficiently addressing the issue of family violence in Aboriginal communities in culturally relevant ways: '[t]he likelihood of receiving inadequate or inappropriate responses, mean Aboriginal women are increasingly vulnerable to the risks and effects of violence'.⁶⁰² In Victoria this is one of the issues being addressed by the The Indigenous Family Violence Strategy (IFVS), a joint community initiative between Aboriginal Affairs Victoria (AAV) and the Department of Human Services (DHS). This initiative has developed an Indigenous Family Violence Primary Prevention Framework, a whole of government response to family violence in Aboriginal communities⁶⁰³ that has been incorporated into the *Victorian Aboriginal Affairs Framework 2013-2018*.⁶⁰⁴

Researchers have stated that the prevalence and seriousness of family violence in Aboriginal communities must be seen in the context of the historical, political, social and cultural environments in which it occurs (Memcott, 2006). For example, the high incidence of violent crime including family violence in some Aboriginal communities is exacerbated by factors not present in the broader Australian community: These factors that have increased Aboriginal families' vulnerability to family violence include:

- Dispossession from land and traditional culture
- Breakdown of community kinship systems and erosion of traditional lores and customs
- Racism and vilification
- Economic exclusion and entrenched poverty
- Effects of overcrowding and inadequate housing
- The effects of institutionalisation and child removal policies
- Inherited grief and trauma
- The loss of traditional Aboriginal female roles, male roles, and status.⁶⁰⁵

Many of these factors may give rise to problematic use of alcohol and other drugs including methamphetamine. The abuse of these drugs in turn can be a major contributor to family violence, a situation noted by many witnesses from Aboriginal community groups who gave evidence to the Committee. For example, as one Aboriginal health and welfare worker from Mildura told the Inquiry:

Family violence in the [Aboriginal] community is off the Richter scale, and I for one, as an Aboriginal man, am appalled by that... when you look at those underlying factors, [such as dispossession and the

601 *Aboriginal Family Health Strategy 2011–2016 — Responding to Family Violence in Aboriginal Communities*. http://www0.health.nsw.gov.au/pubs/2011/pdf/aboriginal_family_health_.pdf

602 *Aboriginal Family Health Strategy 2011–2016 — Responding to Family Violence in Aboriginal Communities*. http://www0.health.nsw.gov.au/pubs/2011/pdf/aboriginal_family_health_.pdf

603 See Indigenous Family Violence Primary Prevention Framework at <http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/plans-and-strategies/children,-youth-and-family-services/indigenous-family-violence-primary-prevention-framework>

See also Strong Culture, Strong Peoples, Strong Families: Towards a safer future for Indigenous families and communities Ten Year Plan.

http://www.dhs.vic.gov.au/__data/assets/pdf_file/0012/620202/Final_10_Year_Plan_Oct08_2nd_Edition.pdf

604 <http://www.dpc.vic.gov.au/index.php/aboriginal-affairs/aboriginal-affairs-policy/victorian-aboriginal-affairs-framework>

605 *Aboriginal Family Health Strategy 2011–2016 — Responding to Family Violence in Aboriginal Communities*. http://www0.health.nsw.gov.au/pubs/2011/pdf/aboriginal_family_health_.pdf

colonial legacy] those who are most vulnerable turn to the things that stimulate them, and ice is one of them. It takes away the pain, the grief and the loss of not understanding why.⁶⁰⁶

Aboriginal Family Violence worker, Sharyn Jenkins made similar comments with regard to the situation in the Wodonga region:

As a family violence worker we are seeing a lot more family violence due to ice, not only in the Aboriginal community also in the wider community. There has been a huge impact — on the women and the men — from ice. There have been a lot of problems there... I think too, from where I sit in this, you see families, you see kids missing out on things, missing out on food in their mouth because their parents are using ice. The money is going towards the ice instead of feeding the children or doing what needs to be done there, and then from that comes the family violence because there is no money to spend and arguments start. It is a vicious cycle, the whole thing, and there are so many paths it can take. Also one of our workers works with child protection and there are a lot of reports going through there that are connected with the ice problem...in family violence and child protection it is a big issue.⁶⁰⁷

Reconnecting families

According to representatives from the Ngala Willumbong Cooperative whilst the loss of connection with family can have devastating results for the individual user, a need to be reconnected with family can also be one of the factors that inspire a person to want to become 'clean':

When you are looking at Aboriginal families, they are more family orientated, so that is where all their support comes from, and it is not just the family of the household that they are in, it is the community as well, and sometimes being isolated from the community can end up having other effects on that person. They can end up with depression because they do not feel they have that support around them. When you are with community and with family and that, you have people who understand where you come from, your background and so on as well, so you have all that support there. When people are using ice and the family end up pushing them away, they do not have that support. That is what gives them the strength. For them to get that strength back, they need that family. The only way to get that family back and that respect back from the community is to start looking at cleaning their own lives up...

[this wish to rehabilitate] is normally because they have stepped on the toes of a family member or are really upset because they ended up stealing from grandma and they really do not want to, and then they have a look at themselves in the mirror and realise, 'Oh my goodness, I stole from the one person that's cared about me'. It is normally because of a relationship with somebody close that they have hurt.⁶⁰⁸

Because crystal methamphetamine is having such a significant effect on Aboriginal families, there must be a focus on healing the family and not just the individual with the methamphetamine problem:

The healing needs to extend into the family too. The family being extended family, other people that are very closely connected to the family as well. They are really hurting. If it is one person within the family that is using ice, that affects absolutely everybody within that family circle, and friends. They are the people who are very strongly connected to those people. Through a healing centre itself we would be able to focus a lot of the healing into the family members, into everybody else around them at the same time, that it becomes a healing for everybody that has been involved with that. Yes, importantly

606 Mr Rudolph Kirby, Chief Executive Officer, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013. For further discussion on the impact of methamphetamine abuse on Aboriginal families and communities, see Chapter 7.

607 Ms Sharyn Jenkins, Aboriginal Family Violence Worker, Mungabareena Aboriginal Corporation, Albury-Wodonga Aboriginal Health Service, Wodonga, 24 February 2014.

608 Ms Miranda Madgick, Alcohol and Drug Women's Worker, and Mr Gilbert Freeman, Counsellor, Ngwala Willumbong Co-operative Ltd, Public Hearing, Melbourne, 24 March 2014.

the person who is using but just as important those family members who have been around it, who have probably copped some of this violence or copped some of this crap from the person, that they can continue to heal within themselves at the same time as the person who is there.⁶⁰⁹

Effect on the wider community

Methamphetamine abuse not only impacts upon the individual and their family, it also has harmful implications for the broader Aboriginal community (Van der Sterren et al. 2006):

Within Aboriginal communities, drug use has implications for the...cultural safety of the broader community. Individual harms are experienced in relation to health and wellbeing, interpersonal relationships, criminal behaviour and employment and study opportunities. It has been suggested that harms to families and communities threaten the social fabric and cultural health of Aboriginal communities, and that approaches to minimising the harms associated with [injecting] drug use must take the broader harms into consideration (ANCD 2011, p.55).

As previously discussed, the Aboriginal sense of family extends to the wider community and in particular the elders of that community who traditionally are held in great respect. Evidence to the Committee has suggested that in some communities where (young) people are using crystal methamphetamine, either alone or in combination with other substances, that respect has broken down. In some cases community elders are fearful and at loss to address the situation as indicated in the following submission from Primary Care Connect in Shepparton:

Shepparton has one of the largest Aboriginal populations in Victoria and the emergence of ice as a Drug of Choice [in a] population that is already dealing with health and social consequences of long term substance misuse, is devastating. Primary Care Connect has two alcohol and other drug clinicians that work within the Aboriginal Community and provide assistance to the Shepparton Koori court. The Koori Court has both Elders and Respected Persons assisting the Magistrate. In recent sittings, the Elders and Respected Persons have expressed their lack of understanding about the social impact, health consequences and Community responses to use amongst their community. They have requested more training and this is imperative if the Community is to have any informed response to this crisis.⁶¹⁰

This knowledge deficit and the capacity of local workers to address the issue are discussed below.

Crime and violence

The issues pertaining to the links between methamphetamine use, crime and violence are for the most part the same between Aboriginal and non-Aboriginal people and are therefore discussed in Chapter 8 of this Report. It needs to be pointed out, however, that as Aboriginal people may be generally over-represented in arrest and imprisonment figures in Victoria, so too are they over-represented in charges for drug-related crime,⁶¹¹ including possession and supply of methamphetamine.⁶¹²

609 Mr Norm Stanley, Youth Justice Worker, Wathaurong Aboriginal Co-Operative, Public Hearing, Geelong, 28 October 2013.

For further comment on the crucial importance of family and family support in Aboriginal culture see:

Ms Di Griffin, Aboriginal Drugs and Alcohol Counsellor, Albury-Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014; Mr Rudolph Kirby, Chief Executive Officer, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013.

610 Mr Hamish Fletcher, Chief Executive Officer, Primary Care Connect, Submission, 18 October 2013.

See also the comments of Mr Joey Chatfield, Aboriginal Community Liaison Officer, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

611 For example Mr Norm Stanley, Youth Justice Worker with Ballarat and District Aboriginal Co-operative told the Committee that at least 70 percent of the juvenile offenders he is working with have used crystal methamphetamine and this is a major reason as to 'why they are getting into trouble' with the law. Mr Norm Stanley, Youth Justice Worker, Wathaurong Aboriginal Co-Operative, Public Hearing, Geelong, 28 October 2013.

612 See Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Submission, 17 October 2013 and ANCD 2011, pp. 93-94.

Ms Lynne McDougall who sits with the Koori Court in Shepparton told the Committee that there has been a great increase in the number of people attending the court whose offending has been related to or committed whilst under the influence of crystal methamphetamine. See Ms Lynne Macdougall, Manager, Alcohol, Tobacco and Other Drugs, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014.

The need for culturally appropriate service provision

An understanding of culture is particularly important in providing education, treatment, and other support services to Aboriginal people with methamphetamine and indeed all forms of substance use problems.⁶¹³ Western concepts of harm reduction for example, may not always be suitable in Aboriginal contexts. For example some community elders may believe that opioid maintenance treatment condones drug use and should therefore be avoided in favour of abstinence programs.⁶¹⁴

Rather than using mainstream services for AOD treatment, Aboriginal service providers have advocated as a priority the need for healing centres that ‘can address individual aspects of treatment for alcohol and other drugs in combination with responding to trans-generational cultural issues’ (ANCD 2011, p.59). Such approaches are necessary, given that Aboriginal people may find mainstream services culturally insensitive or inappropriate to their needs (Ministerial Council on Drug Strategy 2006). Almost all witnesses from Aboriginal agencies and many from non-Aboriginal services stressed the importance of culturally appropriate healing centres and therapeutic communities to treat methamphetamine use and dependence, particularly in rural and regional Victoria.⁶¹⁵ This and other issues pertaining to the treatment of Aboriginal people are discussed in Chapter 29.

The importance of education, employment and training

In Chapter 22 the importance of education and employment as protective factors mitigating against the uptake of drug use will be examined. Whilst this discussion was couched in general terms, arguably the provision of education and employment opportunities for Aboriginal people is particularly important given their position of disadvantage in Australian society. This is especially pertinent in the context of young Aboriginal people given that: ‘One in 10 young Aboriginal people use methamphetamine compared to 1 in 20 young non-Aboriginal people’.⁶¹⁶ Moreover some of the key social indicators influencing the uptake of methamphetamine by youth in the Aboriginal community include high unemployment rates, particularly with young males, and disengaged youth, with Aboriginal participation in education significantly lower (from early learning to post-school education) compared to non-Aboriginal youth.⁶¹⁷

Challenges and Barriers in addressing Aboriginal Education and Employment

The Department of Education and Early Childhood Development (DEECD) has identified a number of key challenges in the provision of effective education and early childhood development services to Aboriginal Victorians. These include:

- ◆ Inaccessibility of some key services and some failure to recognise Koorie talent;
- ◆ Higher rates of vulnerability and poverty among Koorie families mean that too many children are developmentally behind, affecting their wellbeing and learning in the early years;
- ◆ Koorie children starting schooling behind their peers struggle to catch up;
- ◆ Many Koorie young people find themselves within a cycle of low core skills, low attendance and early leaving; and

613 Dr Karen Adams, Researcher, Victorian Aboriginal Community Controlled Health Organisation, Submission, 18 October 2013.

614 See ANCD 2011, p.75 and the discussion in Chapter 29.

615 This issue is discussed in detail in Chapter 29 of this Report.

616 Dr Karen Adams, Researcher, Victorian Aboriginal Community Controlled Health Organisation, Submission, 18 October 2013.

617 Mr Rudolf Kirby, Chief Executive Officer, Mildura District Aboriginal Services, Submission, 21 October 2013.

- ◆ Limited fundamental skills, coupled with limited pathways, restrict many Koorie people's chances of a good job.⁶¹⁸

The Victorian Auditor-General's Office (VAGO) in its *Report on Accessibility of Mainstream Services for Aboriginal Victorians*, (2014) has also identified the main barriers that Aboriginal Victorians face in accessing (education and employment) services and resources as being '... actual and perceived discrimination by service providers, language and cultural barriers, lack of trust in services and organisations, and lack of awareness of and engagement with local Aboriginal communities' (VAGO 2014, p.2).

A proposed Aboriginal Education Strategy

To address the challenges and barriers facing Aboriginal Victorians the DEECD is currently developing a new Aboriginal Education Strategy to improve learning and development outcomes for Aboriginal Victorians:

The Strategy is premised upon addressing the challenges outlined above through system-wide improvements to universal service provision in early childhood, school and vocational training. In addition to establishing the foundations of system-wide improvement, the Department will be retaining or building on those Aboriginal-specific programs and initiatives that augment system capacity in particular ways.⁶¹⁹

The Strategy identifies seven key elements that form the foundations of system-wide improvement:

- Committed and courageous leadership
- Respect and recognition
- Culturally accessible and responsive services
- Strong and resilient families
- A skilled workforce to facilitate change
- Partnership and connectivity at the local level
- Robust accountability.⁶²⁰

Current programs to address Aboriginal disadvantage in education and employment

Clearly there are some obstacles in place reducing the opportunities for Aboriginal people to obtain a good education or employment opportunities; some of which the Aboriginal Education Strategy will aim to address. Nonetheless, there has been some progress made in recent years to address the educational and vocational needs of young Aboriginal people. Some of the programs that currently address the needs of Aboriginal students in Victorian schools include the:

- *Early Years Koorie Literacy and Numeracy Program (EYKLNLP)*: Introduced in 2014, this program supports improved outcomes for Koorie students in Years F-3 in government schools who are below expected levels in literacy and/or numeracy. The program was introduced in response to evidence that the gap in literacy and numeracy outcomes between Aboriginal and non-Aboriginal students is established in the early years of school.
- *Koorie Academy of Excellence*: is driving parental engagement and lifting education aspirations of Indigenous students and their families.
- *Clontarf Academies for Koorie boys*: Clontarf Academies have operated since 2010 as a regional re-engagement initiative. The Academies focus on improving student engagement through Australian Rules Football. Any male Koorie student in Years 7-12 can participate in the program but to remain in the program they must continue to fully participate at school. Clontarf Academies are located at

618 Mr Darren Brown, Chief of Staff, Office of the Hon Martin Dixon MP, Minister for Education, correspondence, 6 August 2014.

619 Mr Darren Brown, Chief of Staff, Office of the Hon Martin Dixon MP, Minister for Education, correspondence, 6 August 2014.

620 Mr Darren Brown, Chief of Staff, Office of the Hon Martin Dixon MP, Minister for Education, correspondence, 6 August 2014.

secondary schools in Mildura, Robinvale, Swan Hill, Bairnsdale and Warrnambool.

- *Wannik Dance Academies for Koorie girls*: The Wannik Dance Academies opened in 2010 to provide an educational program for Years 7-10 female Koorie students based around dance. The Academies also focus on the development of literacy and numeracy skills. Dance Academies are located at Ballarat, Eaglehawk and Mooroopna Secondary Colleges.
- *Wannik Education Scholarships*: Since 2009, a total of 127 scholarships have been awarded to assist high-achieving Koorie students in government schools complete Years 11 and 12. Scholarships of \$5,000 over two years are awarded.
- *Koorie Education Coordinators (KECs) and Koorie Engagement Support Officers (KESOs)*: Approximately 10 KECs manage 108 KESOs who work with education, child and family service providers and Victorian Koorie communities to support Koorie students' engagement and wellbeing; retention and achievement; and entry into and successful completion of high education qualifications. The KESOs work closely with, and provide support to students and staff at the Clontarf and Wannik academies.⁶²¹

Similarly the DEECD have developed a number of programs to support young Aboriginal people in the Vocational Education and Training (VET) sector.

- *The Wurreker Strategy*: The Wurreker Strategy was released in 2002 with the aim of improving services in the vocational education and training sector to achieve quality education, training and employment outcomes for Aboriginal students. Activities include:
 - ♦ Funding to TAFEs to support Wurreker planning, and Koorie Liaison Officers (21 EFT)
 - ♦ A partnership with the Victorian Aboriginal Education Association Incorporated (VAEAI) to support the implementation of Wurreker through eight Wurreker Brokers who seek to link the needs of indigenous communities and the provision of training at local providers and Local Aboriginal Education Consultative Groups.
- *Indigenous Completions Initiative*: This initiative provides access to the concessional fees rate (20 percent of the fee charged) for students enrolled in government subsidised accredited vocational training at all levels, including diploma and above.
- *Training guarantee loading*: The government subsidised providers receive loadings to support students who are Indigenous (1.5 loading), training in regional areas (1.1) and aged 15 to 19 and do not hold a Year 12 certificate or equivalent and from a low SES background. These loadings are multipliers of course subsidy rates and determine the final subsidy paid for government subsidised delivery of training.
- *Family Learning Partnership trials*: In October 2014, sixteen Learn Local providers will commence Family Learning Partnerships trials which will seek to simultaneously raise the educational engagement and attainment of parents and children in family based settings while encouraging parents to progress to training employment. Based on a Community of Practice model, the trials will focus on working with vulnerable and Aboriginal families.⁶²²

In addition to these programs currently in operation, the DEECD in conjunction with other government departments is developing some additional programs to target Aboriginal disadvantage. These include a project to develop the cultural awareness and understanding of school principals and staff in relation to Aboriginal issues, history and culture to enhance the learning environment for Koorie students (Leading Cultural Inclusion and Indigenous Cultural Awareness Professional Learning). Importantly in the context of Aboriginal employment opportunities the DEECD in conjunction with the Department of State Development, Business and Innovation is currently developing an *Aboriginal Employment Plan*.⁶²³

621 Information provided by Mr Darren Brown, Chief of Staff, Office of the Hon Martin Dixon MP, Minister for Education, correspondence, 6 August 2014.

622 Information provided by Mr Darren Brown, Chief of Staff, Office of the Hon Martin Dixon MP, Minister for Education, correspondence, 6 August 2014.

623 For further information on Aboriginal education and employment strategies, see Aboriginal Programs and Initiatives on the DEECD website at <http://www.education.vic.gov.au/about/programs/aboriginal/Pages/default.aspx>.

Future Developments

In developing a new education strategy for Aboriginal Victorians the DEECD has been keen to learn from previous mistakes:

It was determined that Victoria's universal learning and development system — our early childhood services, schools, vocational and higher education institutions — must be the starting point for reform. Almost all Koorie families engage with this system in one form or another, so actions under the new Strategy will aim first and foremost to make mainstream services work well for Koorie people — to be inclusive, accessible and useful, as they should be for all Victorians.

Past strategies to improve outcomes for Koorie people have tended to patch over rather than address underlying system deficiencies. We now understand that the simple application of multiple programs will not produce a sustainable shift in outcomes. The department thus evaluated the capacity of specific programs to augment system capacity so as to produce system-wide outcomes. Where this was shown to be the case, these initiatives have been retained within the Strategy, and may be further developed in the future.⁶²⁴

In developing the Strategy the DEECD has also taken heed of the recommendations of the VAGO audit on *Accessibility to Mainstream Services for Aboriginal Victorians*. In doing so, the Department recognised that there is a need for:

- greater leadership across Government and coordination between departments;
- departments to engage with a broader range of Aboriginal people and organisations in delivering plans and programs;
- enhanced data collection, evaluation and reporting to facilitate service access;
- [government] departments to finalise Aboriginal Inclusion Action Plans.⁶²⁵

The DEECD is also working closely with the Office for Aboriginal Affairs Victoria and other government departments to develop a joint action plan in response to the audit report to address the issues identified.

The Aboriginal Ice Forum

The issues noted above with regard to methamphetamine use in Victorian Aboriginal communities have been viewed with concern by both Aboriginal community leaders and the Office of Aboriginal Affairs Victoria (OAAV). As such, in 2013 the Minister for Aboriginal Affairs met with Aboriginal community representatives who expressed concern about the increasing rates of children and young people being recruited to sell ice, and the impact on the health and wellbeing of users and their families. In response to this, the Victorian Aboriginal Ice Forum was held on 6 February 2014.

The Department of Health with assistance from the Department of Premier and Cabinet, through the OAAV, hosted the forum with Aboriginal community leaders from across the state. Attendees consisted of representatives from the Victorian Aboriginal community, service organisations and Government representatives across the health, human services, justice and education sectors, as well as the Commonwealth Government.

Key themes to emerge from discussions included the need for:

- more education in schools and information for families;
- more early intervention and diversionary options;
- timely access to culturally appropriate and well located treatment services;

624 Mr Darren Brown, Chief of Staff, Office of the Hon Martin Dixon MP, Minister for Education, correspondence, 6 August 2014.

625 Mr Darren Brown, Chief of Staff, Office of the Hon Martin Dixon MP, Minister for Education, correspondence, 6 August 2014.

- a cross government approach; and
- localised community responses.⁶²⁶

As a result of the forum a working group consisting of Government (including OAAV) and community stakeholders, including Aboriginal organisations, has been established to progress actions arising out of the forum. In particular the use of ice and its impact on communities will continue to be discussed and addressed through the Aboriginal Justice Forum, the Indigenous Family Violence Partnership Forum and at the regional level through regional Koolin Balit (health) committees, with information fed back to the working group. In short the OAAV has emphasised to the Committee that:

the use of ice in Aboriginal communities is a complex problem, and one that requires a multifaceted approach across government, including education, health and justice, in partnership with the Aboriginal community.⁶²⁷

Conclusion

The Committee has been made aware of the concerns and challenges confronting Aboriginal communities in Victoria regarding the use of methamphetamine. Addressing the problem, however, is difficult. Ultimately, according to many Aboriginal leaders, tailored models of service delivery that are culturally appropriate and which address the heterogeneity within Aboriginal communities are required. Such approaches need to be community controlled and empower local Aboriginal communities to change rather than impose changes from above.⁶²⁸

As a number of Aboriginal and non-Aboriginal witnesses have told the Committee, whatever form of prevention, education, treatment or support services are offered to Aboriginal people affected by methamphetamine use, it is essential that local communities be given the capacity *as* a community to address them.⁶²⁹ Moreover, in considering Aboriginal methamphetamine use, it is essential to address the issue on multiple levels — that of the individual, the family and the wider community.

Finally, the legacy of colonisation, dispossession and the social and structural determinants of Aboriginal health and disadvantage must also be recognised.

⁶²⁶ Office of the Minister of Aboriginal Affairs Victoria, correspondence, 20 August 2014.

⁶²⁷ Office of the Minister of Aboriginal Affairs Victoria, correspondence, 20 August 2014.

⁶²⁸ See for example, Ms Lisa Briggs, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation, Public Hearing (via teleconference), Canberra, 11 February 2014.

⁶²⁹ See Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

Recommendation 38

The Committee recommends that the Victorian Government provides a raft of culturally appropriate programs and resources on methamphetamine to the Aboriginal community including Aboriginal elders, alcohol and drug, justice, health, youth and other workers. Such resources should include:

- *Aboriginal specific holistic healing centres to adequately cater for the specific cultural needs of Aboriginal communities with regard to substance abuse including methamphetamine*
- *Incentives for the employment of greater numbers of Aboriginal health workers, drug and alcohol workers to address problems of substance abuse within Aboriginal communities*
- *Comprehensive and culturally appropriate training for Aboriginal health, welfare and AOD workers*
- *Additional Aboriginal specific leisure facilities, including youth, sport and recreational clubs and programs, that will provide structured activities, engage young people, enhance their self-esteem, promote Aboriginal culture and tradition and develop a sense of community*
- *Further support for families in undertaking Aboriginal foster care.*

Recommendation 39

The Committee recognises that a key strategy to prevent the uptake of drugs in Aboriginal communities is to retain young people in education for as long as possible and to provide ongoing employment and training opportunities. **The Committee therefore recommends** that the Victorian Government investigate best practice models for retaining Aboriginal young people within the education and/or employment sectors.

13. Methamphetamine Use by Young People

Introduction

In the early 2000s concerns were being raised by researchers, policy-makers and service providers that the use of 'ice' was dramatically increasing in Australia (McKetin & McLaren 2004). Whilst recent data suggests that such trends were not indicative of an 'epidemic' and in fact usage generally may have declined after 2009 (Bruun et al. 2012), there are still real concerns that methamphetamine use is having a significant effect on young people and that it is still one of the most commonly used illicit drugs (Sindicich & Burns 2013; Bruun et al. 2012).

It is important to state from the outset, however, that the category of 'young people' is not a heterogeneous one. The prevalence and patterns of methamphetamine use amongst young people will vary according to a number of factors, including the geographic location of the user and their socioeconomic circumstances. Methamphetamine use may also be higher in certain demographics, for example same sex attracted youth (Howard et al. 2012). Finally, young people, as with the rest of the population, may use methamphetamine in a variety of ways — recreationally, occasionally, functionally or in a dependent manner. The reasons for use may also dictate the ways in which the drug is taken. For example, a recreational user may take the drug for energy to sustain all night dancing and/or drinking. A young person living on the streets with a history of mental illness, however, may use methamphetamine as a form of self-medication (Allsop & Lee 2012).⁶³⁰

A discussion of methamphetamine use by young people needs to examine all these variations in patterns of and reasons for use. In particular, an examination of recreational drug use by youth for whom the use of the drug has not yet become problematic is warranted. In addition, the problematic and entrenched abuse of methamphetamine by young people from disadvantaged backgrounds needs discussion.

The prevalence of methamphetamine use amongst young people⁶³¹

There is a growing concern that an increased number of young people in Australia are using methamphetamine particularly on an experimental basis. (McKetin et al. 2012a). There is, however, a paucity of recent and specific data on the prevalence of methamphetamine use amongst young people:

It is difficult to ascertain recent rates of methamphetamine use among young people in Victoria. One source of data is the Victorian Secondary School Survey (Department of Health 2012). In this research, Victorian secondary school students surveyed in 2011 were asked how many times, if ever, they have used or taken amphetamines other than for medical reasons in their lifetime. Overall, three percent of those aged 12 to 17 years reported having ever used amphetamines, a comparatively low rate

630 Reports have been given to the Committee that it is 'not unknown' for homeless people to use methamphetamine to stay awake on the streets in order to avoid being attacked or robbed. See Chapter 14.

631 This report defines 'young people' as those aged 15–25 years which is consistent with Australian Bureau of Statistics (ABS) and United Nations publications on young people. Having said that, it is recognised that some AOD agencies are seeing children as young as 12 using methamphetamine, and this will be acknowledged where appropriate. It is also recognised that for some purposes 'youth' as a concept can readily be extended to the age of 30; for example in the context of young people who attend nightclubs and dance parties.

compared to students who reported ever having used licit drugs, such as alcohol (76%) and tobacco (25%) (Department of Health 2012). While this data is useful, it is limited. Research indicates that young people who use illicit drugs are less likely to attend school and therefore rates of illicit drug use in this sample are likely to be lower than among young people generally (Department of Health 2012). Further, given that the use of methamphetamine appears to have increased in at least the past 12 months, this particular data set is too old to capture this increase.⁶³²

The results of the Australian Secondary Students Alcohol and Drug (ASSAD) Survey 2011 are discussed in Chapter 5.

Notwithstanding the lack of more recent statistical information, alcohol and other drugs (AOD) agencies have reported their concerns that methamphetamine use amongst young people is increasing. For example, Mr John Ryan recognised from experience in the field that:

While there is a dearth of data concerning young people and the use of methamphetamine, particularly ice, in the course of Anex's work in various communities in Victoria [such as rural community forums], it has been reported to us that young people are increasingly using methamphetamine and/or ice.⁶³³

A submission from Victoria's Youth Support + Advocacy Service (YSAS), drawing from the 2013 census of 1,000 clients in youth AOD services in Victoria, also stated that 'in house' data revealed some disturbing trends:

[There were] some 255 clients (25.5%) whose primary drug of concern was methamphetamine. This illustrates the continuing trend for methamphetamine users to be increasingly represented among the overall population of youth AOD treatment clients.

Methamphetamine use in the Victorian youth AOD client population is also at high levels relative to the general population and when compared to other previous treatment populations of a similar age. Australia's AOD National Minimum Data Set (NMDS) for 2011-12 (all age groups) shows Amphetamines use at 11%. The NMDS 2010-11 identified a more comparative sub-cohort aged 10 to 29 years old that shows Amphetamine users representing 9%. This suggests a sharp rise over the previous 2 years of young people seeking treatment for methamphetamine related problems.⁶³⁴

Junction Support Services (JSS), a youth support agency in Wodonga, for example also noted that seven out of 18 adolescents (38 percent) in their Supporting Young Parents Program have used or are currently using crystal methamphetamine.⁶³⁵ The Australian Community Support Organisation (ACSO) observed further that the average age of a methamphetamine user is younger than that for other drugs.⁶³⁶

In addition to concerns about the increasing numbers of young people using methamphetamine, AOD, health and youth support agencies have also expressed concern about the ways in which methamphetamine is used. Certainly the uptake of smoking methamphetamine by young people is of concern to health workers because of its association with dependence and the possibility that it might lead to injecting forms of methamphetamine use (McKetin, Kelly & McLaren 2006). In particular, young Aboriginal people may also be particularly vulnerable to methamphetamine use and are at particular risk from transiting relatively quickly from non-injecting to injecting forms of using the drug (ANCD 2011, p.96).⁶³⁷

632 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

633 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

634 Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS, Submission, 21 October 2013.

See also Chapter 5 for a discussion of prevalence of methamphetamine use among young cohorts.

635 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014.

636 Ms Heather Carmichael, Community Offender Advice and Treatment Service (COATS) Manager, Australian Community Support Organisation (ACSO), Submission, 12 November 2013.

See also comments in this respect of Mr Tyler Tricarico, Alcohol and Other Drug Clinician, Goulburn Valley Health, Public Hearing, Shepparton, 25 February 2014.

637 See also discussion in Chapter 12.

YSAS expressed its concerns on this issue in its submission to the Inquiry, also noting the spread of methamphetamine use amongst young 'tradies' and apprentices.⁶³⁸

YSAS believes that because methamphetamine is most commonly smoked rather than injected, young people are more easily initiated into using it. The likelihood is increased when young people either associate with others for whom smoking methamphetamine is common or for those who believe it is common among other young people. YSAS is also aware that methamphetamine use is an emerging problem for young trainees, apprentices and those in trades. Unfamiliar with accessing support services, this cohort is reluctant to seek help until they face crisis, making engagement and early intervention difficult. They are not currently significantly represented among clients in Victoria's AOD treatment services.⁶³⁹

Why young people use methamphetamine

The primary reason for young people using drugs, whatever the circumstances surrounding the motivation, is to alter consciousness (Commonwealth of Australia 2006 p.21). This may be for stress relief, relaxation, trauma and personal crisis or simply for 'fun'. Table 13.1 below indicates why the sample of young people surveyed in the National Drug Strategy Household Survey (2010) first took illicit drugs.

Table 13.1: Factors influencing first use of an illicit drug, lifetime users aged 14 years or older, by sex, 2007 and 2010 (percent)

Factor	Males			Females			Persons		
	2007	2010		2007	2010		2007	2010	
Peer pressure	43.2	47.6	↑	43.4	50.2	↑	43.4	48.8	↑
Curiosity	62.3	78.8	↑	58.6	79.3	↑	58.6	79	↑
To feel better	4.4	5.5		4.5	6.6	↑	4.5	5.9	↑
To take a risk	5.6	8.8	↑	6.1	9.1	↑	6.1	8.9	↑
To do something exciting	13	20.3	↑	12.9	19.7	↑	12.9	20	↑
Family, relationship, work or school problems	3.7	4.6		3.9	5.9	↑	3.9	5.2	↑
Traumatic experience	1.7	2.1		2.2	4	↑	2.2	2.9	↑
To lose weight	0.3	*0.5		1.1	1.5		1.1	1	
To enhance an experience	9.3	12.6	↑	8.4	13	↑	8.4	12.8	↑
Other	3.8	2.7	↓	3.7	1.8	↓	3.7	2.3	↓
Don't know/can't say	n.a.	2.8		n.a.	2.1		n.a.	2.5	

* Estimate has a relative standard error of 25% to 50% and should be used with caution.

Notes:

1. Base is those who had used an illicit drug in their lifetime.
2. Respondents could select more than one response.

Source: Australian Institute of Health and Welfare (AIHW) 2011, p.169.

638 See also discussion below in the context of 'situational' use.

639 Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS, Submission, 21 October 2013.

Of particular note is the fact that 48.8 percent of young people in 2010 cited peer group pressure as one of the reasons why they initially took an illicit drug. Equally concerning is that 78 percent of young people cited curiosity as a reason. Such reasons accord with the views of some witnesses who gave evidence to the Committee. In particular, peer pressure to *share* the drug may be particularly noticeable in social settings such as parties and dance clubs.⁶⁴⁰

Euphoria — the ‘rush’

Some young people view methamphetamine as a ‘fun’ drug and use it relatively unproblematically (Bruun et al. 2012). Ms Philippa Norton from JSS for instance explained the ‘rush’ some of the young clients seen by her agency felt after having taken methamphetamine:

We asked our clients ‘Why ice?’ and they told us that mainly because of the euphoria. They said things like, “There’s nothing like it. You know you won’t get that high anywhere else. You feel full of energy, full of life. The first time is the best ...”⁶⁴¹

These sentiments indicate that for young people in particular the ‘feelings’ of intense pleasure that is produced in their bodies by methamphetamine is a powerful inducement to take the drug. Mr John Ryan from Anex also states that:

The rush is incredibly intense. The high is incredibly intense, which means that people will use it and experience great pleasure. In fact it replaces a lot of the pleasures we would get through other natural means, such as eating delicious food or doing exercise, in which case people who are in menial jobs and are bored and work long shifts think it helps them. People who are trying to increase their confidence in a nightclub setting think it helps them.⁶⁴²

Similarly, Dr Frei from Turning Point Alcohol and Drug Centre told the Committee that the pleasure that this drug gives young people, notwithstanding any possible side effects, cannot be underestimated:

People get enhanced energy, they often get an increase in sex drive, they feel more talkative and confident and often very powerful and energetic. I mention these effects because we have to keep in mind that people do not start using or frequently using methamphetamine and those related drugs because they want their teeth to fall out or they want to spend all their money or cause great disruption to their social and family life; they use it because it does give some reward. Those are the immediate effects — alertness, increased energy, the ability to dance and stay awake and have sex and all these things that people generally want.⁶⁴³

The Committee also received evidence from those who had experienced the euphoria personally. Mr Stu Fenton an ex-user and now drugs counsellor stated for example:

The thing about crystal meth is when people eventually use it or come into contact with it, the rush of it is so powerful and intense, it is such a euphoric experience. When you feel that, any other negative emotions or experiences that you have ever had get wiped aside. It is a clear crisp high that makes you feel invincible and powerful. If you are a person who has been through trauma, you do not know how to manage your life, you are irresponsible, your family is critical of you — whatever — this is the perfect answer. You know you can stay awake for days, you can work, you can seem really functional to other people.⁶⁴⁴

640 See for example, Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014; Mr Dion Appel, CEO, Lifelounge Agency, Public Hearing, Melbourne, 16 June 2014.

641 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Public Hearing, Wodonga, 24 February 2014.

642 Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

643 Dr Matthew Frei, Head of Clinical Services, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

644 Mr Stuart Fenton, Drug and Alcohol Counsellor, Public Hearing, Ballarat, 18 November 2013.

For some young people the euphoria of methamphetamine use may be an integral part of their strategic approach to sex; particularly in enhancing and prolonging sexual pleasure and reducing inhibitions (Allsop 2012). Physiologically, methamphetamine may result in particularly intense and longer lasting orgasms (Cruickshank & Dyer 2009).⁶⁴⁵

The sense of euphoria is also captured in the following comments taken from reports to JSS by their young clients:

Euphoria described by clients as: “incredible” “nothing like it” “you feel full of energy, full of life” “once you have tried ice, you would never go back to speed” “you know you won’t get that high anywhere else” “first time is the best, I was one of the one’s chasing the dragon” “IV use is ten times better than smoking it”.⁶⁴⁶

Alleviating boredom

A number of young people have reported to AOD services and youth workers that one of the reasons they turn to ‘ice’ and other drugs is due to boredom, particularly young people who are unemployed or not engaged in any meaningful activity. This may be especially the case for youth in rural and regional centres:

We have had lots of clients say, ‘Life’s boring without the drug’. That is why it is a real challenge. Youth unemployment is really high. It is harder to get into courses these days. There are not necessarily as many opportunities around for young people, and when you have got someone who is just seeing life as boring without drugs, it is a real challenge for the workers.⁶⁴⁷

Ms Philippa Northam also saw a distinct nexus between drug use, including methamphetamine, and a lack of things for kids to do:

the drug use with young people can result in part from boredom — Wodonga is particularly lacking a lot of entertainment and recreational activity. Even small things, like we do not have public basketball courts. It sounds ridiculous but there is no cinema in Wodonga. A lot of youth focused events and activities are in Albury. People in Wodonga are far more isolated from those kinds of opportunities.⁶⁴⁸

A number of Aboriginal agencies also told the Committee that boredom was a major factor contributing to the use of methamphetamine amongst young Aboriginal people.⁶⁴⁹

Ease of access, cheapness and availability

For some young people the attractions of methamphetamine may lie in the ease with which it can be accessed and its relative inexpensiveness compared to alcohol or other drugs.⁶⁵⁰ Evidence given to the Committee suggests this is the case for both Aboriginal and non-Aboriginal youth. For example Mr Peter Wearne from YSAS told the Committee:

In some cases we are seeing methamphetamine challenging alcohol or cannabis as being the more dominant of the drug presentations, [amongst young people] there is no doubt that this has been on the increase and there is no doubt [this is] because of its availability...it is actually very available like other drugs have not been.⁶⁵¹

645 Conversely, it has also been known to be associated with erectile dysfunction (Cruickshank & Dyer 2009).

646 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014.

647 Mr Paul Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013.

648 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Public Hearing, Wodonga, 24 February 2014.

649 See for example, Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Public Hearing, Melbourne, 17 February 2014 and discussion in Chapter 12.

650 Although the cost of methamphetamine may vary depending in which part of Victoria it is purchased. Views as to how inexpensive methamphetamine may be have varied according to different witnesses who gave evidence to the Committee. See discussion in Chapter 3.

651 Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

In the Aboriginal context similar comments were made:

Methamphetamine is easy to get a hold of, possibly even more easy than cannabis is now. ... I ask my clients, 'Do you have any trouble getting it?' They do not have any trouble getting it at all. It seems to be everywhere.⁶⁵²

Methamphetamine is clearly accessible to young people in both Melbourne and regional Victoria. An extended discussion of the accessibility and availability of methamphetamine is presented in Chapter 3.

Weight loss and 'looking good'

Evidence has been given to the Committee that one reason methamphetamine is used by young people in particular is to lose weight and for reasons of personal attractiveness. Ms Kate Hunt from Youth Projects told the Committee that for young women in particular weight loss was an important component of their ice use. This was in turn very much part of the way in which young women felt the need to conform to a particular type of idealised body image.⁶⁵³

It is not only young women who may use the drug for these reasons. Evidence has been given that young men too, particularly sportsmen, favour methamphetamine as a drug of choice. It not only acts as a performance enhancer but, unlike alcohol, does not contribute to weight gain and if used alone does not result in a hangover the next morning:

If you drink a lot of beer or bourbon and Coke it tends to put on weight, so for athletes and sportsmen in particular, rather than putting on weight, drinking copious amounts of beer and waking up with a hangover, if they take a substance like ice they do not have the problems with weight associated with it and they do not wake up with a terrible hangover the next day. I have no doubt that is an issue in the sporting clubs throughout the country, and obviously within this Goulburn Valley area.⁶⁵⁴

Facilitating alcohol consumption

Some methamphetamine users may use ice in combination with alcohol and other drugs particularly in recreational settings such as nightclubs and dance parties. This differs from previous party drugs such as MDMA (ecstasy) which in the past did not tend to be used in conjunction with alcohol.⁶⁵⁵ Ms Martha Tsamis of the Nightclub Owners Association told the Committee in this respect: 'Ice users drink alcohol. I do not know if they drink water but they definitely drink alcohol'.⁶⁵⁶

In some cases methamphetamine use may be used as an adjunct to facilitate heavy drinking because it 'negates the intoxicating effects of alcohol intoxication' (McKetin & Lubman 2011, p.565). This aspect of use whilst not restricted to young people is very much part of the raft of reasons why methamphetamine may be attractive to them as a drug. As Detective Senior Constable Bray from Wodonga told the Committee:

They can take the drug, they can stay up for three, four days, whatever they choose, as long as they continue taking the drug, and they can drink as much alcohol as they like. The methamphetamine has that effect and allows them to do that, and remain active for long periods of time.⁶⁵⁷

652 Ms Di Griffin, Aboriginal Drugs and Alcohol Counsellor, Albury-Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014.

653 Ms Kate Hunt, Collaborations and Development Officer, Youth Projects, Public Hearing, Melbourne, 3 February 2014. See also discussion of the reasons why (adult) women may use methamphetamine. See Chapter 14.

654 Detective Senior Sergeant Paul Maher, Detective Acting Inspector, Goulburn Valley Division 3, Victoria Police, Public Hearing, Shepparton, 25 February 2014.

See also on this issue Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

655 See Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into Amphetamine and Party Drug Use*, 2004.

656 Ms Martha Tsamis, Licensee, Chasers Nightclub and Inflation Nightclub, Public Hearing, Melbourne, 24 March 2014.

657 Detective Leading Senior Constable Jason Bray, Wangaratta Criminal Investigation Unit, Victoria Police, Public Hearing, Wodonga, 24 February 2014.

Similar observations were made by Professor Paul Dietze of the Burnet Institute who told the Committee that there are people who may use methamphetamine solely for the reason of drinking more alcohol.⁶⁵⁸ Dr Rebecca McKetin also told the Committee that this was not an uncommon reason for a young person taking methamphetamine:

One of the problems we are seeing at the moment is that stimulant users — whether it is amphetamines, but I think mostly it is methamphetamine, amphetamine or ecstasy and cocaine — drink quite heavily. They go out and binge drink because the stimulant effects allow them to drink more than you would otherwise. They sober the person up, if you like. They offset the sedative effects of alcohol.

When we talk to stimulant users, they are reporting incredibly high levels of alcohol consumption when they go out binge drinking. This is not your kind of chronic person who would turn up to treatment. This is your 20-something-year-old male on a big night out, and that has got an important risk for alcohol-related violence, because the methamphetamine increases the risk of violence and so does the alcohol, and you have the two together.⁶⁵⁹

Recreational use

There is a significant rate of methamphetamine use in recreational settings such as nightclubs, dance parties and music festivals, pubs and even the ‘pokies’.⁶⁶⁰ This usually occurs on weekends. In such a context, methamphetamine is most often used in combination with other drugs such as cannabis, ecstasy and alcohol (Lee et al. 2007; Miller et al. 2013). In some cases, as discussed in Chapter 9, crystal methamphetamine is replacing cannabis as the recreational drug of choice, particularly given its stimulant properties allowing people to dance and party for hours, even days on end.⁶⁶¹

The POINTED (Patron Offending and Intoxication in Night-Time Entertainment Districts) study is a recent research project on licit and illicit drug use in the night-time economies of five Australian cities including Melbourne and Geelong (Miller et al. 2013). The project explored the interaction of psychostimulants such as methamphetamine with other drugs including alcohol and the effects of drug use, such as violence and aggression. In Melbourne 3% and Geelong 4% of the patrons interviewed used methamphetamine on their night out. Illicit drug use was particularly noticeable in nightclub and dance club type venues and intoxication from illicit drugs exponentially increased as the night progressed. The study found that illicit drug use is a significant contributor to harms associated with the night-time economy such as violence, aggression and injury, but overall only a minority of patrons take illicit drugs when compared to alcohol.

Professor Peter Miller the lead author of the POINTED study, whilst acknowledging that the numbers of methamphetamine users were relatively small, told the Committee that the use of methamphetamine in social settings such as nightclubs and dance parties is definitely on the rise compared to three years or so ago when a similar study, but concentrating on alcohol use (DANTE),⁶⁶² was conducted:

The key point is really that illegal drug use is very common, a lot more common than has ever been documented before, and that is because these are the biggest studies out there, but also we know

658 Professor Paul Dietze, Head, Alcohol and Other Drug Research, Centre for Research Excellence in Injecting Drug Use, Burnet Institute, Public Hearing, Melbourne, 30 September 2013.

On this issue see also comments of Mr Paul Dillon, Director and Founder, Drug and Alcohol Research and Training Australia, Public Hearing, Melbourne, 3 February 2014.

659 Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

660 In this instance see Ms Heather Carmichael, Community Offender Advice and Treatment Service (COATS) Manager, Australian Community Support Organisation (ACSO), Submission, 12 November 2013.

661 Superintendent Andrew Allen, Divisional Commander, Ballarat Division, Western Region, Victoria Police, Public Hearing, Ballarat, 18 November 2013. See also Associate Professor Peter Miller, Principal Research Fellow, School of Psychology, Deakin University, Public Hearing, Ballarat, 18 November 2013.

662 The acronym stands for ‘Dealing with Alcohol related harm in the night time economy’.

that it predicts much greater harm. Between the DANTE and POINTED studies, as I said, we got a doubling of self-reported drug use, and these are big studies. These are not studies that are going to fluctuate because one or two people say yes or no. We are talking about thousands of people, so we are confident that the rates changed substantially in that period over the three years through which the studies were conducted.⁶⁶³

Mr Darren Holroyd, Chair of the Geelong Nightlife Association, acknowledged that illicit drug use was relatively high and increasing in nightclubs particularly amongst patrons aged between 18 and 21, although he told the Committee it was difficult to gauge to what extent this illicit drug use was attributable to crystal methamphetamine:

We believe it [illicit drug use] is increasing...and we feel, particularly in that younger age bracket, the 18 to 21 area — the venues that I own tend to have a little bit of an older crowd, and I feel in those venues, although it has increased a bit over the last few years, it is not as dramatic as the younger groups. What percentage of it is ice, we do not know. We detect a lot more unprovoked aggressive behaviour these days than there used to be, and we believe this is as a result of ice and speed being more aggressive type drugs... It is definitely out there. That aggression is something we never used to see 10 or 15 years ago. It is an unprovoked aggression that is amazing to watch.⁶⁶⁴

Conversely, whilst Ms Martha Tsamis a nightclub licensee and member of the Night Club Owners Association acknowledged that illicit drug use existed in nightclubs including her own, she believed the amount of such use in nightclubs was relatively small.⁶⁶⁵ She attributed this to the heightened security within club premises and the commitments from licensees to exclude crystal methamphetamine and other illicit drug users from their premises:

Firstly, there is no smoking in our venues, so if people wanted to pull a smoke, a pipe, you would see them. You would notice them straightaway, so they would be detected. The consequence of that is that they would be asked to leave, banned, never be able to go back into the nightclub... When you are running 20 security [personnel] and you have got protocols in place where people will be barred and on a black ban list, they are going to be very careful. In King Street, most of the drug use was happening in the car park. Most people do ice at home, in the car, before they walk in; it is very obvious.⁶⁶⁶

Ms Tsamis did indicate, however, that where drug use *did* take place in nightclubs in some cases it was unfortunate that licensees or staff could be penalised for 'doing the right thing'. In other words she told the Committee that there were occasions where licensed venues were given a 'black mark' by police or licensing authorities for calling an ambulance in cases of a drug induced emergency among patrons:

Licensees have made public comments at industry forums and to me personally regarding the decision to no longer call police or ambulances for drug overdoses. The licensees, who I shall not name, stated that other venues were punished by police for reporting overdoses, for calling assistance. My personal experience is the same. In both my venues we have a policy to call the police when required. This is based on harm minimisation policy documents which save lives. The police policy clearly states that people should not be punished or fear prosecution for calling an ambulance for an overdose. In practice this is not the case and the police are punishing venues for ambulance call-outs.

663 Associate Professor Peter Miller, Principal Research Fellow, School of Psychology, Deakin University, Public Hearing, Ballarat, 18 November 2013.

664 Mr Darren Holyroyd, Chair, Geelong Nightlife Association, Public Hearing, Geelong, 28 October 2013.

Mr Holroyd added, however, that he thought more clubbers would 'load up' prior to coming to a venue or alternatively use illicit drugs in pill form as it would be much more difficult to use 'ice' in smokeable or injectable forms in full view of a nightclub.

665 Ms Tsamis is the licensee of Chasers and Inflation nightclubs in Melbourne. She also brought to the attention of the Committee the document *Responding to Drugs: Advice for Venue Operators* which provides information to licensees on how to address illicit drug use within their clubs utilising harm minimisation principles.

666 Ms Martha Tsamis, Licensee, Chasers Nightclub and Inflation Nightclub, Public Hearing, Melbourne, 24 March 2014. Ms Tsamis did state, however, that there is a possibility that some methamphetamine users were spiking 'electronic' cigarettes with shards of ice which would escape surveillance within the nightclub.

In my situation, and many others, we are issued with written warnings by police for incidences that happen in our venues, which include ambulance call-outs and responding to drugs.

Instead of calling police, venues themselves are trying to manage patrons who are drug affected and they are either refused entry or asked to leave. This is because there is now a fear in the industry of receiving written warnings for reporting these matters to police. These drug-affected persons, many of whom are violent, aggressive, are simply moved on so the venue does not get a black mark against it, instead of venues calling the police for these people, who are then left walking the streets.

I have seen many drug-affected people, in particular ice-affected people, walking the streets, causing damage and also assaulting and damaging property. If the police adopted a more cooperative approach, crimes committed by these people could be prevented. It appears that the police are targeting venues based on the volume of call-out data and not looking at the actual nature of the calls. Something has to change because the current approach of police blaming venues for what is a social problem is simply not fair, does not address the drug issue and will not improve public safety.⁶⁶⁷

In Ms Tsamis' view this approach is completely in contradiction of the principles of harm minimisation which police are instructed in.⁶⁶⁸

In response, Victoria Police has commented that the demerit point system used against licensees 'cannot be imposed for drug-related matters':

Demerit points can only be recorded for offences involving supply of liquor to an intoxicated person, permitting drunken or disorderly persons on licensed premises, supplying liquor to minors or allowing minors to be on licensed premises.

There have been *no* instances where a licence has been cancelled due to incidents involving crystal amphetamine use by patrons.⁶⁶⁹

Even the document cited by Ms Tsamis, *Responding to Drugs: Advice for Venue Operators*, produced by the Victoria Police Drug and Alcohol Strategy Unit, specifically states:

'If a person is intoxicated and/or drug affected, refuse admission. If concerned for the affected person's conscious state, call an ambulance'.⁶⁷⁰

Despite these conflicting views the Committee believe stronger relationships need to exist between Victoria Police and nightclubs and entertainment venues particularly regarding illicit drug use. One way this might occur is through a protocol between Victoria Police and nightclub owners that expands upon the information provided in the document *Responding to Drugs: Advice for Venue Operators*.

Police are not the only first responders who have to address methamphetamine use in the nightclub context. Mr Allan Eade of Ambulance Victoria told the Committee most of the methamphetamine users they assist are people who use it at 'parties, festivals, nightclubs and the like'.⁶⁷¹ As such, increasingly paramedics and ambulance services are being pre-deployed at festivals/dance events and other gatherings putting a strain on resources available for 'normal business' (Eade 2012, p.145). Mr Eade also told the Committee that there should be continuing investment in the health aspects of mass gatherings and dance parties, where methamphetamine and other drugs are used:

667 Ms Martha Tsamis, Licensee, Chasers Nightclub and Inflation Nightclub, Public Hearing, Melbourne, 24 March 2014.

668 See discussion on police training in Chapter 25.

669 Lucinda Nolan, Deputy Commissioner, Victoria Police. Correspondence to the Law Reform, Drugs and Crime Prevention Committee, 19 August 2014.

670 *Responding to Drugs: Advice for Venue Operators*, Victoria Police Drug and Alcohol Strategy Unit at http://www.police.vic.gov.au/content.asp?a=internetBridgingPage&Media_ID=55576.

671 Mr Allan Eade, Intensive Care Paramedic, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013.

A code of practice was developed and published in 2004. A 2012 edition has been developed but it has not yet been published, and we recommend that occurs as soon as practicable. Our view is that any advice and guidance we can give to organisers of these events to help them in their planning is important'.⁶⁷²

Ms Jenny Kelsall from Harm Reduction Victoria told the Committee that in the dance party context:

Feedback from a number of our programs clearly indicates increased use of ice, or methamphetamine. DanceWize, a large team of trained volunteers who attend dance party events and music festivals, consistently reports increased use of ice, particularly during periods where MDMA, or ecstasy, has been hard to get or is of lesser quality. This is a very specific group; it is a very young cohort of partygoers. They tend to use a wide range of illicit in a very social and sociable sort of way. As a group they tend to be extremely well informed and eager for information about the cocktail of illicit drugs available at these sorts of events.⁶⁷³

Young people, particularly those who smoke or orally ingest methamphetamine in group settings may distinguish themselves from other users of the drug. As discussed earlier in this Report, for some social users of ice, injecting drug use is the province of 'junkies'. The following sentiments expressed by 'Julia', a self-described middle-class user of methamphetamine to her counsellor is indicative: 'Julia explained that she did not relate to typical drug users because she was raised with values, morals and manners and did not engage in criminal activity' (Baker et al. 2012, p.334). This differentiation between methamphetamine and other drugs, particularly heroin, is explained by a police detective in Gippsland accustomed to observing the drug scene:

The biggest issue is the culture with ice. Heroin was always seen as a dirty, dark, dangerous, 'don't go there' drug that was used by people who were fairly down and out, desperate, unemployed, did the burglaries to support the habit and did not get a lot of support from the community. It was just not accepted by their peers. Heroin use was something you were ashamed of, whereas ice has got a different culture in that it appears that it is more acceptable,

In a night club they use it because it is seen as a more trendy drug. Even the name 'ice' is better than 'heroin'. It does not create the same image. Ice seems sort of cleaner, more jazzier. People are willing to use it in night clubs.⁶⁷⁴

Ironically, although drugs such as heroin are avoided by recreational drug users, according to one senior police officer 'the impact on the community from ice use is far greater than heroin ever has been'.⁶⁷⁵ There is also the concern expressed by many health and AOD workers that recreational use may eventually and in some cases quite quickly spiral into dependent use.

The 'normalisation thesis'

As early as the 1990s, particularly in the United Kingdom, sociologists had been noting that increasingly illicit drug use had become a normal part of young people's leisure time.⁶⁷⁶

672 When Dr Andrew Crellin of the emergency department of Ballarat Hospital gave evidence he told the Committee that after one dance rave at Kryal Castle near Ballarat he spent the whole weekend resuscitating people from drug overdoses. This in his view reflected a spike in emergency presentations associated with illicit drug use combinations at local dance and music festivals.

Dr Andrew Crellin, Director of Emergency, Ballarat Health Services, Public Hearing, Ballarat, 18 November 2013. See also comments of Ballarat local paramedic Mr Grant Hocking, Mr Grant Hocking, Clinical Support Manager, Grampians Region, Ambulance Victoria, Public Hearing, Ballarat, 18 November 2013.

673 Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013.

674 Detective Senior Sergeant Chris Pegg, Divisional Crime Adviser, Division 6, Eastern Region, Victoria Police, Public Hearing, Traralgon, 28 January 2014.

675 Superintendent Andrew Allen, Divisional Commander, Ballarat Division, Western Region, Victoria Police, Public Hearing, Ballarat, 18 November 2013.

676 See in particular the work of Measham et al. 1994 and Measham Aldridge & Parker 2001. For a discussion of the 'normalisation' of amphetamine use by young people in the early to mid-2000s, see Drugs and Crime Prevention Committee, *Inquiry into the Amphetamine and Party Drug Use* 2004.

In Australia too, researchers such as Duff have argued that amphetamine type stimulants (ATS) use has moved away from the locus of marginalised and deviant subcultures to become if not normal then at least regarded as commonplace and unremarkable (Duff 2003; Dwyer et al. 2012, p.59).⁶⁷⁷ Such use is portrayed by the users themselves as strategic and socially responsible. And indeed for such rational and logical users there is some evidence that suggests 'they engage in risk management strategies to allow them to engage in their activities'.⁶⁷⁸ The fact that such use may be illegal does not for such recreational users seem to act as a deterrent as much as it may have once.⁶⁷⁹

As observed earlier in this chapter the smokeable form of methamphetamine is particularly popular in youth culture due to the group nature of the activity; this pattern of use has in turn further 'normalised' methamphetamine use amongst young people (Groves & Marmo 2009, p.420). Certainly evidence has been given to the Committee that suggests some users may be able to use (smoke) it on a weekly or even daily basis for years, with few adverse consequences.⁶⁸⁰ Law enforcement and health agencies are nonetheless concerned about the potential for methamphetamine use to be subsequently 'embedded within the community through its normalised distribution in nightclubs and at dance parties popular amongst young people' (Groves & Marmo 2009, p.417).⁶⁸¹ Mr Dave Rice, an ambulance officer from Gippsland made the observation with regard to young users of methamphetamine:

It is just accepted that people use it. Even people that are fairly health-conscious and fit will still have their weekend bender as such and use some of these drugs... The perception of the drug itself has changed, so it has become a drug that is acceptable to use in certain groups, where it would not have been five or 10 years ago. These are people who, if you had asked, I reckon, in my generation or the generation of the last couple of years, 'Would you use speed or methamphetamine?' would have answered a definite 'No', but now it seems to have become almost acceptable as a drug of choice, which I think is fairly horrifying.⁶⁸²

The perceived normality of methamphetamine use may mask harmful consequences

If young people believe that methamphetamine use can be normal or everyone does it, it can be difficult for service providers and educators to address the harms associated with the drug, let alone engage young people in treatment when their drug use has become problematic (Bruun et al. 2012). The perceived normality of ATS use may also result in some young people overstating the amount of drug being used by their peers, thus encouraging experimentation (Department of Human Services (DHS) 2007). Some users may either not acknowledge their use is causing them trouble or underestimate the seriousness of it.⁶⁸³ As Groves and Marmo state:

The consumer may not have comprehensive knowledge of the product being provided or indeed may assume that it is *normal* or necessary to consume it in order to feel part of the [dance party] atmosphere (2009, p.419). (Authors' emphasis)

677 Numerous witnesses to the Inquiry commented on how methamphetamine use amongst young people is viewed as 'normal' and socially acceptable particularly when shared in a group setting with friends. See for example: Superintendent Malcolm (Jock) Menzel, Divisional Commander, Eastern Region Division 5 — Morwell, Victoria Police, Public Hearing, Traralgon, 28 January 2014.

678 See Dr Andrew Groves, Research Officer, Flinders Law School, Flinders University, Public Hearing (via video conference), Canberra, 11 February 2014.

679 Superintendent Paul Pottage, Division Commander, Division 1 (Geelong) Western Region, Victoria Police, Public Hearing, Geelong, 28 October 2013.

680 Mr Mark Allen, Team Manager, Morwell Mobile Intensive Care Ambulance (MICA) Unit and Single Response Unit (SRU), Ambulance Victoria, Public Hearing, Traralgon, 28 January 2014.

Mr Stuart Fenton, Drug and Alcohol Counsellor, Public Hearing, Ballarat, 18 November 2013.

681 One Aboriginal health worker told the Committee that this concept of normalisation applies to peers in the Aboriginal communities as well. See Ms Kit-e Kline, Drug and Alcohol Worker, Wathaurong Aboriginal Co-Operative, Public Hearing, Geelong, 28 October 2013 and discussion in Chapter 12.

682 Mr Dave Rice, Manager, Sale Advanced Life Support Unit and Bairnsdale and Sale Single Responder MICA Units, Ambulance Victoria, Public Hearing, Traralgon, 28 January 2014.

683 Mr Geoff Munro, National Policy Manager, Australian Drug Foundation, Public Hearing, Melbourne, 14 October 2013.

Some users may not necessarily appreciate the connection between the use of crystal methamphetamine and the negative effects they may be experiencing 'because of the rewards ice is giving them'.⁶⁸⁴ As one JSS client stated: 'The moment of thinking ice is bad never lasts long. As soon as you use again, you wonder why you ever thought that'.⁶⁸⁵ Christine May of YSAS also told the Committee that:

When young people first come to our service and identify that their ice use may be a little bit out of control, and then we ask them what they do not like about the substance, they say, 'Nothing'. They cannot identify one thing they do not like about it.⁶⁸⁶

Others may be vaguely aware of possible harms 'but perceive the benefits to outweigh the harms' (DHS 2007, p.7).⁶⁸⁷ This may be true of recreational users of the drug generally, particularly those who see themselves as coming from a stable middle-class milieu (Dwyer et al. 2012). As Dr David Eddey, Director of Emergency Medicine at Geelong Hospital, told the Committee in the context of younger recreational users:

A lot of my patients identify — there are people who smoke ice and they often identify in a very different group. If you ask them if they are injecting they will say, 'I'm not a junkie', but they are smoking large quantities of ice. They see themselves as weekend recreational users, they use it for a reason, and they might identify with why they started and not that they have ended up highly drug dependent and that has had such a huge influence on their life.⁶⁸⁸

Several AOD workers have told the Committee that some young people, whilst not having medical issues, particularly dependency, associated with recreational use, may nonetheless find themselves in trouble with the police. In some respects this can be beneficial from an education, harm reduction and early intervention perspective as it gives AOD workers a chance to address a person's (recreational) use before it becomes too prolonged or problematic:

Recreational users would not normally be part of the treatment population, except that they are being caught early and sent through a diversionary process, which is wonderful because we get an opportunity for early intervention and to be working with people for whom the substance is not necessarily problematic at this point in time. They are using it as a lifestyle drug. They are going to parties and festivals in the city and are using that substance to try and enhance their experience. They experience getting caught by the police and then being diverted to us to have some support and some information and some intervention.⁶⁸⁹

Problematic methamphetamine use

Not all young people may use methamphetamine recreationally or as part of a middle-class party scene where such use is seen as fun. Findings from the Victoria Adolescent Health Cohort Study (Degenhardt et al. 2007) found that 7 percent of the cohort (1943 adolescents recruited from Victorian secondary schools at age 14-15 years and followed up over a 10-year period to the age of 24-25)⁶⁹⁰ used amphetamines by the age of 17. The incidence of such amphetamine use was associated with later heavier drug use, limitations in educational attainment, mental health problems, dependence and psychosocial problems in young adulthood suggesting the earlier the onset of use the more problems associated with such

684 Ms Kerry Donaldson, Manager, Community Programs, Youth Support and Advocacy Service, Bendigo, Public Hearing, Bendigo, 25 October 2013.

685 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014.

686 Ms Christine May, Manager Latrobe Valley, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

687 Thus necessitating the provision of factual but non-judgemental information and education programs on methamphetamine for young people. See discussion in Chapter 23.

688 Dr David Eddey, Director of Emergency Medicine, Barwon Health, Public Hearing, Geelong, 28 October 2013.

689 Mr Eion May, Alcohol and Drug Worker, Gippsland Lakes Community Health Centre, Public Hearing, Traralgon, 28 January 2014.

690 A 78 percent retention of the sample at that age.

use. Younger initiation of use into methamphetamine seems to be associated with young people who are not recreational users. In Ballarat for example, a relatively high number of 14 to 16 year olds have been observed using the drug, many of whom come from fairly traumatic and disadvantaged backgrounds compared to older, middle-class young people who may use it more for recreational purposes associated with the party scene.⁶⁹¹

The youth support agency YSAS addresses the needs of young people whose drug use is clearly problematic. Basing their findings on data from the Victorian census of youth AOD services, YSAS also noted that young people they engage with who are methamphetamine users are more likely to be unemployed or have difficulties in obtaining employment, less likely to be involved in education or training and/or suspended from school. Those young people who used ice also had a significantly higher degree of family conflict and family breakdown or disconnection. Methamphetamine users were also likely to have poorer physical and mental health and poorer quality of life compared to those young people who did not use illicit drugs or used drugs other than methamphetamine.⁶⁹²

In its submission to this Inquiry YSAS noted extremely high levels of criminal offending and criminal justice involvement for young people with problematic use of methamphetamine:

Methamphetamine clients are more likely than other young people using youth AOD treatment services to:

- Have a current problem with criminal offending (49% v. 38%).
- Have been involved in criminal activity in the last 4 weeks (26% v. 16%).
- Be a Community Offenders Assessment and Treatment Service (COATS) client (41% v.32%).

When current involvement in the Criminal Justice System (CJS) and current criminal activity were combined, methamphetamine clients were more likely to be involved in CJS or crime (54% v. 44%).⁶⁹³

On this issue a submission from the Commission for Children and Young People noted:

The *Youth Parole Board and Youth Residential Board Victoria Annual Report 2012-13* notes that ‘a large percentage of young people whose parole orders were cancelled had serious substance abuse problems’ (p.7). In addition the report includes a snapshot survey of young offenders in custody which found that 88% were drug users; 89% of cases had alcohol or drug use related to their offending and that nearly half were current or former child protection clients (p.13). While the prevalence of ice use is not specifically described in this report, anecdotal evidence provided to the Commission suggests that ice would be a significant factor in the offending histories of many young people in custody.⁶⁹⁴

Methamphetamine as a functional drug — easing the pain

Much evidence has been given to the Inquiry from a variety of witnesses that methamphetamine use can also serve a functional or instrumental purpose for young people who are disturbed, vulnerable or otherwise living in disadvantaged circumstances. For example, a submission from the Northern Mallee Community Partnership stated:

691 See for example Mr Paul Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013; Associate Professor Peter Miller, Principal Research Fellow, School of Psychology, Deakin University, Public Hearing, Ballarat, 18 November 2013.

Youth Projects have also noted being ‘alarmed’ by an upsurge in methamphetamine abuse by a much younger cohort of adolescents in their catchment area (the northern suburbs of Melbourne). ‘We have found that patterns of drug use and injecting drug use tended to be in an older age bracket but were very alarmed by the reports of much younger people starting on harder drugs’. Ms Melanie Raymond, Chairperson, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

692 Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS, Submission, 21 October 2013. See also discussion in Chapter 6.

693 Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS, Submission, 21 October 2013. See also discussion in Chapter 8.

694 Mr Bernie Geary OAM, Principal Commissioner, and Mr Andrew Jackomos PSM, Commissioner for Aboriginal Children and Young People, Commission for Children and Young People, Submission, 25 October 2013.

Young people may predominately use methamphetamine for the purpose of an upper and downer cyclic affect in relation to specific psychological situation e.g. peer pressure, academic achievements, family discord, relationship breakdown and so forth.⁶⁹⁵

According to youth worker Mr Peter Wearne, for some disturbed young people methamphetamine 'provides the illusion of optimism and hope'.⁶⁹⁶ For such young people the euphoric aspects of methamphetamine use may be experienced in much the same ways as people for whom such use is merely recreational but for different reasons:

They [troubled adolescents] report that they love it. They love the euphoric feeling they get from it. If you have someone who has been a victim of sexual abuse, trauma or just having a really crappy life, if they get a drug that makes them feel really good continually, it is hard to challenge that.⁶⁹⁷

Similarly, Mr Peter Treloar, a nurse with the Ballarat Aboriginal Cooperative told the Committee:

One person said to me when I asked her, 'Why do you use it?' 'Well, my life's been so terrible through broken family, broken relationships, domestic violence, that it's the only thing that makes me feel good about myself.' That is the sad part about the drug. For people who have a poor, miserable existence it is the only thing that makes them feel good about life in general. I guess that is the most attractive part of that drug. It actually makes a person who has had a really difficult life feel good for a change. That is what we are up against. How do you tell somebody, 'No, we don't want you to feel good'? That is very difficult.⁶⁹⁸

Other young people may use methamphetamine to self-medicate conditions ranging from depression, bipolar disorders, schizophrenia or ADHD.⁶⁹⁹ For young women in particular, recovery from sexual assault, trauma and domestic violence may also feature in why certain young people turn to methamphetamine to alleviate their pain. As one AOD worker told the Committee:

A number of years ago I did a study on the reasons why young women started using drugs. We looked at a study over 12 months in our withdrawal unit. The reason they identified for their drug use: 85 percent of the young women said they were victims of sexual assault and that is why they started using drugs. It was not because of peer relationships, it was not because of accessibility. They used drugs because they were victims of sexual assault.⁷⁰⁰

Ms Trish Quibell from Berry Street in Shepparton made similar observations with regard to young women who use methamphetamine, particularly those in residential care:

I think one of the things that I would say is that clients from a sexual assault background are often highly susceptible and vulnerable to drug usage, again because of that almost backward-running tape recorder in their heads that says they are not worthy of anything, and they will take any means to numb that emotional pain. Drug usage is the most effective way to do that on a short-term basis.⁷⁰¹

Risk factors — Protective factors

As discussed in Chapter 22, a range of factors can influence why a young person may engage in problematic drug use (risk factors) just as a number of factors may act to impede young people from the uptake of drug use (protective factors). Risk factors have been defined as 'prospective

695 Mr Rob McGlashan, Executive Officer, Northern Mallee Primary Care Partnership, Submission, 21 October 2013.

696 Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

697 Mr Paul Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013.

698 Mr Peter Treloar, Emotional Wellbeing Nurse, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013.

699 See discussion below on 'therapeutic' use of methamphetamine.

700 Mr Paul Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013.

701 Ms Tricia Quibell, Deputy Director, Hume region, Berry Street, Public Hearing, Shepparton, 25 February 2014.

predictors that increase the likelihood that an individual or group will engage in adverse outcomes' (Hawkins, Catalano & Miller in Hemphill, Toumbourou & Catalano 2005, p.11).

The converse concept is that of protective factors which 'both directly decrease the likelihood of antisocial behaviour and mediate or moderate the influence of risk factors' (Hemphill, Toumbourou & Catalano 2005, p.11). A summary of commonly recognised risk and protective factors for youth substance abuse and antisocial behaviour is presented in Table 13.2.

A related concept, which has received much prominence in child psychology and developmental studies in recent years, is that of resilience. In other words, resilience may explain why some young people, including those coming from relatively disadvantaged or troubled backgrounds, may abstain from antisocial behaviours (including substance abuse) or criminal offending. Resilience can be viewed as a key protective factor.⁷⁰²

Table 13.2: Risk and protective factors associated with youth substance abuse and antisocial behaviour

Levels	Risk factors	Protective factors
Community	Poverty Transitions in schooling and into the community Low neighbourhood attachment and community disorganisation Availability of drugs	Cultures of cooperation Stability and connectedness Good relationships with an adult outside the family Opportunities for meaningful contribution
School	Poor relationships in school Academic failure, especially in middle years Early and persistent antisocial behaviour and bullying Low parental interest in children	A sense of belonging and fitting in Positive achievements and evaluations in school Having someone outside your family that believes in you Attendance at preschool
Family	History of problematic alcohol and drug use Inappropriate family management Family conflict Alcohol/drugs interfering with family rituals Harsh/coercive or inconsistent parenting Marital instability or conflict Favourable parental attitudes towards risk taking behaviour	A sense of connectedness to family Feeling loved and respected Proactive problem solving and minimal conflict during infancy Maintenance of family rituals Warm relationship with at least one parent Absence of divorce during adolescence A 'good fit' between parents and a child
Individual/ Peer	Constitutional factors, alienation, rebelliousness, hyperactivity, aggression, novelty seeking Seeing peers taking drugs Friends engaging in problem behaviour Favourable attitude toward problem behaviour Early initiation of the problem behaviour.	Temperament/activity level, social responsivity, autonomy Development of special talents/hobbies and zest for life Work success during adolescence High intelligence (not paired with sensitive temperament)

Source: Department of Human Services (Vic) 2000, in Alcohol and other Drugs Council of Australia (ADCA) 2003, p.4.⁷⁰³

702 For a general discussion of the concept of resilience in children and its relationship to other protective factors, see Howard and Johnson 2000.

703 For a more detailed table of such risk and protective factors, see Stephenson, Giller and Brown 2007, pp.10–11.

No single risk factor can be predictive of problematic drug use, and risk and protective factors can often mediate each other, for example a background of family breakdown or conflict may be balanced by a young person's successful engagement with school (Commonwealth of Australia 2006).⁷⁰⁴

Mr Francis Broeckman, CEO with Brophy Family and Youth Services in Warrnambool, emphasised to the Committee the importance of risk and protective factors in understanding why some young people (and not others) may use methamphetamine and/or other drugs:

The protective factors tend to be around three areas: one being family and how strong that relationship is, the strength of the relationship with your schools and key personnel, and then your connection/relationship with the community, that is Brophy [Youth Services]. The stronger that those three are in tandem then the more likely it is that you will be able to address some of the risk factors. What we try and do from a community perspective is link them up to key people to support them to build those protective factors and to support them through that process. That is mainly our job.⁷⁰⁵

Sometime a person may be able to use methamphetamine in a relatively 'functional' way as long as other aspects of their life are relatively harmonious, or to put it another way, when the protective factors outweigh the risk factors. Mr Peter Wearne from YSAS uses the example of former AFL footballer Ben Cousins to illustrate this point:

I will refer to the most famous methamphetamine user in Australia, Ben Cousins. Ben Cousins took methamphetamine regularly. He played in a premiership team taking methamphetamine regularly. He never took it on match day. He took it recreationally and socially. While he had a training regime and a testing regime that meant that he had to be very cautious about the drug use, he was never detected and it seemed to have no effect on him. But once he stopped playing football, you see the pictures of him, seemingly deranged — or off season, getting out of that car along the highway and running through a swamp to get away from the police at a drug testing and alcohol breathalysing station. The stories are legend about what Ben was like in the nightclub scene anecdotally.

What you see there is a trajectory, 'While it's under control I'll use the drug and I seem to have all these other things that help me control it', but the moment those things fell away that afforded some protection and he started using the drug habitually, then you saw the Ben Cousins that we were used to seeing the police arrest and chase down.⁷⁰⁶

Young people in out-of-home or residential care

One particularly vulnerable group for whom methamphetamine is especially problematic is young people living in out-of-home (residential) care. Methamphetamine use may be more about survival than enjoyment and consequently not viewed by these youth as problematic or risky:

These young people often present with a history of childhood trauma that involves physical, emotional and/or sexual abuse and neglect. They are often marginalised within the school system and there may be increasing conflict with peers and school staff. They usually present with (or are at risk of) a multitude of problems.

In this more complex population, it not just a young person with an alcohol or drug-related problem, but someone who is in pain in all facets of life. It is not uncommon for this group of young people

704 The concept of risk and protective factors has not been uniformly accepted in the context of young people's substance abuse (and antisocial or criminal behaviour) without reservation. A detailed critique of the concept is beyond the scope of this Report. However, the interested reader is referred to the Drugs and Crime Prevention Committee, *Inquiry into Strategies to Prevent High Volume Offending by Young People* and the numerous references therein (July 2009).

705 Mr Francis Broeckman, Chief Executive Officer, Brophy Family and Youth Services, Public Hearing, Warrnambool, 3 March 2014.

706 Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

to view their alcohol and other drug use (and other lifestyle-related problems) as being necessary for survival, as opposed to being risky and problematic (Commonwealth of Australia 2006, p.69).

Certainly for people working with children and young people in the out-of-home care sector, the increasing use of methamphetamine is problematic. A submission from Anglicare outlines the impacts it is having on adolescents within residential care:

Of particular concern is the fact that some young people will exchange sexual contact with adults who can supply them ice for provision of the drug. Alternatively, or in addition to this, a young person may become involved in the supply chain of the drug. Either way, the young person becomes victim and is taken advantage of by manipulative adults who use the young person's drug dependence to further compromise their best interests. This is a particular risk for young people in the out-of-home care system.⁷⁰⁷

Similarly, a submission from the Commission for Children and Young People has noted with concern the ways in which young people in out-of-home care may be preyed upon by older adults providing alcohol and illicit drugs, including crystal methamphetamine, for purposes of sexual exploitation.⁷⁰⁸

Anglicare is also concerned that the options for vulnerable young people who leave the residential care system are few and could lead to either the initiation or continuation/increased use of methamphetamine:

Young people who are exiting the care system into increasingly insecure housing arrangements are particularly vulnerable. They now frequently move from residential care into accommodation provided by adult homelessness services, such as hostels and rooming houses. This brings them into contact with hardened substance-using individuals with complex forensic and mental health pathologies.⁷⁰⁹

Young people in out-of-home care settings in rural communities are also at risk. Junction Support Services in Wodonga work with many children who are or have been in the residential care sector. For example, they note that 39 percent of young people supported by their Intensive Case Management Services have allegedly used crystal methamphetamine. According to JSS such adolescents are:

- Vulnerable
- Protective of self/difficult to develop trust
- Poly-drug users
- Risk taking behaviours
- Limited attachments to adults, friends and family
- Socially isolated
- Trauma related behaviours
- Physically violent to property and people
- Less receptive to support and advice
- Hostile and overly suspicious/paranoid
- Do not respond to interventions such as therapy.⁷¹⁰

Ms Dianne Barker from St Luke's Anglicare in Bendigo also told the Committee about how traumatic life for children in residential care can be, for those who use methamphetamine and other drugs and those who don't:

707 Ms Jacqui Watt, Director Client Services, Anglicare Victoria, Submission, 21 October 2013.

708 Mr Bernie Geary OAM, Principal Commissioner, and Mr Andrew Jackomos PSM, Commissioner for Aboriginal Children and Young People, Commission for Children and Young People, Submission, 25 October 2013.

709 Ms Jacqui Watt, Director Client Services, Anglicare Victoria, Submission, 21 October 2013.

710 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014.

All of these young people have experienced severe and complex childhood traumas. The young people have been exposed to multiple traumatic events, including multiple abuses, neglect, family breakdown, developmental delays and poor mental health. They are low functioning in the main and not engaged in education. A number self-harm and have been in the out-of-home care system for a long time. All of these young people display high-risk and challenging behaviours, and some of the families of these young people have a culture of drug taking, including ice. They are socially marginalised within our community and often isolated from their families, therefore are vulnerable to older sexual predators and drug dealers.

[t]hose ones [in residential care] who are using ice are presenting very unwell physically and emotionally. They are unpredictable in their behaviours and have become violent towards other young people and staff. Bullying is a regular behaviour displayed by these young people, which has created a very unsafe environment for the others.

Victims of ice are standing over others, threatening their lives physically and verbally abusing, stealing or simply taking others' belongings and selling them to purchase ice. One of our young victims has been intimidating another resident so badly that that resident is too frightened to return to the unit, leaving him — we would call — homeless on the street at the age of 14.⁷¹¹

The fact that methamphetamine use (and dealing) can take place openly in residential care units is also a cause of grave concern to youth and support workers.⁷¹² The problem of cross-contamination when one person who uses drugs is placed in close proximity to young people in a small residential unit who may not use drugs or at least not methamphetamine is also of concern to residential youth workers.⁷¹³

Ms Marg Bell made similar comments to the Committee about young people in Berry Street's out-of-home care placements in Shepparton:

They are the most complex young people. They are young people who have generally been through foster care or kinship placements that have broken down because their degree of trauma is so significant that they cannot form attachments or appropriate attachments. They are disengaged from primary and secondary services, so they struggle to even stay home at night or to even go to sleep. We have had some young people who find it fantastic — and they will tell you it is much easier — to use a drug like ice or other drugs because you do not have to think and you cannot feel. It is much easier to have that than to feel the burn.⁷¹⁴

711 Ms Dianne Barker, Acting Senior Manager, ICMS and Residential Care, St Luke's Anglicare, Bendigo, Public Hearing, Bendigo, 25 October 2013.

Similar observations were made by out-of-home care workers and managers in other parts of the state. See for example: Ms Melinda Grady, Youth Worker, Barwon Youth, Public Hearing, Geelong, 28 October 2013; Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Public Hearing, Shepparton, 25 February 2014; Ms Tricia Quibell, Deputy Director, Hume region, Berry Street, Public Hearing, Shepparton, 25 February 2014.

712 See for example comments of Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Public Hearing, Shepparton, 25 February 2014.

713 Ms Marg Bell, Senior Manager, Adolescent Specialist Support Programs, Shepparton, Berry Street, Public Hearing, Shepparton, 25 February 2014. See also comments of Mr David Giles, General Manager, Family and Community Services, Anglicare Victoria, Public Hearing, Melbourne, 3 February 2014.

714 Ms Marg Bell, Senior Manager, Adolescent Specialist Support Programs, Shepparton, Berry Street, Public Hearing, Shepparton, 25 February 2014.

Conclusion

The prevalence, patterns and culture of methamphetamine use by young people and the reasons why they may use are many and varied. As with adults, the reasons young people use may be related to instrumental reasons such as energy to study; affective reasons — to assuage the pain of violence and trauma; or simply because it is fun. Despite many witnesses to the Inquiry giving their accounts as to the patterns of drug use by young people and the causes of such use, academics such as Dr Andrew Groves gave evidence to the Inquiry that much more (qualitative) research is required in this area:

There is not enough understanding or knowledge of how and why these particular drugs — say ice in this instance — are being used by this particular group of young people... So the question is, 'Who are these young people? Why are they using it, and how are they using it?'⁷¹⁵

Moreover, in intervening with young people, clinicians, researchers, youth workers, drug counsellors and other relevant people need to explore what methamphetamine use means for the young person and particularly what is attractive about such use (Bruun et al. 2012). Such workers also must ensure that they place their understanding of (and interventions for) young people's methamphetamine use within the context of their 'physical, cognitive and emotional development' (Lee et al. 2007, p.56).

Recommendation 36

The Committee recommends that Victoria Police establish a formal mechanism to further develop working relationships with the clubs and entertainment industry including peak bodies such as the Nightclubs Owners Association.

Recommendation 37

The Committee acknowledges the impact on and risks to children when their parents use methamphetamine, particularly crystal methamphetamine. The Committee recommends that the Victorian Government investigate measures to address the continuing need to enhance and support the capacity of adult-focused drug and alcohol services to have a more child inclusive approach. **The Committee further recommends** support for child protection services to better assess risks and provide support to children in these situations.

⁷¹⁵ Dr Andrew Groves, Research Officer, Flinders Law School, Flinders University, Public Hearing (via video conference), Canberra, 11 February 2014.

14. Methamphetamine Use in Specific Populations

Introduction

In addition to the problems associated with ice use amongst young people, and in Aboriginal and rural and regional communities, there are other specific population groups in which the use of the drug is becoming increasingly common and problematic. This chapter examines the methamphetamine use of these other discrete groups in Victoria. The groups profiled include transport drivers who rely on 'meth' and/or prescription drugs to maintain punishing delivery schedules (situational drug use), and women (or men) who take methamphetamine to 'self-medicate' their physical or mental health conditions. Often there may be overlap between those groups. For example, a long-distance transport driver may use methamphetamine in order to stay awake to meet deadlines but may also use them, or indeed other drugs, for recreational purposes.

Other groups where methamphetamine use may be prevalent include the gay and lesbian community, prisoners, and the homeless and disadvantaged.⁷¹⁶ There are also examples of people for whom methamphetamine is used as a 'therapeutic agent'; for example, people with Attention Deficit Hyperactivity Disorder (ADHD). Each of these groups may use methamphetamine in different ways — the patterns of use and the culture that sustains it may vary significantly.⁷¹⁷

Similarly, there may be a range of reasons why these disparate groups use methamphetamine. These reasons are also discussed throughout this chapter.

General profiles of methamphetamine users

Methamphetamine users represent a diverse cross-section of society, 'from young children to old age pensioners, and dance party patrons to university lecturers' (Carson et al. 2012, p.38). Many of the witnesses to the Inquiry supported the views expressed in the academic literature, that methamphetamine users 'are from all walks of life'.⁷¹⁸ The comments of Mr Peter Treloar, a nurse within Ballarat's Aboriginal community are representative in not being able to pigeonhole a 'typical' user. As he told the Committee: 'I cannot specifically say, "Yes, it's 15-year-old boys", or, "Yes, it's 30-year-old women". It is crossing all age barriers and all socioeconomic areas as well'.⁷¹⁹

Similarly Dr Rebecca McKetin told the Committee:

The exposure to this drug in the general population is sufficiently broad that it is very hard to typecast people. Like any drug, it is more prevalent in your 'down and out' population, if you want to describe them like that, so with homeless people or people in low socioeconomic brackets. It is overrepresented in the gay and lesbian population as well. However, it is not restricted to those populations. It is

716 Given that young people, Aboriginals and people in rural and regional Victoria are populations specifically listed in the Terms of Reference, they are discussed separately in Chapters 11–13.

717 In understanding patterns of use it is also important to refer to the statistical data currently available detailing demographic characteristics of users. See discussion in Chapter 9.

718 See Ms Carol-Anne Lever, Nurse Unit Manager, Emergency Department, Bendigo Health, Public Hearing, Bendigo, 25 October 2013.

719 Mr Peter Treloar, Emotional Wellbeing Nurse, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013.

common to find your average working class person involved with use, a housewife who is at home with children involved with use, methadone clients involved with use and people in suits, such as dentists, doctors. — There are tradies as well.⁷²⁰

Mr John Ryan from Anex also emphasised the diversity of methamphetamine user profiles when he addressed the Committee:

The curious thing about the diversity of methamphetamine use is one of our great challenges, which is to say that it is from people who are very young — early initiates are in the low teen years — to people in their 60s. There are some communities that are particularly affected... the Aboriginal community has been, I think, very significantly affected. The gay community is very significantly affected. Some of the range includes people who are in post-high school study — so, TAFE colleges and universities — being affected and also people who have never really been involved in illicit drug use previously. So whilst we still have the dynamic of that cohort of people who are heroin users et cetera using ice, we now have lots of people who are novices to illicit drug use who are picking up ice use, with very little capacity to actually manage that. So my sense is that the demographic for ice is extremely broad, both across the age range and across different ethnicities.⁷²¹

Mr Zach Mason, youth worker with Junction Support Services (JSS) in Wodonga, also commented that the diversity of the client groups being seen by his agency was surprising:

From our experience...the demographics of those who use the drug ice can be just about anyone. We have always dealt with the normal drug user, the low socioeconomic background, unemployed, poor education etcetera, but we are now seeing an influx of middle-class blue collar clients who have lost everything from their ice addiction. The youngest age of a client that we have had reported to us about use and addiction is 13 years old, and in the past 12 months 38 percent of the parents within the Supporting Young Parents Program at Junction Support Services have reported to have tried ice....⁷²²

Finally, drug treatment agency UnitingCare ReGen said they see two distinct profiles of user coming to them for assistance. First are young ‘party users’ of methamphetamine who may have been sent to the agency through a diversion program as a result of criminal offending related to their drug use.⁷²³ Such clients may be assessed and counselled but do not necessarily see that they have a ‘problem’. The other group are hard core users of methamphetamine, often injecting users with multiple and complex problems associated with their drug use. It is much harder to tailor treatment intervention strategies for this group.⁷²⁴

Functional use of methamphetamine

There are as many and varied reasons as to why methamphetamine is used as there are diverse profiles of those who take it.⁷²⁵ A key reason for use is that it serves a specific function

720 Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

Earlier research by McKetin and her colleagues on methamphetamine users in Sydney found that there were three general ‘types’ of methamphetamine user amongst their respondents each with different patterns and ‘cultures’ of use. These were:

‘(1) Primary methamphetamine injectors who took methamphetamine once to several times per week and had high levels of cannabis and alcohol use and sporadic use of other drugs (2) long standing injecting heroin users for whom methamphetamine injection was a pattern of polydrug use and (3) younger non-injecting drug users who took ecstasy and would also snort or swallow powder methamphetamine or smoke ice’ (2006, p,xvi).

721 Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

For further evidence on this ‘multiplicity’ of users’ profiles with regard to methamphetamine use, see also evidence of Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol and Drug Association, Public Hearing, Melbourne, 14 October 2013.

722 Mr Zach Mason, Youth Worker, Junction Support Services, Public Hearing, Wodonga, 24 February 2014.

723 What drug agency VAADA call ‘naïve’ drug users. Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol and Drug Association, Public Hearing, Melbourne, 14 October 2013.

724 See Ms Donna Ribton-Turner, Director, Clinical Services, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013.

725 For a succinct general account of why different profiles of people may use methamphetamine, see von Mayrhauser, Brecht and Anglin 2002.

or purpose. Functional use overlaps significantly with and is often interchangeable with the terms situational or circumstantial use. As stated in a United States landmark report on drug abuse, this pattern of drug use is defined as a task-specific, self-limited use which 'is variably patterned, differing in frequency, intensity and duration'.⁷²⁶ It is motivated by a perceived need or desire to achieve a known and anticipated drug effect deemed desirable to cope with a specific condition or situation. A common example may be the use of methamphetamine by students to stay awake and/or enhance study performance. Situational drug use is most often episodic in pattern, when circumstances require it.

Methamphetamine have long been associated with this 'functional' use of guaranteeing longer and more sustained work performance. Klee argues that in this regard amphetamines are the perfect drug for the capitalist economy:

The [meth]amphetamines are ideally suited to the age of economic expansion in a non interventionist capitalist environment as the work load increases and workers need to keep up to stay up in business. Low cost, sustained action and a reputation as harmless, make these drugs acceptable for working people... the value of amphetamine in facilitating performance in certain jobs, for example shift work, long distance driving and construction work, has become fairly commonplace (Klee 2001a, p.27).

Dr Roger Volk, a forensic drugs counsellor with the South East Alcohol and other Drug Service (SEADS) spoke to the Committee about the importance of understanding 'functional' aspects of methamphetamine use:

[a] lot of our consumers talk about the functional uses of ice... Tradies who come to us having not been convicted but on cautioning notices from the police will talk about using ice at the weekend to complete a job. It makes people tremendously focused and energetic. I have got a father [who attends the service] who cleans his house before DHS visits on a bit of ice because it gets the whole thing done in about 2 hours... In short, there is [an aspect to methamphetamine use] that is functional, for want of a better word, rather than simply disruptive and dramatic.⁷²⁷

Methamphetamine use in the workplace and industry

The functional nature of methamphetamine use can be seen in various workplace environments. The World Health Organization conducted a collaborative study on instrumental methamphetamine use among drivers, factory workers, sex workers and students in China, Nigeria, the Philippines and Thailand. Certainly it would seem countries with the highest poverty rates and lowest per capita incomes have high levels of instrumental/functional drug use among their workers (see Marsden et al. 2000).

Wermuth argues, however, that while workers in developing countries may be particularly dependent on methamphetamine to sustain energy levels for long hours of work,⁷²⁸ such instrumental use is also apparent in developed countries such as the United States:

Adult pressures are often centered around working long hours while also carrying out family responsibilities. Dual earner marriages are often essential in maintaining middle-class incomes and life styles, and a broad array of individuals feel they need more time and energy to meet life's demands. The economic and time pinches are most intensely felt by single working parents, composed mostly of lower paid women, and by the working poor generally, a growing proportion of the U.S. labour force. Given this social landscape, the appeal of a drug that boosts energy is not surprising. In parallel fashion, perhaps because of Japanese achievement pressures and 'workaholism', a methamphetamine epidemic took hold there earlier than in the United States, resulting in some of the few studies of long term effects (Wermuth 2000, p.431).

726 https://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1985-01-01_2_page003.html

United States Commission on Marijuana and Drug Abuse, 1973.

727 Dr Roger Volk, Forensic and Other Drugs Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

728 This would particularly be the case in countries where there is no minimal guarantees of working hours or conditions in favour of the worker or worker protection legislation.

Such views have been borne out in Australia. A 2006 study by the National Centre for Education and Training on Addiction (NCETA) estimated that 9.3 percent of Australian hospitality workers, 5.2 percent of construction workers and 5.4 percent of transport workers had used methamphetamine in the previous 12 months largely to inhibit fatigue and sustain work performance (NCETA 2006). Despite the stated reasons for such use being increased productivity, methamphetamine is conversely associated with poor work performance, absenteeism and the risk of workplace accidents (Nicholas 2006; Victorian Government Department of Human Services 2007).⁷²⁹

The use of methamphetamine has also been thought of as being quite high within the fishing industries of Western Australia and Queensland, the mining industry in Western Australia,⁷³⁰ the construction and food processing⁷³¹ industries in Victoria and the hospitality sector across the country, including sex workers (Berry et al. 2007; Lee et al. 2007; Roche et al. 2008; Pennay & Lee 2008; Du Plessis & Corney 2011).⁷³² According to some witnesses, methamphetamine may possibly have been used amongst workers during the construction of the desalination plant in Gippsland.⁷³³

Factors such as long working hours, tight schedules, and particularly in the case of the hospitality industry, ready access to alcohol and other drugs have been attributed as reasons why this may be the case. Witnesses presenting to the Committee have spoken of the use of methamphetamine to get through tight deadlines, long hours including double and triple shifts, and just to 'get through their working day'.⁷³⁴

Methamphetamine use in the workplace can be disruptive and damaging for employers as well as employees, as a submission from Anex stated:

Methamphetamine use is associated with a number of industries and workplaces, including hospitality and transport ... Currently, methamphetamine and other drug use may result in lateness and absenteeism, lost time and reduced production and work quality as a result of incidents and injuries. There may also be losses associated with inefficiency and damage to plant, equipment and other property.⁷³⁵

Methamphetamine use amongst apprentices and 'tradies'

Methamphetamine and/or other drug use has been identified as being relatively high amongst young 'tradies' and apprentices. For example, a Victorian study that surveyed 172 male construction industry apprentices found that 12 percent of the sample had

729 See Chapter 7 for a discussion of the economic consequences of methamphetamine use, including absenteeism and a loss of productivity.

730 Although the mining industry has some of the most comprehensive and stringent drug and alcohol testing regimes, particularly in W.A, methamphetamine use within that community is still relatively high. One reason for this may be the short time in which the drug stays in the body. See Collins 2014; Heber 2013.

731 In the book *Fast Food Nation*, author Eric Schlosser discusses the increasing 'occupational' use of methamphetamine in various sectors of American industry. This is most graphically described in an examination of the meatpacking and abattoir industries:

'The unrelenting pressure of trying to keep up with the [processing] line has encouraged widespread methamphetamine use among meatpackers. Workers taking "crank" feel charged and self-confident, ready for anything. Supervisors have been known to sell crank to their workers or to supply it free in return for certain favours such as working a second shift. Workers who use methamphetamine may feel energised and invincible, but are actually putting themselves at much greater risk of having an accident. For obvious reasons a modern slaughterhouse is not a safe place to be high' (Schlosser 2002, p.174).

732 The survey of Australian workplaces by the National Centre for Education and Training on Addiction found that 5 percent of men and 3 percent of women in the workplace reported using ice (Roche et al. 2008).

733 See for example, Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates' Court, Public Hearing, Traralgon, 28 January 2014.

734 See for example Mr Simon Ruth, Director of Services, Victorian AIDS Council, Public Hearing, Melbourne, 14 October 2013. See also Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

735 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

Anex's submission notes that early intervention and harm reduction strategies should be put in place in these industries. 'The workplace is an ideal place to run effective drug and alcohol prevention programs because the peer support network in a workplace can be used to shape behaviour'. The concept of harm reduction and how it can be applied to methamphetamine use is discussed in Chapter 26.

experimented with methamphetamine, compared to 94 percent using alcohol and 63 percent using cannabis. Interestingly, very few of the apprentices (less than 2 percent) reported injecting any substances. The majority of the apprentices gave as their reason for using 'It's fun/I like it' (63 percent) whereas 38 percent gave the reason that their 'friends are using it'. More metropolitan respondents used methamphetamine (and other illicit substances) compared to their rural and regional counterparts, who were likely to consume alcohol at greater rates (Du Plessis & Corney 2011).

Despite the views of respondents that their substance use did not affect their work performance, the authors caution that such use could 'interfere with the apprentices ability to successfully complete their apprenticeships and thus has implications for the retention of skilled workers' (2011, p.49).

Witnesses to the Inquiry shared their concerns about the effects methamphetamine use was having on young apprentices and 'tradies'.⁷³⁶ As Ms Christine May told the Committee:

We are seeing young tradesmen that are affected by it. Really young tradesmen used to either, firstly, go to the pub or, secondly, use ecstasy, but now they are using methamphetamine and they are losing everything. Their families that we are coming in contact with are what we might call middle-class families who do not have the faintest idea what to do with their young people and basically are saying to us, 'Look, just put him into detox or put him into rehab and make him get better'.⁷³⁷

Another witness from Gippsland told the Committee that occupational use amongst the industries operating in that region was growing:

While the media stereotypes the ice user as being of low socio-economic background, there is anecdotal evidence to suggest that there is an increase in occupational users, including those who work shifts and in industry. This is particularly relevant to Gippsland due to major industry in the area, so forestry, energy, [trucking] and the desalination plant.⁷³⁸

An Ambulance Officer from the Bendigo region similarly commented that the profile of the methamphetamine user they were seeing did not necessarily fit stereotypes for other users of drugs, such as heroin. Often they were professionals or tradespeople and from fairly stable 'middle-class backgrounds':

It is probably interesting to note that these people have a background of being stable people in the community; they have been working and they have been functioning people who have families. That is probably more surprising of late. A case occurred at a new subdivision in Bendigo the other week. We turned up and the boss said, 'What's wrong with these two blokes?'. There was no doubt they had been on the meth over the weekend. These are the common sorts of cases we are getting. They are not people that you necessarily think are drug addicts or low-lives of the community. We are seeing more of the middle-class types of people.⁷³⁹

These young 'tradies' may also come from stable and loving homes, 'good families as well as bad, good parents as well as those who do not do so well' for whom illicit drug use may come as a shock, for which they are not prepared.⁷⁴⁰

736 Numerous witnesses gave evidence as to their concerns about increased methamphetamine use amongst 'tradies'. See for example, Superintendent Andrew Allen, Divisional Commander, Ballarat Division, Western Region, Victoria Police, Public Hearing, Ballarat, 18 November 2013.

737 Ms Christine May, Manager Latrobe Valley, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

738 Mr James Dale, Acquired Brain Injury and Alcohol and Other Drug Clinical Consultant, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

739 Mr Kerry Strachan, Group Manager, Ambulance Victoria, Public Hearing, Bendigo, 25 October 2013. See also on this point Ms Kerry Donaldson, Manager, Community Programs, Youth Support and Advocacy Service, Bendigo, Public Hearing, Bendigo, 25 October 2013.

740 See Superintendent Daryl Clifton, Victoria Police, Public Hearing, Bendigo, 25 October 2013.

Mr Peter Mellas, a magistrate with the Warrnambool Magistrates' Court told the Committee that he had also observed a significant number of tradesmen appearing before him who were using methamphetamine. He speculated that one of the reasons this may be is that methamphetamine unlike alcohol allows some users to both 'party' and still put in a sustained day's work:

The only thing I could put it down to was that you can go and put in a 12-hour shift after using ice. In fact you might be able to put in a 12-hour shift because you have been using ice. You cannot do that on a slab of beer. You cannot do that on some other drugs. There is a certain attraction from that point of view.⁷⁴¹

The ability to function at work after having used methamphetamine may however be only apparent in the early stages of the drug's use. More prolonged or heavy use of the drug may indeed affect work performance, as the following remarks from Ms Bev McIlroy, Manager of a drug treatment service in the south-west of the state attests:

... in the last 18 months, we have had employers ask us for help because good, valuable employees are starting to use this drug, and as a result their concentration at work is affected, their ability to pass drug tests etc. We do drug screening right across the western district and more and more employers are asking for random drug screens based on the fact that methamphetamine is in the workplace.⁷⁴²

Methamphetamine use is not restricted to young workers and apprentices in regional areas; evidence was given to the Inquiry that similar problems were apparent in Melbourne. The manager of a youth outreach program based in the northern suburbs of the city told the Committee:

We see carpenters, plumbers and people who work in all different trades coming through, and they are using it for different reasons. Obviously with the other substances we had before, you would not necessarily take lots of heroin and go to work, because it would be fairly obvious. If you took benzos it would be fairly obvious. With methamphetamine, particularly in those trades or industries where people need to perform, [it enhances their productivity].⁷⁴³

Methamphetamine use that impacts on the workplace clearly requires structured support and assistance from industry partners and stakeholders including employer groups and unions. Such support should include educational and awareness training on the drugs in question, health promotion activities and an industry-wide substance abuse policy. These are all important measures to address methamphetamine and other forms of substance abuse in the workplace (Du Plessis & Corney 2011, p.49).⁷⁴⁴

Methamphetamine use in the transport industry

The occupational use of psychostimulants by long-distance and other drivers has been an issue of concern for some time. Early survey research cited by Hall and Hando (1993) suggested that in both Australia and the United States — countries with huge amounts of territory covered by road transport — between 40 and 60 percent of long-distance truck

741 Mr Peter Mellas, Warrnambool Magistrates' Court, Public Hearing, Warrnambool, 3 March 2014.

742 Ms Bev McIlroy, Manager, Glenelg Southern Grampians Drug Treatment Service (QUAMBY), Public Hearing, Warrnambool, 3 March 2014.

See also comments of Superintendent Don Downes, Western Region, Division 2, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

743 Mr Richard Michell, Manager, Youth Outreach, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

744 Magistrate Clive Alsop from the Latrobe Valley Magistrates' Court endorsed such an approach when he gave evidence to the Inquiry stating that education on methamphetamine (and other drugs) should be targeted at trade schools in particular:

'Tell the young blokes who are about to finish their apprenticeships, "You're going to be out in the wide world. You'll be making more money than you've ever seen before in your life. These are the dangers you might fall into". Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates Court, Public Hearing, Traralgon, 28 January 2014.

drivers had taken stimulants (particularly ephedrine) to remain awake. Victoria Police notes:

The occupational use drug driving cohort is associated with occupations where fatigue through long periods of wakefulness occurs such as long distance truck drivers. This cohort is predominantly involved in stimulant type drug use to combat fatigue when working. This group also uses sedative type drugs to rest after prolonged periods of wakefulness induced by stimulant type drug use. Members of this cohort usually have a valid driver licence and an offence history relating to driving offences.⁷⁴⁵

There is some evidence in Australia that long-distance truck drivers are also taking methamphetamine to keep awake during long haul drives (Davey, Richards & Freeman 2007; Carson et al. 2012).

Many factors contribute to fatigue being a major problem within the road transport industry.⁷⁴⁶ These include structural factors within the industry and problems pertinent to individual drivers, including:

- ◆ Extended driving periods;
- ◆ Tight delivery schedules;
- ◆ Penalties for late delivery;
- ◆ Lack of rest or sleep prior to commencing long hauls;
- ◆ Monotonous scenery;
- ◆ Job competition (or taking on more than one job or contract);
- ◆ Related to the previous point is undercutting of rates with some operators willing to offer a faster service for the same price or less; and
- ◆ Products requiring urgent delivery (such as livestock).

Researchers such as Mabbot and Harley recognise that driver education, particularly with regard to the side effects of methamphetamine, is very important. However, according to the authors such a measure will not prove effective in reducing fatigue-related crashes without a change to industry practices.⁷⁴⁷

The use of methamphetamine by women

[I]n drug and alcohol research male experience has often been considered to be normative, and research has traditionally been designed to examine the issues in drug use that are problematic for men (Donath 2004, p.103).

Donath makes a convincing argument that 'women and women's issues remain seriously under-represented in the research literature on alcohol and drugs' (Donath 2004, p.103). This has certainly been the experience of this Committee in undertaking this Report. Not only is there a paucity of literature on methamphetamine use among women, there has been very little response or input from the community by way of submission or other evidence that details the specificity of female experience with regard to these drugs.

⁷⁴⁵ Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

⁷⁴⁶ American studies have also testified to quite serious cases of amphetamine abuse by pilots and other aviation personnel, particularly in the United States. Drug and Alcohol Testing of personnel by the US Federal Aviation Administration from 1995–2000 demonstrates that people working in safety sensitive workplace occupations such as aviation are being found positive to substance abuse. See for example Canfield et al 2000. On drug testing of aviation personnel in Australia, see ADF 2012; Bull et al. 2010.

⁷⁴⁷ For a discussion of the law in Victoria allowing the testing of motorists for methamphetamine, see Chapter 18.

Of the limited ethnographic and qualitative work that does examine gender difference in drug use patterns few studies examine methamphetamine specific issues (Brecht et al. 2004). This is a regrettable as gender focused research and contributions are an essential element in producing good policy that draws from and addresses women's experience. Research and policy need to recognise that for both biological and social reasons there are distinct differences in the way men and women use and are affected by drugs. Moreover, it has also generally been the case that there has been far more disdain shown to women who misuse drugs, both illicit and licit (particularly alcohol), than to males:

A survey of alcohol and drug treatment personnel in Australia found that most believed that there was more stigma attached to women with alcohol and drug problems than to men (Swift and Copeland 1998). In addition, women with alcohol and drug problems also believed that society looked down on them more than on men with similar problems (Copeland 1996). Women who already occupy a marginalised position in society (for instance Indigenous women, non-English speaking women, lesbians) are even more stigmatised than heterosexual, white, 'Anglo' drug users (Donath 2004, p.107).

Whilst it is clear that men are more likely to be users of illicit drugs than women (Dietze, Laslett & Rumbold 2004), it does not mean that the effects of such drugs on the women who do so use are any less severe. Indeed for both physiological and social/cultural reasons, it is arguable that the effects may be more profound on women. For example, some early American research indicated concerning findings with respect to gender differences in methamphetamine use; one of which was that women may have a more rapid trajectory of rapid escalation from occasional to frequent use than males (Brecht et al. 2004). Another American study of 98 female users of methamphetamine found that the great majority were characterised by personal, social and economic disadvantage, high rates of psychiatric illness and high levels of risky sexual behaviours including multiple partners and unprotected sex (Semple, Grant & Patterson 2005). The use of methamphetamine by pregnant women, as discussed in an earlier chapter, also has the capacity to seriously damage the health of the woman, the unborn foetus and the child's development once he or she is born.⁷⁴⁸

Although generally men may still use methamphetamine in greater numbers than women, the trend may be changing and the gap narrowing.⁷⁴⁹ As Mr David Kirby from Mildura Base Hospital told the Committee:

The change that we are seeing is a change in the demographic of the people who are presenting with substance abuse and ice use. Traditionally for us it has been males; now we are seeing younger females in the 18 to 25-year-old demographic presenting to our service.⁷⁵⁰

Similarly, Mr Paul Cranage the alcohol and other drugs (AOD) Program Manager for Uniting Care Ballarat told the Committee that there 'is no significant difference' between males and females who are using methamphetamine amongst clients seeking assistance from their agency.⁷⁵¹

The profiles of women using methamphetamine are as varied as those users in the general community. Dr Yvonne Bonomo, an addiction medicine specialist, stressed that despite a history of chronic disadvantage experienced by many, if not most, of the women who visit the Royal Women's Hospital Alcohol and Drug Service (WADS), their methamphetamine use has to be seen as part of a general spectrum of use with many and varied causes:

748 See Chapter 6 for a discussion of the effects of methamphetamine on pregnancy. See also Ms Teresa Lynch, Manager, The Royal Women's Hospital, Submission, 11 March 2014.

749 See Chapter 5 for data on the extent of male and female use of methamphetamine respectively.

750 Mr David Kirby, Director, Mental Health Services, Mildura Base Hospital, Public Hearing, Mildura, 5 December 2013. How representative this statement is of other areas of the state including Melbourne is difficult to ascertain on the basis of the limited data presented to the Inquiry.

751 Mr Paul Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013.

The women who attend the WADS clinic largely reflect the patterns of drug use that we see in the community, and that is a spectrum. There are those women who use ice in a typically dependent pattern — they will use every day for a period of time, from a number of days at a time to a fortnight and they will typically crash, as it is called — or there are those women who will use sporadically. They might use ice once a week or every few weeks. Then there are the so-called party drug users. They are ladies who will use ice recreationally, from time to time, and they consider it a recreational use of the drug. So there is that spectrum of ice use that we see in the clinic just like you would see in the community.⁷⁵²

Motivations of women for using methamphetamine

The reasons women may use methamphetamine are wide ranging and varied. A study in San Diego California, for example, found that some of the reasons given by their interview respondents as to why they used 'meth' included: 'to get high' (56%), to get more energy, including to help cope with child rearing and household chores (37%); to cope with mood swings and depression (34%); to lose weight and/or feel more attractive (29%)⁷⁵³ and for a sense of 'escape' (27%) (Semple, Grant & Patterson 2005).

The intensity of meth use was also positively correlated to feelings of sexual pleasure, with 18 percent of the sample citing increased sexual desire and enhanced sexual pleasure as reasons for using methamphetamine (Semple, Grant & Patterson 2005). There was also evidence that some women may use methamphetamine and/or other drugs because of overt and sometimes subtle forms of pressure from their male partners, although the authors note that more research into the role and influence of male partners of methamphetamine-using women is warranted. (See also Klee 2001a and 2001b.)

Early research by Morgan and Beck highlights the use of methamphetamine as an adjunct for what the authors term 'welfare mothers' as a way of coping with mundane tasks such as housework or to relieve the tiredness associated with childcare. One of the women surveyed as part of this study claimed:

'I stayed up and did my bills, got my paperwork done, got my coupons organized, started projects I had been procrastinating on, like filling photo albums and doing baby books. Just getting caught up on laundry and housework. I never stopped' (Morgan & Beck 1997, p.145).

Klee's British research found that for 'young mums' the main aim of using amphetamine:

[i]s to have enough energy to look after the children, do the housework and still have some leisure time. It seems the responsibility of having babies at a young age, with the associated problem of the confinement in the home until the children can be safely left with others, results later in a desire to have a good time while they are still young enough to enjoy it (1997b, p.44).

Despite the use of methamphetamine to circumvent tiredness in this way, long-term use of the drugs may result in the opposite effect.⁷⁵⁴

Unfortunately for most [women] who first tried methamphetamine to improve their work capacity, increased and prolonged use had the opposite effect. Respondents reported becoming increasingly dysfunctional after prolonged use, especially after transitions to a stronger mode of use. For example, one respondent described the difficulties encountered as a hair cutter when she switched from snorting to shooting meth, and bingeing for longer periods of time:

752 Dr Yvonne Bonomo, Addiction Specialist, Royal Women's Hospital Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

753 Anecdotal evidence was presented to the Committee that weight loss may also be one of the reasons Australian women use amphetamines and methamphetamine. See evidence of Ms Kate Hunt, Collaborations and Development Officer, Youth Projects, Public Hearing, Melbourne, 3 February 2014. See also the discussion in the context of young people in Chapter 13.

754 As was pointed out in Chapter 6.

'You do become dysfunctional. You shake real bad, that's kind of hard when you're cutting hair! ...you think you're going fast but you're going slower. At first you're going real fast and then the more you stay on it, you start slowing up and then your hands start shaking and your vision gets blurry' (Morgan & Beck 1997, p.145).

Methamphetamine used to self-medicate

In many of the research studies undertaken by Klee, a constant factor that arose with regard to women's use of amphetamines and methamphetamine was their use of the drug as self-medication for either physical health or more often mental health problems, particularly depression:

Women confined to the home by children, who have several small children and other responsibilities and are tired, find that not only is their depression lifted, but they [also] have more motivation and energy. It is not surprising that amphetamine is particularly attractive to them, and perhaps gives rise to the reputation of this drug as 'a woman's drug'.

Some women start their drug career early with a prescription from their doctor for dexamphetamine or get the tablets from relatives or friends and then move on to street amphetamine...

Tiredness and depression are the critical features of a self-medicating female amphetamine user. The tiredness is often associated with children.

The younger women with partners may be criticised by them for putting on weight, which threatens their fragile self-esteem further. It is difficult to determine how body image interacts with depression — the women get depressed when they put on weight but frequently they have eating habits strongly influenced by depression that cause obesity and the pattern becomes cyclic. Most self-medicating women have a history of depression from traumatic life events in childhood or adolescence. However, not all women are introduced to amphetamine by a medical prescription — doctors are extremely reluctant to prescribe dexamphetamine. The majority start their use, like most amphetamine users, by being offered street drugs (Klee 1997b, pp.61, 62).

Australian research has also found that women with substance abuse disorders have a much higher prevalence of mental health problems, particularly depression for which they self-medicate in a vicious circle of use:

Forty four percent of women with an alcohol dependence or abuse disorder suffer from depression or anxiety or both. For women with a diagnosis of illicit substance abuse or dependence, the rates are even higher, with more than half of these women (55 percent) suffering from at least one of the mood disorders (Donath 2004, p.109).

Moreover, it would seem now fairly apparent that there are strong links indicating that women who have suffered childhood sexual assault may develop substance abuse problems later in life. The number of women with substance abuse disorders who had been sexually assaulted has been estimated as at least one-quarter and possibly as many as half. (Covington, 2008; Simpson & Miller, 2002; Ullman, Najdowski, & Filipas, 2009; Tarczon 2012). For example, Ms Teresa Lynch from the Women's Alcohol and Drug Service at the Royal Women's Hospital notes that many of the women who present to the service have highly complex medical, social and psychiatric conditions and needs, many of which lead them to use methamphetamine and other drugs as a form of medicating or otherwise alleviating those conditions:

The women who come to our service usually have horrendous experiences of childhood trauma, violence, sexual assault and neglect, and poor mental health.

A recent audit of our service indicated that 84 percent of the women have had experience of a past psychiatric disorder, with 60 percent having more than one psychiatric disorder. Women suffer as a result of homelessness, poverty, poly-drug use and past experiences of infant removal from child protection, and their current experiences are also ones of trauma, sexual assault, neglect and often

forensic involvement. Over 75 percent of our women have involvement with the Department of Human Services at the time at which they deliver their babies ...⁷⁵⁵

Gender differences in the use of methamphetamine suggests that specialist strategies in education, prevention and treatment need to be tailored to meet different audiences of men and women, in addition to different sub-groups within those broad categories (such as middle-class users versus street users or recreational users as opposed to 'functional' users (Brecht et al. 2004, p.102).

Methamphetamine in the gay, lesbian, bisexual and transgender communities

Methamphetamine use and harmful consequences associated with the drug generally only affect a minority of same sex attracted persons (Howard et al. 2012). Nonetheless, 'there is increasing recognition that the use of illicit drug use [including methamphetamine] are considerably higher among same sex attracted people than among heterosexual populations' (Howard et al 2012, p.296).⁷⁵⁶ In Australia, methamphetamine use may be especially high among young same sex attracted people and those living in rural communities (Australian Institute of Health and Welfare (AIHW) 2008; Hillier 2005; Howard et al. 2012).⁷⁵⁷ Lesbian and bisexual women have also been found to have high rates of drug use compared to heterosexual women (Matheson et al. 2010; Hyde et al. 2007).

It may also be the case that young gay men in particular, who spend much time in the 'gay community' or adopt a consciously gay oriented lifestyle, may be more likely to use illicit drugs including methamphetamine than those who do not follow these behaviours (Howard et al. 2012). As with the heterosexual population, the gay and lesbian communities are by no means heterogeneous; the needs of Aboriginal gay men or women for example or those from non-English speaking background (NESB) communities who use methamphetamine may be quite different from 'mainstream' gay communities (Australian National Council on Drugs (ANCD) 2011).⁷⁵⁸

There may also be many men who have sex with men (MSM) who do not identify as being gay or part of the gay community. These men may engage in particularly risky behaviour with regard to both drug taking and their sexual practices (Lee et al 2007; Howard et al 2012). They are also at high risk of transmitting diseases such as HIV or hepatitis to their heterosexual partners.

Methamphetamine as 'party drugs' in the gay community

Methamphetamine as a pleasure-seeking drug has long been identified with the gay club scene and has been viewed with particular concern by members of the gay and lesbian community itself, particularly gay health workers and educators (Frankland et al. 2009; Dwyer et al. 2012; Matheson et al. 2010). Drug use at dance venues, nightclubs and parties is not of course an issue restricted to gay culture, but it is definitely part of that culture. Indeed much of the mixed or 'straight' dance, music and club scene that grew up in the 1980s 'rippled out from a predominantly gay base...the embryonic features of the gay dance club scene were evident in gay and lesbian clubs many years earlier' (Measham, Aldridge & Parker 2001, pp.56–57).

755 Ms Theresa Lynch, Manager, Royal Women's Hospital Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

756 See also Groves and Marmo 2009; Degenhardt et al. 2005.

757 American studies have indicated similar results (Marshall et al. 2008).

758 The ANCD study of injecting drug use in Indigenous communities found that HIV diagnoses in gay Aboriginal men, men who had sex with men and transgendered Aboriginals who had sex with men (known as 'Sista Girls') in the Indigenous communities were some of the highest ever seen by health workers (ANCD 2011, p.96).

It should be added, however, that methamphetamine use by people who happen to be gay or lesbian may have no connection to the club, dance or party scene. Gay and lesbian people, similar to heterosexuals, may take methamphetamine in a variety of settings and for a number of reasons. Many if not most of the reasons will be similar to heterosexual use. The following discussion therefore highlights only those parts of the gay, lesbian, bisexual and transgender (GLBT) communities for whom methamphetamine may be a party or dance drug.

Drug use, particularly methamphetamine, serves several purposes for gay men and lesbians in similar ways that it does for heterosexuals. It gives dancers the energy to stay on the dance floor all night. It has an aphrodisiacal effect. It lowers inhibitions allowing a person to 'succumb' to the aphrodisiac. It has also been suggested that it provides them with a mechanism to cope with the social and sexual demands of their lifestyles (Lee et al. 2007) including different emotions, tensions of socialisation and the prejudice experienced for being gay (Halkitis, Fischgrund & Parsons 2005). As for young people generally, for young gay men and women drug use including methamphetamine use may simply function as a normalised part of that culture (Dwyer et al. 2012). Methamphetamine use is very much a peer group activity and that is as true of peers within the gay community as in other sub-populations.⁷⁵⁹ As with young people generally, for young gay men in particular methamphetamine use may be increasingly seen as part of normal leisure activity (Slavin 2004; Dwyer et al. 2012):

Slavin's research on the use of crystal methamphetamine among gay men in Sydney highlighted the way in which drug experiences are a central component in the production of particular forms of sociality, including dancing, socialising and 'chem sex', intense sexual encounters enhanced through the use of crystal methamphetamine. The men in Slavin's research established and deployed a range of 'boundaries' in order to manage and control their methamphetamine use. At the same time these boundaries served to produce a shared cultural identity — middle class, masculine and not 'junkies' (ie people whose drug use is out of control) (Dwyer et al. 2012, p.59).

Concerns were expressed to the Committee about the use of methamphetamine by the gay community in Victoria. For example, Ms Jenny Kelsall from Harm Reduction Victoria (HRV) noted the high and widespread prevalence of methamphetamine use amongst sexually adventurous young men (SAMS) in the dance party scene. In partnership with the Victorian AIDS Council, HRV is looking at ways they can get safe sex and drug use messages across to this particular cohort, especially when they don't identify themselves as hard drug users:

[We] are seeing exactly that nexus of methamphetamine that has resulted in very, very unsafe sexual practices. I think part of the problem with getting to methamphetamine users with education or anything else, including treatment...is that a lot of ice users do not identify as drug users. They do not identify with our organisation. They do not want to be labelled as a drug user. That is not their identity, and that is the problem within the gay community. The people who are using ice and even injecting it do not identify as drug injectors, and so we have to design very nuanced information and education to work with this particular group.⁷⁶⁰

Risks for users

Despite the 'liberating' aspects of much gay dance and party culture, concerns have been raised as to the extent, type and level of drugs being used at dance parties and nightclubs within the gay, particularly male homosexual, community (Green & Halkitis 2006; Race 2009; Hurley & Prestage 2009).

759 See comments of Dr Matthew Frei, Head of Clinical Services, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

760 Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013.

Health risks linked to combined sexual and drug taking behaviours

Concerns have been expressed with regard to the health consequences of unsafe sex as a result of the libido heightening/sexual enhancement effects of the drug *and* injecting drug use.⁷⁶¹ An American ethnographic study by Reback and Grella for example found that methamphetamine use was extremely high among gay and bisexual users in Los Angeles or in gay operated and owned institutions such as nightclubs, sex clubs, bars and saunas.⁷⁶²

The men in this study reported that they had incorporated methamphetamine use within their sexual activities and described methamphetamine as the vehicle for greater sexual risk taking. The ability to have continuous sexual encounters and multiple sex partners was viewed as a beneficial function of the drug, particularly for those men who exchanged sex for drugs or money.⁷⁶³ Further, HIV positive men in the study were less likely to use condoms than HIV negative men. Methamphetamine was central to the self-identity of the men in the study, for whom sexuality has been fraught with the threat of HIV. Using methamphetamine enabled them to be sexually active within the context of this risk and to reclaim a sense of pre-AIDS sexuality (Reback & Grella 1999, p.156. See also Howard et al. 2012).⁷⁶⁴

In particular, young gay men are at risk of engaging in unsafe sexual and drug-taking behaviours (Howard et al. 2012). For young men who have not come out, drug taking may be one way of coping with the pressure of leading double or secret lives; for example hiding their sexuality from family, friends or workmates (Hillier et al. 2005; Rosario, Schrimshaw & Hunter 2009).

Other young men may naively view themselves as invincible as a result of their ingestion of methamphetamine.⁷⁶⁵ This sense of invincibility may encourage risk taking in what Lewis and Ross term the eroticising effects of set and setting; for example the erotic environments of saunas or dance clubs, loud music and ready availability of drugs.⁷⁶⁶

Risks to mental health associated with methamphetamine use

Members of the GLBT community may also suffer from high levels of mental health problems compared to the heterosexual community, particularly depression.⁷⁶⁷ The largest Australian study into the health issues pertaining to gay men and lesbians — *Private Lives* — found that nearly three-quarters of those surveyed reported some experience of depression and nearly half of both men and women surveyed met the criteria for a major depressive episode. Such depressive episodes may be compounded if not exacerbated by the physiological and psychological consequences of methamphetamine use (Howard et al. 2012).⁷⁶⁸

Such problems are not assisted by attitudinal and structural barriers to effective treatment interventions for gay men and lesbians to address both their methamphetamine use and related health issues such as depression. Not the least of these may be homophobic and discriminatory attitudes from staff and other (non-gay) clients (Howard et al. 2012; Matheson et al. 2010). These barriers to treatment will be discussed in detail in Chapter 27.

761 See discussion in Chapter 6.

762 In Australia, a high and early profile HIV/AIDS prevention strategy that worked in tandem with the gay community has for the most part meant that gay operated venues are more likely to cooperate in disseminating harm reduction messages and providing harm reduction information or materials such as condoms, lubricant etc than may be the case in the United States.

763 Part of the functional or instrumental use of amphetamines as discussed above. A later study also based in Los Angeles found that the long-acting stimulant qualities of amphetamines enabled users, particularly street workers, to:
‘[e]ngage in sexual activities with one, two or many partners while using methamphetamine. Homeless street users report that the drug has functional aspects; its use enables them to increase their number of paid sexual customers’ (Shoptaw, Reback & Freese 2002, p.93).

764 Reback and Grella used outreach workers to gather the data for this study. They believe outreach interventions are a crucial strategy for disseminating harm reduction messages to these populations. For further discussion of such interventions, see Chapter 23.

765 See discussion in Chapter 13.

766 Lewis and Ross (1995) are drawing from the work of Zinberg (1984) in this context, see earlier in this chapter.

767 See discussion on psychological consequences of methamphetamine use in Chapter 6.

768 See also Chapter 6.

Inter-generational users

Evidence has been given to the Inquiry that many families have a culture of drug taking including ice that transcends generations; in some cases from grandparents down to grandchildren. As Ms Dianne Barker advised the Committee:

Historically and currently we see young people who are below social par. They have left school at a very early age, so they have no education. They come from dysfunctional families who also present as substance users, so it's cross-generational. So the young person is brought up in that family and therefore it is normal behaviour... Their substance use starts at a very early age, via mum or dad, who either give them alcohol or cannabis or give them a fit and assist them in injecting. Because they are doing it in a family atmosphere, it is seen as being correct and appropriate.⁷⁶⁹

Ms Dianne Barker, from St Luke's Anglicare Bendigo, related the somewhat alarming account of a mother who was facilitating the delivery of ice to her children *whilst* they were in residential care in St Luke's.⁷⁷⁰ Mr Geoff Munro of the Australian Drug Foundation also told the Committee that problematic intergenerational use of alcohol and/or illicit drugs was not uncommon.⁷⁷¹ Similarly, Superintendent Daryl Clifton of Victoria Police in the Bendigo region told the Committee that he has observed cases of 'drug institutionalisation' across different generations of the same families.⁷⁷² And even if the children of drug using parents are not currently using themselves, there is, according to Ms Melanie Vidler from The Bridge in Shepparton, always the risk and potential that they may follow suit:

There has been an increase in some referrals from child protection that we are getting where their parents are using ice, so it is not necessarily the young people who are using ice themselves but their parents, which in itself is quite difficult because we are a youth service, so it is really hard to try to get mum and dad to go and seek their own treatment. I guess our fear is that then young people are going to follow on with mum and dad, because if that is what is seen as normal, then that is what you do...⁷⁷³

A submission from the Commission for Children and Young People also noted this inter-generational and intra-family use and drew attention to the fact that services for adults who use methamphetamine can be ill-equipped to address the needs of children whose parents (or grandparents) use methamphetamine.^{774 775}

The issues pertaining to the welfare of children whose parents or other family members use methamphetamine are comprehensively discussed in Chapter 7.

Methamphetamine users with pre-existing mental illnesses

There is a strong link between people who use drugs and co-morbid mental illness.⁷⁷⁶ For example, 35 percent of people who use drugs also have a dual diagnosis for a mental

769 Ms Christine May, Manager Latrobe Valley, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

770 Ms Dianne Barker, Acting Senior Manager, ICMS and Residential Care, St Luke's Anglicare, Bendigo, Public Hearing, Bendigo, 25 October 2013.

771 Mr Geoff Munro, National Policy Manager, Australian Drug Foundation, Public Hearing, Melbourne, 14 October 2013. See also in the context of family stress and family breakdown discussed in Chapter 7.

772 Superintendent Daryl Clifton, Victoria Police, Public Hearing, Bendigo, 25 October 2013.

See also the evidence of Tricia Quibell of Berry Street Shepparton. Ms Quibell noted that it was distressing to observe the children of former clients coming back through the child protection system as clients themselves often with similar types of alcohol and drug problems as their parents.

Ms Tricia Quibell, Deputy Director, Hume region, Berry Street, Public Hearing, Shepparton, 25 February 2014.

773 Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Public Hearing, Shepparton, 25 February 2014.

774 Mr Bernie Geary OAM, Principal Commissioner, and Mr Andrew Jackomos PSM, Commissioner for Aboriginal Children and Young People, Commission for Children and Young People, Submission, 25 October 2013.

775 The problems associated with co-morbid mental illness and methamphetamine use, particularly when there is a dual diagnosis, are discussed in greater detail in Chapter 6 and the treatment chapters in Part H.

776 See discussion in Chapter 6.

health condition (Ministerial Council on Drugs 2011, *National Drug Strategy 2010–2015*). People with pre-existing mental illnesses may be particularly vulnerable towards the risks associated with methamphetamine use.

This may be the case for those suffering with a psychotic form of illness such as schizophrenia, as methamphetamine can trigger an acute psychotic relapse in individuals with schizophrenia and bipolar type affective disorders.

People with depressive illnesses may also use methamphetamine to counter the symptoms of depression (lack of energy, low mood, lack of drive and motivation) but they run the risk of exacerbating the depression once the euphoric effects of methamphetamine have worn off (Lee et al. 2007). People with pre-existing problems pertaining to intellectual disabilities may also be more at risk of using methamphetamine and/or other drugs in harmful ways.⁷⁷⁷

Prisoners

People in police custody or prison have high rates of drug use; the use of methamphetamine being no exception (MacGregor & Payne 2011).

According to the National Drug Strategy, 71 percent of Australian prisoners, for example, had used illicit drugs in the 12 months prior to their current incarceration (Ministerial Council on Drugs 2011, p.6). Trend analysis by the Australian Institute of Criminology's Drug use Monitoring in Australia (DUMA) project has also found that a decline in methamphetamine use among police detainees may now have ended with the rates of use among such detainees increasing in 2010 and 2011 (MacGregor & Payne 2011). Drug use by prisoners may also be particularly problematic for Aboriginal Australians. Despite accounting for 2.5 to 3 percent of the overall Australian population, Aboriginals account for 25 percent of people incarcerated in Australian prisons at any given point in time, even if in Victoria the ratio is lowest (5.5 percent of the state's prison population) (ANCD 2011, p.45). Moreover, Aboriginal prisoners had very high rates of illicit injecting drug use prior to entering prison compared to non-Aboriginal users of methamphetamine.⁷⁷⁸

A recent report into drug use in Victorian prisons by the Auditor-General's Office (VAGO)⁷⁷⁹ made the following comments:

A study of the health of Australia's prisoners in 2012 found that 54 percent of discharged prisoners reported drinking alcohol at unsafe levels prior to their recent imprisonment, 70 percent of prison entrants used illicit drugs during the previous 12 months and 44 percent had injected drugs. Research into alcohol and drug use by police detainees across Australian jurisdictions in 2009-10 found that 66 percent of detainees who were drug tested had used at least one drug in the 48 hours prior to their arrest and 45 percent indicated that substance use contributed to their current offences. Based on these patterns of drug use, many prisoners start their period of imprisonment with drug problems. Untreated or undiagnosed drug problems can result in demand for drugs in the prison system, which creates a range of risks and challenges for prisoners, prison staff and the community. The use of drugs in prisons is associated with increased violence, occupational health and safety risks and corruption. Additionally, prisoners may use threats or commit acts of violence against other prisoners and staff to obtain drugs, and drug debts and withdrawal symptoms can lead to further violence (VAGO 2013, p.1).

The VAGO report found that buprenorphine, a drug used for opioid substitution therapy to treat heroin addiction, was the most commonly detected drug used illicitly by prisoners in 2012-13, accounting for 57.7 percent of all positive urinalysis tests. Amphetamines and cannabinoids were the second and third most commonly detected drugs, with 12.5 percent

777 Dr Andrew Crellin, Director of Emergency, Ballarat Health Services, Public Hearing, Ballarat, 18 November 2013.

778 See Chapter 12 for a discussion of methamphetamine use amongst Aboriginal people generally.

779 *Prevention and Management of Drug Use in Victorian Prisons*, Victorian Auditor General's Office (VAGO), October 2013.

and 9.8 percent of positive urinalysis results, respectively (VAGO 2013, pp.x, 4).⁷⁸⁰ Other studies of illicit drug use in prison do not identify the type of drug use in question, or primarily refer to opiates such as heroin.

Methamphetamine use by prisoners and those in custody

Knowledge about methamphetamine use specifically by those in prison, on community corrections or awaiting trial remains scant, although some evidence has been received by the Committee which suggests it is increasing. For example, a substantial percentage of clients being seen on referral to the Drug Court of Victoria have been using methamphetamine, usually in conjunction with other drugs and alcohol. Magistrate Tony Parsons told the Committee that this situation had changed dramatically in recent years. Whereas in 2008 the number of clients presenting with methamphetamine-related problems was virtually zero, the great majority having heroin-related issues, in 2013 the number had risen to almost 50 percent.⁷⁸¹

A submission to the Inquiry from the Community Offenders Advice and Treatment Service (COATS) also reported that in 2013 crystal methamphetamine ('ice') comprises approximately 38% of all referrals to treatment when the primary drug category is amphetamines.⁷⁸² Such referrals included clients on Community Corrections Orders, released on parole or referred through a range of diversionary programs.⁷⁸³

Evidence has also been given that female users of methamphetamine in the prison system are also compromised by their drug use. A submission to this Inquiry from Melbourne City Mission, one of whose services is to conduct outreach with women prisoners, stated:

- Women withdrawing from ice in prison can be a risk to themselves or others and may therefore be placed into the management unit initially.
- Those women who use ice and have children tend to:
 - ♦ Not engage with the family support program until they are more stable
 - ♦ Or will refer to the program, but be difficult to engage (for example, some women will not have the capacity to comprehend their own circumstances or the situation with their children).⁷⁸⁴

An increase in methamphetamine use amongst prisoners, detainees in police cells and people on remand has been observed by other health, welfare and support agencies and from law enforcement officers.⁷⁸⁵ For example, Primary Care Connect (PCC) has recently established an outreach service that includes cell assessment of detainees at the Shepparton Police Station. According to PCC this is in a response to the increasing numbers of methamphetamine impacted persons being held in custody there. It is also the view of PCC that Magistrates are increasingly requesting alcohol and drug assessments, where there is either unstable presentations being observed by the accused in the cells, and or violent behaviours have been reported. Withdrawal from methamphetamine is increasingly leading to such behaviours.⁷⁸⁶ Superintendent Jock Menzel noted the increase in the number

780 The Report however did not break down the class amphetamine into its various types such as methamphetamine or ice.

781 Mr Tony Parsons, Magistrate, Drug Court of Victoria, Public Hearing, Melbourne, 9 December 2013.

Further discussion of the Drug Court of Victoria is found in Chapter 21 of this Report.

782 COATS is a state-wide program that administers both State funded and Commonwealth funded (NIDS) treatment pathways. COATS provides specialist drug and alcohol assessments, treatment planning and brokerage (including purchase of) treatment for clients referred from the criminal justice system, including the Adult Parole Board, courts, community corrections, youth justice and drug treatment providers thus providing a link between Justice and Drug Treatment services. COATS currently facilitate over 25,000 referrals and assessments each year.

Ms Heather Carmichael, Community Offender Advice and Treatment Service (COATS) Manager, Australian Community Support Organisation (ACSO), Submission, 12 November 2013.

783 See also the discussion on criminal justice diversion options in Chapter 21.

784 Rev Ric Holland, Chief Executive Officer, Melbourne City Mission, Submission, 1 November 2013.

785 See for example, Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013

786 Mr Hamish Fletcher, Chief Executive Officer, Primary Care Connect, Submission, 18 October 2013.

of people in custody who had been using methamphetamine and the need for additional police vigilance whilst they were incarcerated:

There is a significant issue in relation to people held in custody while under the effects of ice, or actually coming down, as we call it, from the effects of ice, because they pose a risk to themselves and police. While they are actually coming down they need to be kept separate from the general prisoner population as their behaviour can be erratic and they can scare and injure other prisoners. This reduces capacity in police cells, and of course the opposite reaction can also occur, where the person just wants to be left alone. So, due to the unpredictable nature of the effects of the drug on people in custody, assaults against police are a real risk.⁷⁸⁷

Superintendent Mick Sayer from the Shepparton district also noted increasing problems in police cells due to methamphetamine use:

In recent times in particular I have been noting custody issues. With the amount of people we have in custody and in cells, whenever there is an incident occurring in police cells it is recorded on what is called an 'incident fact sheet'. I have noticed a large increase in behavioural problems of persons in custody, and it is quite often noted that these people are coming down from ice. So it is obviously a health problem as well. We have these people in custody, and they are suffering the effects of withdrawal from ice. We are then having assaults in the cells amongst other persons in custody, and police officers are also involved, which is causing us issues.⁷⁸⁸

Injecting drug use

A substantial proportion of the Australian prison population who use drugs have reported injecting drug use (IDU). According to some Australian studies, 55 percent of adult prisoners report having injected drugs at some point with 34 percent having done so in the month prior to their incarceration (Butler & Papanastasiou 2008; Kinner et al. 2012⁷⁸⁹). In Victoria, the Auditor-General's Report into *Prevention and Management of Drug Use in Prisons* found that 70 percent of prisoners in the Victorian correctional system used drugs in the year prior to incarceration and of that number 44 percent were injecting drug users (VAGO 2013).⁷⁹⁰

Moreover, 'despite intensive and costly efforts to restrict the flow of drugs into prison settings' a substantial proportion of users continue to inject drugs in prison (Milloy et al. 2008; Kinner et al. 2012).⁷⁹¹ Clearly there are significant dangers associated with injecting drug use by any cohort of user.⁷⁹² But injecting drug use, and the resultant spread of blood borne viruses in particular, is possibly even a greater risk for prison populations:

Prisoners are likely to perform injections in a hurry, use unsterile equipment and may not have access to quality peer education or harm reduction messages. Further the risks are compounded for those who are initiated into injecting in prison, due to the less than optimal environment and equipment (ANCD 2011, p.93).

Kinner et al.'s (2012) study of prisoners in Queensland, for example, found that the vast majority of prisoners who did inject in prison shared needles and other injecting equipment:

Such findings add support to calls for the introduction of NSP [needle and syringe programs] in Australian prisons, to bring health services in custody in line with those in the community ...There

787 Superintendent Malcolm (Jock) Menzel, Divisional Commander, Eastern Region Division 5 — Morwell, Victoria Police, Public Hearing, Traralgon, 28 January 2014.

788 Superintendent Michael Sayer, Eastern Region, Victoria Police, Public Hearing, Shepparton, 25 February 2014.

789 Kinner et al.'s study of adult prisoners in Queensland found that almost one in four prisoners has injected drugs whilst in prison and more than one in 8 injected during their current prison sentence (2012, p.158).

790 See also Ms Michelle Wood, Assistant Director, Community Correctional Services, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014.

791 Some people working in the Victorian correctional system whilst acknowledging 'off the record' that methamphetamine use was relatively common in prisons, declined invitations to give evidence to the Committee. In part this was due to their concerns about their employment being jeopardised, particularly given that many corrections workers are on short-term service contracts.

792 See discussion in Chapter 9.

is now persuasive evidence that prison NSP like community NSP can reduce the spread of infection among people who inject drugs and has no substantial collateral harms (Jurgens et al. 2009). Given the high prevalence of injecting among prisoners in this large and rigorous study, and the potential for infections acquired in prison to spread into the wider community, there is a clear and compelling case for the trial of NSP in Australian prisons (2012, pp.150, 159).⁷⁹³

Another problem associated with IDU amongst prisoners is a relatively high related prevalence of depression, attempted suicide and other mental illnesses particularly where such prisoners have had a history of non-fatal drug overdose. Such a finding ‘highlights the need for a coordinated approach between mental health and alcohol and other drug services for prisoners returning to the community’ (Moore et al. 2013, p.49). The Victorian Ombudsman’s recent report into prisoner welfare, *Investigation into deaths and harms in custody*, has criticised the provision of both physical and mental health care in Victorian prisons, noting that with current overcrowding in the prison system the situation has worsened for prisoners with mental health issues and that specialist medical care such as drug treatment is not available in some regional prisons (Victorian Ombudsman 2014, p.13).⁷⁹⁴

Managing drug use in prisons

Acknowledging that drug use, including methamphetamine, exists in prisons is one thing, addressing it may be more difficult. For example, Mr Gino Vumbaca from the Australian National Council on Drugs told the Committee that methamphetamine use amongst prisoners was a significant problem for prison management:

The corrective services system is not a great environment to be speeding in, basically. There are a lot of restrictions in your movement, and if you are stuck in your cell potentially for a 23-hour lockdown, you are more after a depressant such as cannabis or heroin so you can create a different atmosphere and provide yourself with a different way of dealing with that time. Prisoners have a lot of time on their hands. One of the issues within prisons is how you manage prisoners’ time, how they manage their time in there and how they deal with the long hours — in some cases quite long hours of lockdown — and restricted time. Speeding is more about being out and potentially drinking as well. We have seen it linked a lot with alcohol because it increases your ability to drink and to drink more without feeling intoxicated or drowsy drunk. It keeps you alert while you get drunk. That is not really a prison environment.⁷⁹⁵

Mr Vumbaca added that in his view, at least with regard to non-violent or low level offenders, prison was not the most suitable environment in which to address their drug-related problems:

793 The VAGO report notes the lack of needle exchange programs in Victorian prisons and whilst acknowledging the research evidence as to their desirability does not make a recommendation in this regard (VAGO 2013, p.28).

See also the submission to this Inquiry from Anex as to why NSPs in prisons are urgently needed. Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

794 Conversely some witnesses to the Inquiry gave evidence that for some methamphetamine users custodial settings such as police cells or prisons may be the only time they get to receive effective treatment for their addictions including forced withdrawal. Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

Other witnesses, particularly family members of methamphetamine users remarked that ironically gaol may have been the only location in which the user could be safe from the reach of methamphetamine. See for example Ms Kerry Johnston, Public Hearing, Wodonga, 24 February 2014.

Mr Peter Mellas, Magistrate at Warrnambool Magistrates’ Court similarly told the Committee:

‘I’ve had people come in [to court] who say they are almost relieved that the police have picked them up because they now have an excuse, they have a reason to stop using’. Mr Peter Mellas, Warrnambool Magistrates’ Court, Public Hearing, Warrnambool, 3 March 2014.

795 Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

See also comments of Ms Michelle Wood, Assistant Director, Community Correctional Services, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014.

The nature of prison life is not constructed in a way that is conducive to a therapeutic environment dealing with people's problems. A lot of drug use is related to people's problems, either traumatic incidents within their life or a response to mental health problems. In some cases it can be a factor of all those things. Prison is not the place you are going to deal with it, and the best thing we can do to reduce reoffending is to divert people into treatment and deal with their drug use problems. It does not mean everybody will benefit, but you have much more of a chance of dealing with that problem in a therapeutic environment like a residential or rehab facility than you have in a prison.⁷⁹⁶

Managing drug use in prisons — the view from Corrections Victoria

Notwithstanding the criticisms contained in the VAGO and Ombudsman Reports and the comments made in evidence to this Inquiry, spokespeople from Corrections Victoria have told the Committee that a statutory framework has been put in place that attempts to both manage compliance with the orders that an offender may be subject to whilst supervising and addressing needs particular to their drug using backgrounds. Mr Jan Shuard, Victoria's Corrections Commissioner outlined this approach in evidence to the Committee in February 2014:

The policy framework that we operate under is an evidence-based offender management framework, and that outlines to our staff the set of practice principles that guide the consistent, system-wide approach to offender management. What those principles basically ensure is that we maintain system integrity, and by that I mean that whatever interventions we provide are based on evidence and are assigned to the person's level of risk and need. We make sure that we are not over-intervening in people's lives if they do not need it and that people are getting the services they need to reduce their risk of reoffending.

Our other principle is that we increase self-responsibility — that is, for those people who come to us our job is to teach them how to access services in the community so that support and services can be ongoing even after their statutory obligation has been completed with community corrections.⁷⁹⁷

Ms Shuard, whilst acknowledging that the management of a prisoner's drug use or drug dependency could be difficult, believed that nonetheless, comprehensive programs had been put in place to address these needs. Such programs, whilst case-managed by Corrections Victoria, were for the most part developed and delivered by contracted services such as COATS/ACSO:

Our services include our assessments, case management, reducing reoffending programs, and drug and alcohol treatment and testing, although I need to make it clear that we do not provide the drug and alcohol treatment and testing. That is a subcontracted service, both in community corrections and in prisons. We say that we look after the statutory responsibilities of an order. We do the case management. We set the environment so that people will participate in those treatment programs, and then we send them off to the experts to provide the treatment according to their level of risk and need.⁷⁹⁸

Corrections Victoria also incorporates the three pillars of harm minimisation in their approach to drug management:

We are dealing with a very high drug-taking group of the population and we have a drug strategy to deal with it across the system. Just because somebody comes into prison, it does not mean that their desire for drugs reduces. We have to work to make that desire for drugs reduce.

The first arm of the strategy is managing supply, so we make sure that we have good intelligence systems to know if drugs are getting in, how they might be getting in and the like. We have targeted searching. We have really strong barrier control with a range of technologies that identify if people are coming through the gate with drugs, and we have a range of searching. So managing the supply is the first part of it.

796 Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

797 Ms Jan Shuard, Commissioner, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014.

798 Ms Jan Shuard, Commissioner, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014.

We have a very extensive drug testing program. Around 26 000 targeted drug tests were conducted in 2012-13, and of those around 5 percent came back positive, so it is quite a low rate when you consider that you are dealing with a population of which 70 percent reported to have used drugs before they came into our system ...⁷⁹⁹

In relation to harm reduction, Ms Shuard also spoke to the difficult issue of needle exchange programs in prison environments. Acknowledging that some health promotion advocates believe the introduction of these programs are useful harm reduction measures,⁸⁰⁰ she told the Committee that for the most part their introduction in prisons was inappropriate:

It [NSPs] is a difficult issue for a prison environment, because on one level you would say the introduction of a needle exchange program in prisons is in some way endorsing the use of drugs within a prison environment. That is a difficult one for us because we have a no-tolerance approach to the use of drugs in prison. That is not a punitive approach.⁸⁰¹

Notwithstanding the evidence of Corrections Victoria, it is unclear how effective programs conducted both within and outside prison are in addressing the methamphetamine use of prisoners and ex-prisoners. This is particularly the case when it comes to the treatment of methamphetamine use and dependence.⁸⁰² In this regard the VAGO report into drugs in prison was inconclusive as to whether any programs run in prisons to address illicit drug use had been effective in reducing incidence of drug use or drug-related harms 'due to the shortcomings of performance measurement and program evaluation' (VAGO 2013, p.xi).⁸⁰³

Prisoners released into the community

Methamphetamine use post-release may also contribute to drug-related mortality and morbidity amongst ex-prisoners.⁸⁰⁴

In addition to deaths and harms associated with people currently in prison, the estimated annual number of deaths among recently released prisoners continues to grow. The death rate amongst released prisoners is 'considerably greater than the annual number of deaths in custody, highlighting the extreme vulnerability of this population on return to the community' (Kinner et al. 2011, p.64). This is particularly the case in the first few weeks after release and often because of drug-related causes such as drug overdose. On this issue the recent *Investigation into deaths and harms in custody* report by the Victorian Ombudsman called the deaths of recently released prisoners a 'hidden toll'.⁸⁰⁵

Post-release deaths raise concerns about the duty of care owed to people after they leave custody. It requires a multi-disciplinary approach from government and community agencies to ensure that ex-prisoners are provided with adequate housing, health, employment and education opportunities in the community so as to minimise the risks of death upon their release and limit the chances of them re-offending.

While 6,609 prisoners were released from Victorian prisons into the community, intensive transitional support is available to a maximum of 695 prisoners per year. It is also concerning that the community

799 Ms Jan Shuard, Commissioner, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014.

800 See Chapter 26 for a discussion of harm reduction measures generally.

801 Ms Jan Shuard, Commissioner, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014.

802 See discussion in Chapter 29 pertaining to treatment issues.

803 For a list and description of current programs to address and manage drug use by Victorian prisoners including opioid substitution therapy and Hepatitis B treatment, see VAGO 2013, pp.37ff. Health programs and services for Victorian prisoners and those on community corrections are primarily provided by contractors and sub-contractors brokered through the Justice Health Unit of the Department of Justice and Corrections Victoria. See <http://www.justice.vic.gov.au/>.

804 See also Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol & Drug Association VAADA, Submission, 11 November 2013.

805 As such, the Ombudsman's Report recommended the Department of Justice: 'Arrange for an independent research study to be conducted to identify the number and nature of deaths which occur within four weeks of a person leaving prison, and within one year of a person leaving prison'.

Recommendation 24 *Investigation into deaths and harms in custody* Report (Victorian Ombudsman 2014).

integration program for prisoners with mental health issues is limited to 100 prisoners and operates at only two prisons. The availability of suitable housing alternatives for ex-prisoners is also a major concern. With the Victorian prison system overcrowded and greater numbers of prisoners presenting with complex problems such as mental health issues, it is important that there are sufficient community support programs available to assist ex-prisoners in re-entering the community; that the programs allow for adequate time with support workers; and that the programs are delivered in an efficient and cost effective manner (Victorian Ombudsman 2014, p.103).

Ex-prisoners may also be particularly vulnerable to continuing drug use once they have left prison, including whilst on parole. A submission to this Inquiry from Anex made similar observations stating:

The challenge facing many individuals in the twelve months following release has been evidenced in a recent report by the Australian Housing and Urban Research Institute (Baldry, McDonnell et al 2004) which showed the significance of housing instability on the lives of many released offenders and the significance of changes of residence during the first six months on the likelihood of return to custody. The report also found ex-prisoners were more likely to return to prison if they had an increase in the severity of AOD problems in the months following release. The study concluded that a trained caseworker should be allocated to every prisoner pre-release in order to aid integration into the broader community. The policy implications of these findings point to the need for AOD services to be delivered in conjunction with housing support services, rather than separate from them.⁸⁰⁶

This lack of post-release options may be even more problematic for Aboriginal prisoners:

Our concern is that if we do not provide therapeutic approaches to resolving the issues going on for these people, we are simply allowing them to be released back into society no safer or better prepared in terms of their resilience or ability to cope with the challenges that might be confronting them. If they simply get locked up with little or limited therapeutic or restorative justice approaches or justice reinvestment approaches⁸⁰⁷, they come out and their behaviours have not necessarily adjusted or amended. One of the things lacking in the prison system in terms of the way it deals with people is what we would call the after-care or post-release stages.⁸⁰⁸

The little research that has been done into this population tends to confirm the views of this witness. For example, one study of detainee amphetamine users in Perth remarked that given the generally lower socioeconomic status observed in the population under review and the slim chances of finding stable housing, employment or training opportunities, a relapse into methamphetamine use and/or further offending was if not likely, certainly possible (Gately et al. 2011).

Culturally and linguistically diverse communities

It is extremely difficult to ascertain the extent to which methamphetamine use may be a problem in culturally and linguistically diverse (CALD) communities. There is very little information or research about drug use patterns among people from non-English speaking or ethnically diverse backgrounds. This is particularly true with regard to methamphetamine use specifically.

Whilst there has been some (limited) data and other research which suggests misuse of alcohol and other drugs is not a major issue in CALD communities, Rowland, Toumbourou and Stevens 2003 warn that '[t]his general conclusion masks some "pockets" in which there do appear to be more serious issues'. Such examples may include analgesic and tobacco

806 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

807 For a discussion of these approaches, see Chapter 21.

808 Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Public Hearing, Melbourne, 17 February 2014.

use among Arabic-speaking Australians, heroin use among some young Vietnamese men (Rowland, Toumbourou & Stevens 2003, p.5).⁸⁰⁹

Moreover, it is probable that the levels of methamphetamine use in people of non-English speaking backgrounds is under-represented as many research surveys of drug use are advertised and conducted in English or otherwise contains an English speaking or cultural bias (McKetin, Kelly & McLaren (2006). CALD groups may experience even greater difficulties in accessing information, support and treatment options to address their methamphetamine use than mainstream communities (Lee et al. 2007).

The experience of the Centre for Multicultural Youth

The Committee *did* receive a submission from the Centre for Multicultural Youth (CMY) which provided some insights into the extent to which crystal methamphetamine specifically may be used by people from CALD communities, particularly young people. The submission stressed that their views were anecdotal given 'there is little or no research or documentation on the trends or patterns of ice use among CALD people'.⁸¹⁰ Nonetheless, the Centre made some interesting observations as indicated in the following discussion.

The extent of the problem

Formal statistics on the use of crystal methamphetamine use by CALD youth are not available. Nonetheless, CMY based on their vast experience in working with youth believe that in the western metropolitan area of Melbourne the use of methamphetamine is increasing. This is particularly the case for a number of CALD communities including the African, Pasifika, Chinese, and to some extent, the Vietnamese communities:

Traditionally, drug use centered on alcohol and marijuana but increasingly, there has been a move to the use of 'ice'. About two thirds of YSAS African clients regularly use it as compared to 5 years ago where it was a rarity. Anecdotally, the feedback is that the use of 'ice' is reaching significant proportions but that it is not talked about within communities and young people because of the shame and illicit nature of use. Other characteristics include:

- 'ice' is consumed through smoking rather than injecting
- It may be used in combination with marijuana: ice is used for 2–3 days followed by marijuana use to come down on
- Associated cost is high — around \$750 — \$1,000 per week is not unusual
- Trade is conducted mainly through mobile phone rather than the traditional perception of street corner deals. It is therefore more invisible but there are lots of runners to do the drop offs.⁸¹¹

A lack of information about ice and its effects

The CMY were also of the view that young people and their families are often ignorant of or misinformed about crystal methamphetamine and its effects and very little information is sought from, or provided by, formal sources such as mainstream AOD services:

Young people tend to get their information or talk about the issue with other young people rather than family member or other adults. Similarly, we suspect community or family members tend to talk to other community or family members rather than approach formal services. The level or quality of information through these informal networks is difficult to ascertain. Anecdotally, we understand that they are very poorly informed and don't fully understand all of the impact and consequence of the use of 'ice'.

809 There is a reasonable amount of research collected on (injecting) drug use among Vietnamese youth. Most of it, however, focuses on heroin. See for example, Kelsall et al. 1999; Louie et al. 1998; Reid et al. 2002.

810 Ms Carmel Guerra, Chief Executive Officer, Centre for Multicultural Youth (CMY), Submission, 4 August 2014.

811 Ms Carmel Guerra, Chief Executive Officer, Centre for Multicultural Youth (CMY), Submission, 4 August 2014.

The submission also stated that in many cases the use of crystal methamphetamine by CALD youth is unknown to their parents or families, with many users not communicating to their families about their drug use:

CALD families are, in the main, ignorant of the types of drugs available and the extent of use by young people in their communities and unaware of how widespread 'ice' has become in the last five years. Community elders/community members (often adults) are often uninformed and condemning of young people's behaviour, making it hard for young people to find support within their communities. Conversely, the use of 'ice' appears to carry a larger notion of 'shame' for young people. For instance, CMY's bi-cultural African youth out-reach worker is well connected to networks of highly dis-engaged African young people in the west. He works with young people who are involved in drug and alcohol use, disconnected from family and community and who hang out in the parks with their peers. They have come to trust the worker and often use him as a "go to" point of contact and support. It was only recently that the worker discovered that alcohol use was often used as a cover for 'ice' use by young people as they themselves considered 'ice' as too taboo and shameful to disclose. However, the issue of 'ice' was frequently spoken about amongst youth peer networks.⁸¹²

Access, impact and reasons for use

The submission also stated that young people from CALD backgrounds in the northern and western suburbs of Melbourne are being introduced to the drug from both within and outside friend and community networks:

Young people are often introduced to 'ice' by older friends, siblings and sometimes friends and acquaintances from outside their communities. Once they have formed a habit, a number of complex and inter-related issues arise. They include:

- More family violence incidents
- Involvement in crime networks to support the habit
- Involvement in petty crime — shoplifting, theft
- Higher contact with the police and youth justice system
- More acts of serious/sudden violence in the community owing to how 'ice' changes behaviours of users
- Young people disconnecting from their families.⁸¹³

The experience of CMY workers is that the reasons for crystal methamphetamine usage are 'many and varied':

However, issues of mental health are coming to the fore. Of particular concern too is the use of 'ice' by young women of African and Pasifika backgrounds as a weight loss strategy, often in ignorance of the longer term health cost.⁸¹⁴

The latter point is of particular interest as it accords with the evidence received by the Committee about reasons for use by young women, and to a lesser extent some men, in the mainstream community.⁸¹⁵

Challenges facing the CALD community with regard to ice use

The submission from CMY mentions that there are a number of important challenges for young people (or their families) who may seek the assistance of mainstream services to address their ice use. First, people from CALD backgrounds require culturally competent and flexible services:

812 Ms Carmel Guerra, Chief Executive Officer, Centre for Multicultural Youth (CMY), Submission, 4 August 2014.

813 Ms Carmel Guerra, Chief Executive Officer, Centre for Multicultural Youth (CMY), Submission, 4 August 2014.

814 Ms Carmel Guerra, Chief Executive Officer, Centre for Multicultural Youth (CMY), Submission, 4 August 2014.

815 See discussion in Chapter 13.

Mainstream services need to be supported to deliver on culturally appropriate responses which include

- Individual worker's capability and capacity to be culturally competent, and
- Organisational capability in having the processes and systems, values and flexibility to allow for cultural responsiveness.⁸¹⁶

Moreover, the submission argues that there is a lack of clear service linkages to respond to multiple needs.

For instance, mental health issues can be perceived as a 'drug-led' issue, needing a response from the drug and alcohol system, or vice versa. In the meantime, while the issue is being tossed from one service system to another, the young person is left without any support and will disengage from services. There is a need for dual diagnosis service options to address the complexity of drug use as the issues cut across service systems.

A further issue relating to service coordination is the need for improved linkages between other service systems, eg. improvement in information sharing/joint case management between youth justice, police, mental health and drug & alcohol services. Treatment services and support services cannot be divorced from the consequences of offending behaviours.⁸¹⁷

The submission also argues that a further service improvement needed across all types of services is the overall principle of engaging families in communities in working with young people. For instance, Crisis Assessment Teams (CAT) should be more closely engaging families to provide direct and accurate information to family members.⁸¹⁸

Moving forward

Finally the submission recommends a number of interventions to 'go forward' to address ice youth in CALD communities. These include:

- Given the taboo and 'shame' associated with the use of 'ice', greater community and youth engagement is needed to inform any strategy. The following initial steps are proposed:
- Employment of bi-cultural youth facilitators to work alongside bi-cultural youth outreach workers (mental health, drug & alcohol services, police) to build trust and service pathways into mainstream services.
- Bi-cultural workers to work with families and communities to initiate conversations/discussions with communities and community leaders about the causes of drug use and prevention. By doing so, it will inform the ways in which communities speak about drugs especially 'ice' and the language they use instead of the mainstream discourse about 'ice'.
- Support and resource community associations eg. African Think Tank, United Pasifika Council of Victoria to help their own communities to speak about the issue and to support them to find ways of addressing the issue.
- Work with communities and young people to develop more appropriate resources on drug education.
- Youth-led approaches involving ex-users to deliver drug and alcohol education in schools, youth justice settings and community setting.
- Resource a range of youth-led, youth leadership opportunities in sports, arts, community cohesion projects to give young people other opportunities for social connections and a healthier sense of belonging.
- Online resources: may be of help for some young people but often the language in which it's written is not youth-friendly. For family or community members where English is not their first language, online resources offer very little information in other languages.⁸¹⁹

816 Ms Carmel Guerra, Chief Executive Officer, Centre for Multicultural Youth (CMY), Submission, 4 August 2014.

817 Ms Carmel Guerra, Chief Executive Officer, Centre for Multicultural Youth (CMY), Submission, 4 August 2014.

818 Ms Carmel Guerra, Chief Executive Officer, Centre for Multicultural Youth (CMY), Submission, 4 August 2014.

819 Ms Carmel Guerra, Chief Executive Officer, Centre for Multicultural Youth (CMY), Submission, 4 August 2014.

Whilst there is a lack of formal research into crystal methamphetamine (and other drug) use in CALD communities, the insights given in the CMY submission are a valuable addition to understanding both the problems facing CALD communities associated with methamphetamine use and possible interventions to address it.

The Culturally and Linguistically Diverse Alcohol and other Drugs Project

A current project that is examining drug use in CALD communities in Victoria is being undertaken by the Victorian Alcohol and Other Drug Association [VAADA]. In 2013 the Victorian Alcohol and Drug Association (VAADA) received funding from the Department of Health to deliver the CALD AOD Project.

This two year project, which will run from January 2014 to December 2015, aims to support Victorian drug treatment services to improve outcomes for individuals and families in CALD communities who are affected by harmful alcohol and other drug use. More specifically its objectives are to:

- ◆ Inform improved access to culturally appropriate drug and alcohol information and services
- ◆ Inform improved cultural competence of staff in alcohol and drug treatment services so that they can more effectively work in cross-cultural situations

In order to achieve these objectives a number of activities will be undertaken, including a targeted literature review, training needs assessment, consultations with CALD and AOD stakeholders, identification and customisation of culturally appropriate resources and the development of strategies so that these resources reach those in need.⁸²⁰

A growing problem?

Notwithstanding the dearth of ethnic specific studies into methamphetamine use, some evidence has been given to the Committee that methamphetamine use may be increasing amongst refugee and asylum seeker communities, as a result of settlement failure over previous decades: 'this is particularly prevalent among young men who are experiencing housing insecurity, low rates of employment, disengagement with education/training and detachment from their cultural communities'.⁸²¹

Mr Gary Pearse, Vice-President, of the Sunraysia Mallee Ethnic Communities Council (SMECC), believed this was true of some ethnic and refugee groups residing in the Mildura district where younger generations 'may be exposed to a completely new way of life' attendant with new freedoms and new temptations including recreational drug use.⁸²² The Committee notes that in Melbourne some agencies are also reporting increased illicit drug use, including methamphetamine, amongst new arrivals particularly in groups for whom alcohol is forbidden for religious or cultural reasons.

For example, Youth Projects, based in the northern suburbs of Melbourne, reported that methamphetamine use was becoming prevalent amongst African youth and that:

We think for some in emerging communities and different religious and ethnic groups there is a prohibition on alcohol where they perceive there is no such prohibition on illicit drug use. So that is a better way to get high...

...the north-western area is very culturally diverse but particularly concentrated with Lebanese, Muslim and religious cultures, there may be a smaller sector where they could say 'alcohol is not within our

820 Information provided by Sam Biondo, Executive Officer, VAADA in correspondence with the Law Reform, Drugs and Crime Prevention Committee, 3 July 2014.

821 Ms Lyn Morgain, Chief Executive Officer, Western Regional Health Centre, Submission, 22 October 2013.

822 Mr Gary Pearse, Vice-President, Sunraysia Mallee Ethnic Communities Council (SMECC).

religious beliefs yet drugs are.’ So if you imagine that you are a teenager — and this has come from the clinicians at Youth Project — they often hear stories where the client will come in and say, ‘Look, Mum and Dad will not accept it. Alcohol is just not right. I cannot do it. But I can do drugs’. That is not in the Koran, literally. So for some reason it is more culturally acceptable to do that.⁸²³

Given the above qualifications as to the quantum of drug use among CALD communities, and the fact that there may be many commonalities between CALD and non-CALD users, particularly young people, as to why they use drugs (curiosity, stress management), it is also true that there may be specific factors such as migration, integration and resettlement problems or language and cultural barriers that increase the risk of initiation into drug use by (young) people from CALD backgrounds (Lee et al. 2007, p.57). However with the exception of the instances cited above, unfortunately the Committee has received very little input from the public about experiences of methamphetamine use in non-‘Anglo’ communities.

The use of methamphetamine as a therapeutic drug

As discussed in Chapter 3, various forms of amphetamines have been prescribed by doctors for a variety of health conditions. In the context of the therapeutic use of amphetamine type stimulants (ATS), dexamphetamine becomes ‘a medication that instils discipline rather than producing pleasure’ (Keane 2008, p.402). With regard to ADHD there is little indication of abuse, euphoria or pleasure associated with ATS use (Dwyer et al. 2012).⁸²⁴

Such usage, however, may not be merely an historical footnote. For example, the amount of prescription amphetamine use for ADHD has apparently increased dramatically in Australia over recent years: ‘Dispensing of stimulants in Australia increased 87% between 2002 and 2009’ (Hollingworth et al. 2011 in Carson et al. 2012, p.38).

Nonetheless much use of stimulants today, particularly methamphetamine, as a ‘therapeutic agent’ tends to be clandestine. For example, some homeless clients of the welfare agency VincentCare, (which runs the shelter for men, Ozanam House) self-report that methamphetamine acts as a ‘calming relief’ for their ADHD, particularly as Ritalin has become too difficult (and expensive) to get on prescription.⁸²⁵

Evidence has also been given to the Committee that some juvenile users of legitimately prescribed dexamphetamine can go on to use recreational methamphetamine. For example, Mr Eion May, an alcohol and drug worker with the Gippsland Lakes Community Health Service, gave evidence that some of the methamphetamine clients he sees have had histories of ADHD and had been taking dexamphetamine or other therapeutic forms of amphetamine to control the disorder which may have potentially led to methamphetamine abuse later in life:

Another interesting thing is the profile [of some users]. It is only anecdotal and it is probably something that needs a little bit of further research, but we certainly see a lot of young men; quite often [with] a history of learning difficulties, often a diagnosis of attention deficit disorder and/or there is speculation that it may not have been diagnosed because they did not have access to a paediatrician, and often there has been, as adolescents, the prescription of dexamphetamines, or Ritalin if you like, so then they find themselves self-medicating to try and navigate a life... I have had a number of, again, young men particularly who had a diagnosis as a young person of attention deficit disorder and being prescribed dexamphetamines and then often finding that, upon turning 18, they no longer saw the paediatrician and went and saw their local GP and were no longer prescribed Ritalin. They found their way onto ice,

823 Ms Melanie Raymond, Chairperson, and Ms Kate Hunt, Collaborations and Development Officer Youth Projects, Public Hearing, Melbourne, 3 February 2014. See also comments of Mr Les Twentyman, OAM, 20th Man Fund.

824 The prescription of dexamphetamine to children, whilst arguably problematic, is a different and separate issue beyond the scope of this Inquiry.

825 Mr John Blewonski, Chief Executive Officer, VincentCare Victoria, Submission, 21 October 2013. See section below for a discussion of methamphetamine use amongst homeless people.

and so they are saying, 'If only there was some sort of support for me to more slowly make changes in my medication regime', or, 'If only there was something else that I could take'.⁸²⁶

Or the reverse may happen. One client of the Salvation Army's Alcohol and Other Drugs Unit in Geelong brought to the Committee's attention the case of a client who was diagnosed with ADHD late in life who had been up until that stage self-medicating with dexamphetamine:

Interestingly, I happened to speak to a gentleman the other day who confided that he had been on dexamphetamine for 10 years, there is a GP that prescribes it, and it can be done for prior speed use. For him it turned out he was self-medicating. He was not diagnosed with ADHD until his 40s. For many years he had been self-medicating with speed around his ADHD but was not aware of that.⁸²⁷

Methamphetamine use amongst the homeless and poor

Methamphetamine is becoming a drug of choice for the homeless and itinerant according to some witnesses who gave evidence to the Inquiry. Staff from various welfare agencies testified to the increasing number of homeless people, often quite young people, using 'ice'. For example, VincentCare has estimated that 'at any one time three quarters of the Ozanam House⁸²⁸ population are using ice usually in combination with other drugs and alcohol'.⁸²⁹ Similar reports as to the magnitude of the problem particularly amongst homeless youth were also given by Melbourne City Mission:

In our homelessness services, staff note that when clients are using methamphetamine, they:

- Typically present to the service paranoid and aggressive — they can often be violent and threatening
- Find it difficult to concentrate and appear confused
- Display poor emotional self-regulation — including a heightened intolerance for normal and standardised worker/client conversations, reduced capacity or willingness to take responsibility for actions
- Have an absence of structure
- Are often in financial difficulty and are requesting material aid — budgeting for food is a particular issue
- Show a lack of self-care — there are hygiene issues that are not evident when clients are not using.⁸³⁰

Homeless young people in rural Victoria have also been reported to have had a problematic relationship with crystal methamphetamine. For instance, JSS gave evidence to the Committee that of 30 young people who had recently presented to their agency as homeless, 11 (36 percent) had disclosed they were using crystal methamphetamine.⁸³¹

Many of these methamphetamine users may also have severe mental health disorders and a history of trauma and dislocation.⁸³² Methamphetamine may also be used as a form of self-medication by the homeless and/or seriously impoverished.⁸³³ This may be particularly

826 Mr Eion May, Alcohol and Drug Worker, Gippsland Lakes Community Health Centre, Public Hearing, Traralgon, 28 January 2014. See also Mrs Sue Medson, Chief Executive Officer, Gippsland Lakes Community Health, Submission, 21 October 2013.

827 Ms Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013.

828 A 60 bed crisis accommodation hostel for homeless men.

829 Mr John Blewonski, Chief Executive Officer, VincentCare Victoria, Submission, 21 October 2013.

830 Rev Ric Holland, Chief Executive Officer, Melbourne City Mission, Submission, 1 November 2013.

See also the comments of Ms Melanie Raymond from Youth Reports in the context of youth homelessness and disadvantage. Ms Melanie Raymond, Chairperson, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

831 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014.

832 Mr John Blewonski, Chief Executive Officer, VincentCare Victoria, Submission, 21 October 2013.

833 Mr John Blewonski, Chief Executive Officer, VincentCare Victoria, Submission, 21 October 2013; Rev Ric Holland, Chief Executive Officer, Melbourne City Mission, Submission, 1 November 2013.

the case for homeless Aboriginal people who could have difficulty in accessing mainstream homelessness and substance abuse services.⁸³⁴

Finally, reports have been given to the Committee that it is 'not unknown' for homeless people to use methamphetamine to stay awake on the streets in order to avoid being attacked or robbed.⁸³⁵

Even those people who are not technically homeless may live in circumstances of extreme poverty, in part due to unemployment or underemployment⁸³⁶ and/or their drug induced debts.⁸³⁷ Methamphetamine, however, is reported as being affordable and accessible by homeless clients at least in comparison to other drugs.⁸³⁸

People in such circumstances may have little choice but to live in substandard accommodation which may discourage the continuation of drug rehabilitation therapy after an initial period of withdrawal with a treatment agency. The environment of a deficient living space (or worse no home) may consequently contribute to them recommencing their drug use.⁸³⁹ This point was underscored by Dr Andrew Crellin from Ballarat Health Services when he gave evidence to the Committee:

Once we have dealt with the issues, the contact resources and accommodation options locally in terms of disposition of these patients are very poor. We end up sending a lot of these patients to guesthouses if they don't have other accommodation options, where they are again just re-exposed to more alcohol use, drug use et cetera, and the resources Monday to Friday, nine till five, in terms of counselling and support services are fantastic, but outside of those hours the contact resources for helping these people in the community are not there, so if someone presents Friday night, it may be Monday before a referral can be made.⁸⁴⁰

Methamphetamine use in sport

The use of methamphetamine by athletes and sportspeople to enhance physical prowess is a classic example of situational drug use; that is, where drugs are used with a specific, usually functional, purpose in mind.

Whilst there is little research data on the links between methamphetamine and sport; evidence has been given to the Committee that methamphetamine use if not 'rife' is not uncommon by sportspeople and in sporting and recreational clubs. This may particularly

834 For a discussion of homelessness and substance abuse by Indigenous people, see ANCD 2011 and the discussion in Chapter 12.

835 Mr John Blewonski, Chief Executive Officer, VincentCare Victoria, Submission, 21 October 2013.

836 Conversely, stable employment may act as a protective factor preventing the uptake of or at least ameliorating the worst features of drug dependence. See Du Plessis and Corney 2011; Gately et al. 2011 and the discussion in Chapter 22. Contrary to this, Superintendent Malcolm (Jock) Menzel stated that employment may be maintained whilst methamphetamine usage is relatively slight or occasional but 'as usage becomes more frequent maintaining employment becomes increasingly difficult'.

Superintendent Malcolm (Jock) Menzel, Divisional Commander, Eastern Region Division 5 — Morwell, Victoria Police, Public Hearing, Traralgon, 28 January 2014.

For a discussion of unemployment often of an intergenerational nature and its relationship to substance abuse, particularly in rural and regional Victoria see the discussion in Chapter 11 and in the context of the relationship of unemployment, poverty and (youth) homelessness the comments of:

Mr Martin Hawson, General Manager, Community and Culture, Mildura Rural City Council, Public Hearing, Mildura, 5 December 2013; Ms Fiona Harley, Deputy Executive Director, Mallee Family Care, Public Hearing, Mildura, 5 December 2013; Ms Kaz Gurney, Managing Lawyer, Goulburn Valley Community Legal Centre, Public Hearing, Shepparton, 25 February 2014.

837 Which may in turn result in not being able to pay rent for their rental property; not being able to raise money to put a deposit on a house or if they do 'own' a house, having the banks foreclosing for their inability to pay the mortgage. See Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014.

838 Rev Ric Holland, Chief Executive Officer, Melbourne City Mission, Submission, 1 November 2013.

839 Mr John Blewonski, Chief Executive Officer, VincentCare Victoria, Submission, 21 October 2013.

840 Dr Andrew Crellin, Director of Emergency, Ballarat Health Services, Public Hearing, Ballarat, 18 November 2013.

be the case given methamphetamine, unlike alcohol, tends not to result in either weight gain or a hangover, thus being particularly attractive for athletes.⁸⁴¹

Drug use in sport may take place at either professional or community levels.

The use of methamphetamine in elite sport

There has clearly been significant media attention paid to prominent and elite sportspeople who are alleged to have used methamphetamine; AFL footballer Ben Cousins being a notable example.⁸⁴² The mass media intensely scrutinises elite athletes and drug use with 'widespread reporting of athletes testing positive to banned substances'.⁸⁴³ While that scrutiny is most acute when athletes are suspected of using performance-enhancing drugs, it also occurs in the context of recreational drug use including methamphetamine. In spite of the media's interest, the little research that has been undertaken suggests that the use of methamphetamine by elite sportspeople in Australia is limited.

Recently completed research conducted by Australian researchers Thomas et al. provides an insight into the use and prevalence of methamphetamine among elite sportspeople. The research was based on a survey of 974 elite sportspeople, including athletes from the Australian Institute of Sport (AIS), in relation to illicit drug use including methamphetamine. Thomas et al. found that elite athletes perceived illicit drug use, including methamphetamine as something that would 'negatively impact athletic performance'.⁸⁴⁴ Athletes were specifically asked about ketamine, GHB, cocaine, meth/amphetamine, ecstasy and cannabis use, with the majority of respondents indicating that these would negatively impact performance (75.3%).⁸⁴⁵ Interestingly, the respondents identified mental health issues as negative impacts of using these drugs (such as addiction, psychosis, and depression), but more so for meth/amphetamine.⁸⁴⁶ The researchers separately investigated the prevalence of illicit drug use among elite Australian athletes, with a focus on recreational drugs including meth/amphetamine. They found that one-third of the respondents had been offered or had the opportunity to use illicit drugs, in the year preceding the survey. In spite of that, the self-reported prevalence of drug use for elite athletes was lower than that reported for the general population. When nominating the drug of concern in their sport, 16% nominated cocaine, ecstasy and alcohol.⁸⁴⁷ In contrast, very few respondents reported meth/amphetamine (3.2% of the sample) as being problematic.⁸⁴⁸ Given the dearth of research, the study conducted by Thomas et al. provides a good reference point for assessing the prevalence of methamphetamine in elite sport, which appears to be quite limited. Such a conclusion is bolstered by the extremely small number of positive drug tests conducted by the Australian Sport Anti-Doping Authority (ASADA).

The drug testing regime in Australia is the responsibility of ASADA and the Anti-Doping Rule Violation Panel (the Panel) in conjunction with peak sport organisations and their administrators. Under the regime, ASADA is responsible for implementing the World Anti-Doping Code (the Code), investigating doping violations (including the carrying out of

841 See Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

842 Mr Cousins was suspended for 12 months by the AFL for bringing the game into disrepute on the basis of public incidents related to drug issues. See Seear & Fraser 2010, 'The "sorry addict": Ben Cousins and the construction of drug use and addiction in elite sport'.

843 See Dunn et al. 2011, 'Recreational substance use among elite Australian athletes'. See also Seear & Fraser 2010, 'The "sorry addict": Ben Cousins and the construction of drug use and addiction in elite sport'.

844 Thomas et al. 2010, 'Elite athletes' perceptions of the effects of illicit drug on athletic performance', p.189.

845 Thomas et al. 2010, 'Elite athletes' perceptions of the effects of illicit drug on athletic performance'.

846 Thomas et al. 2010, 'Elite athletes' perceptions of the effects of illicit drug on athletic performance'.

847 Dunn et al. 2011, 'Recreational substance use among elite Australian athletes'.

848 Dunn et al. 2011, 'Recreational substance use among elite Australian athletes'.

drug tests) and enforcement action.⁸⁴⁹ The Panel is responsible for making decisions under the *Australian Sports Anti-Doping Authority Act 2006* on doping violations, and established and maintains the Register of Findings on which doping violations are listed.

Elite sports and sportspeople are subject to ASADA drug testing both during and in between sporting events. Methamphetamine is an illicit drug under the code and therefore subject to drug testing and enforcement action by ASADA. An analysis of ASADA published drug violations is illustrative of the limited use of methamphetamine by elite sportspeople in Australia. In the period between 2007-08 and 2012-2013, a total of six athletes were found to have used methamphetamine or amphetamine, from a total of 194 publicly announced doping violations.⁸⁵⁰ Given that ASADA conducts 6000–7500 drug tests in each financial year period, with at least half of these occurring in the off-season,⁸⁵¹ the six doping violations are an extremely small number.

Given the limited research in this area, it is difficult to gauge the prevalence and usage of methamphetamine among and by elite sportspeople. However, given the ASADA doping violations, the Committee believes that methamphetamine use, as a performance enhancing or recreational drug, is rare in elite sport something which may be explained by the negative perceptions held by sportspeople of this and other recreational drugs on performance.

The use of methamphetamine in community sport

Whilst, there has clearly been significant media attention paid to prominent and elite sportspeople who have used methamphetamine; concerns have also been expressed about an increasing trend for methamphetamine to be used by people engaged in sport at local and amateur levels. For example, Dr Stefan Gruenert of Odyssey House Victoria told the Committee how a new cohort of users — kids in sporting clubs — were using methamphetamine to enhance sporting performance. Often such sportspeople may also be ‘tradies’ who are using methamphetamine on a Friday or Saturday night after the game in a recreational setting — ‘a whole new cohort of people who have not been exposed to harm reduction messages’.⁸⁵²

Ms Karen Heap from the Ballarat Aboriginal Co-operative expressed her concerns on this issue to the Committee:

It is quite a large problem amongst the football clubs in Ballarat, and it was quite disturbing for me, having a young son myself, to hear that it is quite common for it [methamphetamine] to be offered at parties held by the football clubs. I also found out recently that an 18-year-old went to a nightclub and it took him a while to get served a beer because they were dealing drugs at the other end of the bar. That is anecdotal, of course, but it was quite disturbing to hear that — how common it is and how out there it is. There just does not seem to be any fear amongst people that it has crept into sports clubs and nightclubs. It is not all just underground like originally I guess we thought it was, so that was quite disturbing.⁸⁵³

Similarly, Mr Peter Wearne told the Committee that methamphetamine use and distribution was apparent in some amateur sporting clubs in Gippsland:

849 ASADA, *About Asada*, 2014, accessed at <http://www.asada.gov.au/about/index.html>

850 See: ASADA, Annual report, 2008/09, pg. 114. Annual report ASADA, 2012-13, pg 52. Annual report, ASADA, 2007/08, Appendix B. Annual report ASADA, 2012-13, pg 52. Appendix B, annual report, 2008/09 Annual report ASADA, 2012-13, pg 52. Annual report 2009/10, Appendix B, accessed at http://www.asada.gov.au/publications/annual_reports/asada_annual_report_2009_10/appendixes/appendixB.html Annual report ASADA, 2012-13, pg 52. ASADA annual report 2010/11, Appendix B accessed at http://www.asada.gov.au/publications/annual_reports/asada_annual_report_2010_11/appendixes/appendixB.html Annual report ASADA, 2012-13, pg 52. ASADA, Annual report, Appendix B. 2011/12, Annual report ASADA, 2012-13, pg 52.

851 Thomas et al. 2010, ‘Elite athletes’ perceptions of the effects of illicit drug on athletic performance’, p.192, citing the ASADA annual report 2007-08. See also the Annual report, ASADA, p.114.

852 Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, Submission, 21 October 2013.

853 Ms Karen Heap, Chief Executive Officer, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013.

We were at a public forum that was held in Warragul, and there were people there from sporting associations and sporting clubs talking about how methamphetamine — and I have had this experience in Melbourne too — has been introduced into what we call normal party or normal social circumstances [after sport].

I have been called now by half a dozen sporting clubs to come in and talk to their players about drug use, particularly methamphetamine, because they have become aware that it is so accepted within the social groups and social hierarchies of the clubs... The biggest challenge is going to be the pervasiveness of illicit drugs across the whole of society. When you hear of a coach rewarding a player with a point of methamphetamine for a good game, you realise how far back we might be starting in some areas.⁸⁵⁴

In contrast, other witnesses were less convinced that methamphetamine use is common amongst amateur sportspeople. For example, Gippsland Lakes, drug and alcohol worker Mr Eion May, himself an amateur league footballer, told the Committee:

Because I am a president of one of the local football clubs in Bairnsdale and a footballer myself, and a drug and alcohol practitioner... I guess that gives me a little bit of insight there. Substance use happens quite commonly in most sporting clubs and social environments. Usually alcohol is the most common lubricant and therefore tends to be the one that is also the most problematic.

Members of the East Gippsland community use methamphetamine, so therefore you will find there are members of sporting clubs, including football clubs, in East Gippsland that use amphetamines. Unless the guys I am playing with are not telling me something and through what I have learned as a drug and alcohol clinician I am completely missing what I am seeing in them, it is certainly not an issue with the clubs. It is not an epidemic. It is not an issue that we as a club are having to work at addressing. In the club that I was president of there were some young men who did use it and it did in fact become problematic for them. [But] if we are talking about 150 to 200 footballers then we are talking about two for whom it is problematic. Perhaps it is an unacceptable number of people but it is still not the majority that is using it.⁸⁵⁵

Whatever the levels of methamphetamine use amongst athletes and in sporting clubs, it is acknowledged by the Committee that in many, indeed most, sporting clubs the management or administration would neither encourage nor condone such use. In fact many clubs may not be aware that it is going on. Nonetheless this is an issue of concern and one that needs to be addressed.⁸⁵⁶

Methamphetamine users in nightclubs and entertainment venues

As previously discussed, methamphetamine may be used in the context of gay nightclubs and dance-clubs, particularly as an aphrodisiac and/or to facilitate mood and enhance energy. This may also be the case in the mainstream/non-gay entertainment scene where young people in particular may use methamphetamine as a so-called 'party drug' before, during or after a night out at a pub, club or music or dance venue. Given that dance clubs and nightclubs are an integral part of youth culture, a discussion of methamphetamine use in such venues is discussed further in Chapter 13.

854 Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

855 Mr Eion May, Alcohol and Drug Worker, Gippsland Lakes Community Health Centre, Public Hearing, Traralgon, 28 January 2014.

856 For further comment on the possible use of ice in community or amateur sporting clubs see: Mr Geoff Munro, National Policy Manager, Australian Drug Foundation, Public Hearing, Melbourne, 14 October 2013; Mr Richard Marchingo, Ambulance Paramedic, Ambulance Victoria, Public Hearing, Bendigo, 25 October 2013; Ms Shea Grant, Advanced Life Support Paramedic and Team Manager, Ambulance Victoria, Barwon District, Public Hearing, Geelong, 28 October 2013; Ms Jo Warren, Health Unit Manager, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013; Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

Conclusion

As this chapter has suggested, why and how ice is used may vary considerably according to the profile of the user and the context in which they use. There is, however, little comprehensive research being undertaken on the profiles of those who use methamphetamine. This is particularly the case with regard to women, the homeless and people from CALD communities.⁸⁵⁷ Nevertheless, what this chapter does demonstrate is that strategies to address methamphetamine use cannot be based on a 'one size fits all' template — this is particularly the case when it comes to the treatment and support needs of discrete populations. Whilst there may be many similarities in the use patterns of the drug and the reasons why it is used across different groups, there are also notable differences that need to be factored into our understanding of methamphetamine use.

Recommendation 10

The Committee recommends that the Victorian Government undertake an Inquiry into the Victorian child protection system and its capacity to respond to all high-risk cases involving children and young people impacted by methamphetamine use.

Recommendation 41

The Committee recommends that the Victorian Government in developing drug policy and in the delivery of services, in the area of methamphetamine, ensure the specific needs and requirements of young people, women, and people from Gay Lesbian Bisexual and Transgender communities be taken into account.

⁸⁵⁷ See discussion on research gaps with regard to methamphetamine in Chapter 31 of this Report.

PART E

Manufacture, Supply and Distribution of Methamphetamine

15. Direct Importation

Introduction

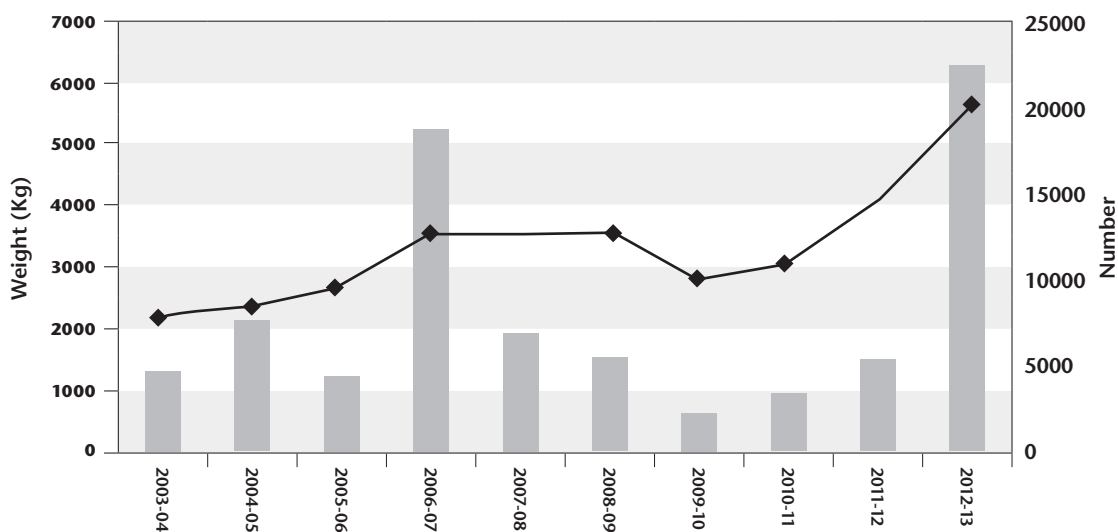
In order to restrict the supply of methamphetamine and crystal methamphetamine in Victoria, it is necessary to understand how the drug is produced and where its constituent elements are sourced. This chapter examines the various ways in which both final product and precursor chemicals are brought into Victoria. Subsequent chapters will consider how drugs are manufactured and distributed. Evidence is presented on the extent to which law enforcement agencies, at Commonwealth, state and territory level, detect and seize both drugs and precursor chemicals at Australia's international border and at borders within Australia. The Committee questioned whether border detections have increased and what problems arise for law enforcement agencies in knowing which cargo to target for inspection. The Committee examined the origins of drugs and precursors and whether they are imported directly from particular overseas countries or are obtained from legitimate sources, such as chemical companies and pharmacies in Australia. Finally, this chapter explores the evidence regarding the use of online markets for the sale of methamphetamine and crystal methamphetamine, and whether Victorians make use of these to obtain drugs.

Law enforcement drug seizures

Australian Crime Commission data

The primary source of evidence concerning the importation of illicit drugs into Australia is the Australian Crime Commission (ACC). According to the ACC's *Illicit Drug Data Report* (IDDR) the weight of ATS seizures has increased by 310.4 percent, from 1,572.6 kilograms in 2011-2012 to 6,453 kilograms in 2012-2013 (ACC 2014a). The ACC's report also presented information on the methods of importation of ATS detected at the national border. The postal stream was associated with the majority of ATS (excluding MDMA) detections accounting for 86.1 percent of detections in 2012-2013 (ACC 2014a). Other importation methods were found in smaller proportions with air-cargo comprising of 9.5 percent of detections followed by importation by air passenger or crew (3.6%) and by sea cargo (0.8%). In terms of the number of ATS seizures, since 2003-04 this has continued to increase, with the number in 2012-2013 being the highest on record, as shown in Figure 15.1. Between 2011-12 and 2012-13 there was a 38.6 percent increase in national ATS seizures from 15,191 in 2011-2012 to 21,056 in 2012-2013 (ACC 2014).

Figure 15.1: National ATS seizures, by number and weight, 2003–04 to 2012–13



Source: ACC IDDR 2012-2013, Figure 17, p.49.

The submission from Ms Judith Lind, Executive Director of the ACC, suggested that this increase was largely due to the rising popularity of crystal methamphetamine.⁸⁵⁸ However, it is also thought that domestic manufacture may be responsible for a proportion of the market, although the rate of increase of imports exceeds the rate of increase of domestically manufactured methamphetamine (ACC 2014a). Ms Lind’s ACC submission to the Committee gave examples of recently detected importations of methamphetamine into Victoria:

129.7 kilograms of liquid methylamphetamine detected on 14 October 2011, suspended in liquid, via sea cargo from Mexico to Melbourne and 26 kilograms of crystal methylamphetamine detected on 20 March 2012, declared as plastic toys, glass beads and stone, via air cargo from Hong Kong to Melbourne.⁸⁵⁹

Australian Customs and Border Protection Service data

The other source of information on international importation is the Australian Customs and Border Protection Service (ACBPS). Border controls designed to detect illicit drugs and precursors are implemented by ACBPS personnel who make use of law enforcement intelligence coupled with strategic cargo examinations. Techniques of concealment are, however, increasingly innovative and sophisticated. For security reasons, the Committee is not at liberty to disclose all the ways in which drugs were imported, or the methods used for their detection.

National detections

The latest ACBPS annual report for the 2012-13 financial year provides the number and weight of ATS and crystalline methamphetamine (ice) detections at national borders.

Table 15.1 shows that there were no significant changes in ATS detections between 2010-2011 and 2012-2013. However, the weight of ATS detected between the period from 2010-2011 and 2011-12 increased from 41.5 kilograms to 187.4 kilograms (146%). Furthermore, between 2011-2012 and 2012-13, there was a further increase in detection from 187.4 kilograms to 608.7 kilograms (511%). In regard to the detections of crystalline methamphetamine, significant increases were found between 2011-2012 and 2012-2013 (i.e. from 171 to 1,084 detections of ice). The weight of methamphetamine detected during that period also

858 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

859 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

increased from 160.2 kg to 1,456.2 kg (ACBPS 2013). These figures demonstrate growth in the national ATS and crystal methamphetamine market in the recent years, presumably driven by high demand, as well as the effectiveness of efforts to intercept the drugs.

Table 15.1: Number and weight of amphetamine-type stimulants and crystal methamphetamine (ice) detections at national borders

Description	Detections			Weight (kg) ^(a)		
	2010-11	2011-12	2012-13	2010-11	2011-12	2012-13
ATS ^(b)	917	907	917	41.5	187.34	698.7
Crystalline methamphetamine (ice) ^(c)	160	171	1,084	63.8	160.2	1,456.2

Note: ATS= amphetamine-type stimulants.

- Weight shown in the above table is an estimate. Weight is calculated using 0.29 grams per tablet where a weight was not available. Some small quantity shipments of ATS do not have weight recorded, so these weight figures are a slight under estimate.
- ATS includes amphetamines and methamphetamine in liquid, capsule, paste, powder or tablet form. Figures do not include MDMA (ecstasy) or crystal methamphetamine (ice).
- Crystalline methamphetamine is shown separately, but would usually be included in ATS figures.

Source: Australian Customs and Border Protection Service Annual Report 2012-2013, pp.62.

It has been emphasised by the ACBPS that methamphetamine and its precursors remain popular materials for importation into Australia. This is mainly due to the fact that the price of methamphetamine is significantly higher in Australia than many other countries.⁸⁶⁰ Multi-national drug syndicates are exploiting opportunities to export these drugs into the Australian market. Further information on the border situation associated with the importation of methamphetamine and precursor chemicals used for the production of ATS was provided in the ACBPS submission. Table 15.2 presents data from 2004 to 2014.

Since 2009, there has been a substantial increase in the number of methamphetamine detections at the national border (218 in 2013 as compared to 37 in 2009). It is important to note that between 2011 and 2013, there was a substantial increase in both the number of seizures and the quantity of the drug seized at the national border. Increases in the number of methamphetamine seizures were preceded in 2011 by a large-scale increase in the seizure of ATS precursor chemicals intercepted. Information given by the ACBPS directly to the Committee shows that the increases in detection and seizures seen nationally have also been seen in Victoria, for crystal and other forms of methamphetamine as well as ATS precursors.⁸⁶¹

860 Mr Roman Quaadvlieg, Deputy Chief Executive Officer, Border Enforcement, Australian Customs and Border Protection Service, Submission, 11 April 2014.

861 Mr Roman Quaadvlieg, Deputy Chief Executive Officer, Border Enforcement, Australian Customs and Border Protection Service (ACBPS), Submission, 11 April 2014.

Table 15.2: National Border Methamphetamine and Amphetamine Type Stimulant (ATS) Precursor Seizures

Year	Methamphetamine		Crystal Methamphetamine (1)		ATS Precursors (2)		Total	
	Number	Kilograms	Number	Kilograms	Number	Kilograms	Number	Kilograms
2014 (3)	28	63.5	146	318.8	142	142.4	316	524.7
2013	218	717.9	1228	1579.1	1217	2108.4	2663	4405.4
2012	188	64.8	607	592.2	800	1331.5	1595	1988.5
2011	64	149.1	136	106.9	944	1423.8	1144	256.0
2010	69	10.1	150	44.9	150	44.9	910	676.8
2009	37	27.9	54	56.1	352	631.0	443	715.0
2008	27	1.3	28	238.3	311	2599.8	366	2839.4
2007	66	5.2	181	86.2	515	346.2	762	437.6
2006	20	13.1	25	2.1	495	185.8	540	201.0
2005	16	17.2	20	66.0	320	485.9	356	569.1
2004	11	16.0	11	115.0	259	30.9	281	161.9

1) Pseudoephedrine, Ephedrine, Phenyl-Propane (P2P)

2) As at 28 February 2014

Note: Figures are subject to slight variation as updated data is received and adjustments made.

Source: ACBPS submission, April 2014, p.8.

The increase in the number of arrests relating to methamphetamine seized at the border and the substantial increase in quantity of the drug and its precursors are indicative of a potential increase in the demand for the drug in Australia in recent years. However, caution should be exercised in drawing such conclusions as increased detections could simply reflect increased law enforcement activity. Similarly, research would need to be conducted to assess the extent to which drugs imported are sold to users in Australia. In conversation with the Committee, AFP Assistant Commissioner Jabbour described the nature of activities at the border:

If we look at the amphetamine seizures Australia-wide, there has certainly been an increase since 2004. Between 2004 and 2010 we were looking at approximately 250 kilograms being seized per year. In 2011 we had an increase of up to 680 kilograms, and in 2012 there was one particular job, which is still before the courts, where we seized 4.4 tonnes of MDMA with a number of arrests being made. We are now talking Victorian-based, and I think that is a case that is well known through the media, albeit that it is still a matter before the courts. These very large seizures were being attempted to be imported into Australia, or in this case particularly Victoria, from overseas, and we allege by sophisticated organised criminal syndicates which have tentacles both in this country and reaching out through numerous countries overseas.⁸⁶²

In light of the extent of such detections at the border, the Committee requested ACBPS to provide further information regarding its capacity to identify and detect drug importations. The Committee was particularly interested in the current screening technologies used at the border, intelligence-sharing capabilities and strategies developed by the ACBPS to restrict the importation of illicit drugs and precursors into Australia. The ACBPS reported:

All cargo screening is underpinned by intelligence to make informed judgements about which consignments should be examined. This allows the ACBPS to employ resources to target at-risk cargo,

⁸⁶² Assistant Commissioner Ramzi Jabbour, National Manager, Serious and Organised Crime, Australian Federal Police, Public Hearing, Canberra, 10 February 2014.

based on threat information and risk profiling methods, to produce the most effective outcomes in detecting the movement of illicit goods. The detections are informed by a range of intelligence and information sources to produce risk profiles, resulting in targeted inspections.⁸⁶³

It is difficult to establish a direct relationship between supply and demand of drugs, although increased activity at the border is indicative of a growing prominence of the drug in the community. As previously mentioned, caution should be exercised in drawing direct causal links between law enforcement activities, the demand for certain illicit drugs and prevalence based on supply.

Victorian detections

In its submission to the Committee, the ACBPS presented data on interceptions of methamphetamine and ATS precursors detected coming into Victoria from overseas (see Table 15.1). These data show a steady increase in methamphetamine detected within the last five years (15 in 2009 to 41 in 2013). Both the number and weight of seizures at the Victorian border increased substantially between 2011 and 2013 compared with previous years. There was a large number of crystal and other methamphetamine seizures in 2013, which may indicate either increased levels of production overseas or more effective law enforcement detection capabilities. At the same time there has been a decrease in precursor chemical seizures from a peak in 2011, which may be indicative of a reduction in domestic manufacture, enhanced supply control measures, or a reduction in detections.

Table 15.1: Victoria border methamphetamine and amphetamine type stimulant (ATS) precursor seizures

Calendar Years	Methamphetamine		Crystal Methamphetamine		ATS Precursors (1)		Total	
	Number	Kilograms	Number	Kilograms	Number	Kilograms	Number	Kilograms
2014 (2)	9	26.8	49	46.1	26	10.3	84	83.2
2013	41	368.2	270	149.7	188	389.5	499	907.4
2012	22	5.3	81	72.0	192	265.8	295	343.1
2011	21	133.0	27	10.3	245	426.9	293	570.2
2010	15	1.8	18	2.4	203	84.2	236	88.4
2009	14	2.9	15	4.1	163	41.5	192	48.5
2008	1	0.008	2	66.0	123	25.0	126	91.008
2007	5	0.9	8	0.9	182	6.5	195	8.3
2006	2	0.7	5	0.008	153	17.9	160	18.68
2005	3	2.1	1	0.02	102	8.0	106	10.12
2004	3	0.1	6	0.05	73	3.4	82	3.51

Notes:

Figures are subject to slight variation as updated data are received and adjustments to previous years made.

1. Pseudoephedrine, Ephedrine, Phenyl-Propane (P2P);

2. As at 28 February 2014.

Source: ACBPS submission April 2014.⁸⁶⁴

863 Mr Roman Quaadvlieg, Deputy Chief Executive Officer, Border Enforcement, Australian Customs and Border Protection Service (ACBPS), Submission, 11 April 2014.

864 Mr Roman Quaadvlieg, Deputy Chief Executive Officer, Border Enforcement, Australian Customs and Border Protection Service, Submission, 11 April 2014.

The Australian Federal Police (AFP), in collaboration with partner agencies, also engages in operations to intercept methamphetamine and precursor chemicals coming into Australia. Assistant Commissioner Ramzi Jabbour gave the following evidence to the Committee about the nature of importation networks:

The AFP typically looks at the source countries. We look at how the illicit substances are coming into the country, and we work with customs, the ACC and others in relation to that. We reach out through the international network of AFP liaison officers and we try to determine a source. We work very effectively with the states and territories who have a far better understanding of the distribution network because the two are typically linked. We are looking at the supply, they are looking at the distribution and there is a nexus there at some point. But what percentage of product is imported versus what percentage is available locally — I am sorry, that I do not know.⁸⁶⁵

Much of the success of law enforcement operations relating to the interception of illicit drugs at the border relies on effective gathering and sharing of intelligence amongst agencies. The AFP has a lengthy history of engaging international Liaison Officers whose primary role is to ‘foster collaboration and intelligence-sharing with the host country’s law enforcement and government agencies over criminal matters’ (Ayling & Broadhurst 2013, p.3). In addition to international intelligence networks, information also needs to be shared amongst state and territory police, which is facilitated by federal law enforcement intelligence-sharing networks.

Precursor chemicals and ingredients

Importation and access

Specific issues arise with respect to the importation of precursors. The illegal production of ATS is dependent upon ready access to precursor chemicals such as ephedrine and pseudoephedrine. These could be bought as over-the-counter cold and flu remedies in any pharmacy in Australia until 2006. In 2007, the Australian Government funded a national roll-out of ‘Project STOP’, an initiative aimed at reducing the diversion of pharmaceutical products containing pseudoephedrine to the illicit drug manufacturing market (ACC 2014a).⁸⁶⁶

The process of manufacturing methamphetamine using ephedrine and pseudoephedrine is not difficult. Extracting the precursor involves simply ‘soaking the tablets in methylated spirits, decanting or filtering to remove sediment, and then evaporating the solvent, leaving the precursor’ (Schloenhardt 2007, p.24). Evidence collected during the Inquiry indicated that to obtain such precursor chemicals, criminal groups have stolen bulk supplies of medicines from pharmacies and distilled them into their constituent elements including ephedrine and pseudoephedrine. Once obtained, these chemicals can be used to manufacture methamphetamine and ice.

Victoria Police in its submission to the Committee described the channels through which both precursor chemicals and ready-made ATS enter the Australian market, and the relevant processes used to manufacture and distribute ATS in Australia.

Precursor chemicals (ephedrine and pseudoephedrine) for large-scale methamphetamine manufacture in Australia are mostly imported from overseas, although some precursors used by large scale manufacturers are obtained through diversion from local industries. Access to imported precursor chemicals is likely contributing to the success of domestic production.⁸⁶⁷

⁸⁶⁵ Assistant Commissioner Ramzi Jabbour, National Manager, Serious and Organised Crime, Australian Federal Police, Public Hearing, Canberra, 10 February 2014.

⁸⁶⁶ See Chapter 20 for further discussion of Project STOP.

⁸⁶⁷ Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

The prices of precursors imported directly from overseas can be much lower, as the ACC's submission illustrates by comparing precursor prices in China and India with prices in Australia:

According to the UNODC, pseudoephedrine can be purchased both in China and India for between US\$600 and US\$2,000 (A\$652-A\$2174) per kilogram, whereas in Australia, the 2011-12 Illicit Drug Data Report reported that price for a kilogram of pseudoephedrine ranged between A\$35,000 and A\$100,000 per kilogram, being more consistent with Customs and Border Protections figures (ACC 2013, p.10).⁸⁶⁸

Controls

There are few controls on the sale and supply of precursor chemicals in many South-East Asian and East-Asian countries, which, coupled with the relatively low prices, make importation attractive for criminals involved in illicit trade. For example, Ritter, Bright and Gong (2012) found that criminals overseas will purchase pseudoephedrine or ephedrine in bulk and send multiple smaller packages back to Australia by mail in order to ensure that at least some of the packages will not be detected.

Mr Jeremy Douglas from the United Nations Office on Drugs and Crime (UNODC) presented evidence to the Committee of the increasing availability of precursor chemicals in South-East Asian countries. He observed that:

Since 2009–10 there has been a change in the market in South-East Asia. In Thailand and Cambodia-Laos there has been crystal meth coming into the market. Again, that crystal meth often comes from Myanmar, or Burma, and it comes from China. Increasingly it is coming from countries such as India which have manufactured precursors. Now at the airport the Thais are arresting quite a lot of Indians coming in with high-purity crystal methamphetamine, so there is obviously manufacture in India. The same is happening for Pakistan; people are flying in from Pakistan. Both countries have very active pharmaceutical markets, with a lot of companies.⁸⁶⁹

Internationally, precursor controls commenced in the 1980s and 1990s in an attempt to prevent illicit ATS production, however such controls triggered a new illicit trade in pre-precursors and the use of substitute precursors that are not regulated (Schloenhardt 2007). Between 2011-12 and 2012-13 there was an 11.3 percent increase in the number of detections of ATS precursors, excluding MDMA, at Australian borders from 937 to 1,043, making the number detected in 2012-13 the highest in the last decade (ACC 2014). In the ACC's IDDR 2012-13 report, information was presented on drug profiling based on analysis undertaken by the AFP Forensic Drug Intelligence (FDI) team through the capability of the National Measurement Institute.

The results are based on the analysis of samples of methamphetamine and MDMA seized at Australian borders. The FDI team operates a forensic drug profiling capability through the National Measurement Institute which enables the identification of the synthetic route of synthesis for samples of methamphetamine and MDMA submitted from the border seizures. The capability also allows for comparisons within and between seizures to identify distinct batches of drugs or potentially demonstrate links between groups involved in illicit drug manufacture or trafficking (ACC 2014a).

Table 15.2 illustrates the results of this type of analysis for methamphetamine samples as a proportion of analysed AFP border seizures classified by precursor between 2010 and June 2013. Between January and June 2013, the principal method used to manufacture methamphetamine was based on ephedrine/pseudoephedrine (Eph/PSE) which comprised

⁸⁶⁸ Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

⁸⁶⁹ Mr Jeremy Douglas, Regional Representative for South-East Asia and the Pacific, United Nations Office on Drugs and Crime, Public Hearing, Canberra, 12 February 2014.

74.6% of samples collected through border seizures. During the period, the only other distinguishable method of manufacture from seizures at the border was found to be phenyl-2-propanone (P2P) that represented 25.5% of the samples collected (ACC 2014a).

Table 15.2: Methods of manufacture of methylamphetamine samples as a proportion of analysed AFP border seizures classified by precursor, 2010–June 2013

Year	Synthetic Route		
	Eph/PSE%	P2P %	Mixed/Unclassified %
Jan-June 2013	74.6	25.4	–
2012	71.8	19.1	9.1
2011	56.8	13.6	29.6
2010	80.4	5.9	13.7

Source: Australian Federal Police, Forensic Drug Intelligence cited in ACC IDDR Report 2012-2013, p.34.

These data have important implications for law enforcement and regulatory agencies. The ACC has been aware of this shift in manufacturing methods in recent years and determined that it is mainly due to difficulties faced by producers of methamphetamine in sourcing pseudoephedrine and ephedrine, as outlined in a submission from Ms Judith Lind, to the Committee:

A range of chemicals was identified that indicated production of both ephedrine and P2P, as well as some additional chemicals which could be used to facilitate conversion of P2P to methylamphetamine. Of note, this case provided clear evidence of offshore suppliers mislabelling original containers to avoid the interdiction efforts of Customs and Border Protection.⁸⁷⁰

Further analysis was conducted by the AFP FDI team on the total bulk weight of methamphetamine from samples of seizures at the border collected between 2010 and June 2013 (see Table 15.3). Higher proportions of samples were found to have been manufactured using Eph/PSE method in 2010 (48%), 2012 (72.2%) and between January and June 2013 (83.8%) with the exception of 2011 when the P2P method had been used in 62.8% of the total weight of methamphetamine seized at the border. In 2010, almost more than one-half (49.7%) of the samples was found to have been manufactured using mixed or unclassified techniques.

Table 15.3: Synthetic route of manufacture of methylamphetamine samples as a proportion of total bulk weight of analysed AFP border seizures, 2010–June 2013

Year	Synthetic Route		
	Eph/PSE%	P2P %	Mixed/Unclassified %
Jan-June 2013	83.8	16.2	–
2012	72.2	8.0	–
2011	35.6	62.8	1.6
2010	48.5	1.8	49.7

Source: Australian Federal Police, Forensic Drug Intelligence cited in ACC IDDR Report 2012-2013, 2014a p.34.

⁸⁷⁰ Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

Some individual border detections can be substantial. In 2011-12, for example, ACBPS detector dog teams detected 216 kilograms of drugs (98 kilograms of heroin and 118 kilograms of pseudoephedrine) concealed in a shipping container at the Sydney Container Examination Facility (ACBPS 2012). During the same year 129.7 kilograms of liquid methamphetamine were detected in sea cargo in Melbourne and 118.4 kilograms of pseudoephedrine precursor chemical detected in sea cargo in Sydney (ACBPS 2012). More recently, and in response to increased detections of ContacNT at the Australian border, ACBPS initiated a joint agency operation with key law enforcement partners to identify and prosecute those involved in importing the medicine. ContacNT is a cold and flu medication that contains a high proportion of pseudoephedrine as an active ingredient and although manufactured legitimately in China, pseudoephedrine is a precursor chemical regularly used in the manufacture of methamphetamine. The operation involved the following activities.

Operation Quadrel is a joint operation between ACBPS, NSW Police Force and Victoria Police that targets ContacNT importing organisers, coordinators and couriers. Since starting in September 2011, Operation Quadrel has seized more than 1.3 tonnes of ContacNT that could have been used to manufacture almost 400 kilograms of 'ice' (methamphetamine). That quantity of ice has a wholesale value of about \$78 million and an estimated potential street value of up to \$300 million. Since Operation Quadrel began...officers have made 347 seizures of ContacNT, with a combined weight of over 1,365 kilograms. The operation has had 28 successful prosecutions relating to ContacNT offences, resulting in custodial sentences ranging from three months to three years (ACBPS 2013, p.38).

The Law in Victoria

In Victoria, the possession of precursor chemicals is regulated under the *Drugs Poisons and Controlled Substances Act 1981* (Vic.), section 71D of which states:

A person who, without being authorized by or licensed under this Act or the regulations (if any) to do so or other otherwise without a lawful excuse, possesses a prescribed precursor chemical in a quantity applicable to that precursor chemical is guilty of an indictable offence and liable to a penalty of not more than 600 penalty units or level 6 imprisonment (5 years maximum) or both.

Part VB of the Act establishes provisions regarding control of precursor chemicals and apparatus for supply and storage, end user declarations, record of supply, police inspection of records and creates the offence of failing to produce records and associated penalties.

Schedule 1, *Drugs, Poisons and Controlled Substances (Precursor Chemicals) Regulations 2007* (Vic.) specifies the precursor chemicals and quantities prescribed for legitimate use. As precursor chemicals have both legitimate and illicit uses it can be difficult to apply this legislation in practice, a point made by Victoria Police in its submission to the Committee:

The legislation around precursor chemicals and reacting agents is complicated, as most have a legitimate purpose other than ATS manufacture. While possession of amounts of these chemicals is regulated under the *Drugs Poisons and Controlled Substances Act 1981*, there is a lack of any scaling to indicate whether the amounts possessed are sufficient for charges of Trafficking a Commercial Quantity or Large Commercial Quantity.

While the legislation establishes penalties for an individual who purchases precursor chemicals of any amount more than 25 grams, there are no higher penalties for individuals who have been found with much larger quantities of precursor chemicals in their possession. Legislative amendment to introduce maximum penalties based on the quantity of precursor involved could, arguably, deter traffickers who may currently be able to avoid large penalties simply by limiting individual purchases to the 25 gram limit.

Equipment

In addition to precursor chemicals, a number of issues arise with respect to the purchase of equipment used to manufacture methamphetamine, as indicated in Victoria Police's submission to the Inquiry:

The sale of chemical glassware and equipment is regulated under the *Drugs Poisons and Controlled Substances Act 1981* and requires a purchaser to provide identification and complete an End User Declaration (EUD). There is a requirement for the seller to keep the EUD for 2 years. There is no mandate for the seller to notify Victoria Police of such sales although a number of businesses do this on a voluntary basis which has resulted in a number of investigations and prosecutions for serious drug offences. There is an argument for legislative change to ensure that all EUDs are forwarded to Victoria Police.⁸⁷¹

The introduction of scaled penalties and improved procedures relating to End User Declarations for equipment would, arguably, assist law enforcement agencies in identifying, monitoring, and prosecuting individuals engaged in the manufacture, supply and distribution of methamphetamine in Victoria. These policy initiatives are discussed further below.

Final methamphetamine product

The methamphetamine product being imported into Australia is often concealed with other goods in shipping containers and parcels. The perception of high profits and lower expenditure, in part due to low trafficking costs and importation using well established heroin routes, has made it attractive for illicit drug manufacturers to import methamphetamine directly into Australia (Groves & Marmo 2009). The ACC described one recent shipment that contained a substantial volume of liquid methamphetamine:

A joint investigation by the Australian Federal Police, Australian Crime Commission, Australian Customs and Border Protection Service and Victoria Police identified a shipping container that was believed to contain methylamphetamine being imported into Australia. The container, holding 46 pallets of liquid carpet stain cleaner, arrived in Melbourne from Hong Kong in April 2013. Examination of the contents revealed that 96 of the 3,332 bottles of liquid cleaner contained methylamphetamine. It is estimated that the 365 litres of liquid methylamphetamine would equate to 280 kilograms of pure methylamphetamine, with a total street value of up to \$205 million (ACC 2013b, p.31).

Professor Richard Hobbs from the Mannheim Centre for Criminology described to the Committee the attractions of direct importation of drugs. Although speaking of the situation in the United Kingdom, some parallels exist in view of Australia's similar island status.

From our point of view, we hear a lot about importation and we hear a lot about the street, but we are an island, we have so many ways to bring illicit goods into the country, so that importation level becomes quite important. With investment, you never see the drugs, you invest the money and you triple your money over a week or two weeks. It is very, very attractive, particularly if we are in a recession.⁸⁷²

Evidence of the precise extent to which finished methamphetamine product is imported into Australia is limited. The ACC noted the difficulties of determining the exact proportions of drugs that are imported as opposed to manufactured domestically.⁸⁷³

Just to summarise that, we believe importations, particularly of ice, are creating changes in the proportion of domestic production versus importation. We still believe domestic production probably trumps importation, but increases in importation are probably growing at a faster rate than domestic production. The total supply chain is growing. That is how we are seeing the situation....We still think domestic production is probably 50 to 60 percent, but with importation growing quite quickly.⁸⁷⁴

871 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

872 Professor Richard Hobbs, Mannheim Centre for Criminology, London School of Economics and Political Science Meeting (via video conference), Canberra, 12 February 2014.

873 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

874 Ms Judith Lind, Executive Director, Australian Crime Commission, Public Hearing, Canberra, 10 February 2014.

Further research is needed to quantify the extent of methamphetamine imported directly and how much effect law enforcement and ACBPS activity has on the behaviour of drug traffickers in this area. Where border controls increase and final product is targeted, local production may increase, and the detection of precursors at the border may increase the need to obtain precursors locally, such as by distilling chemicals from medicines that can be purchased legally (Ritter, Bright & Gong 2012). Effective responses to the problem require a coordinated strategy that deals with all avenues of supply, not only within Australia but also in countries from where drugs and precursors are sourced (Fischer, Curruthers, Power, Allsop & Degenhardt 2012).

Online drug markets

In addition to the traditional sources of importation of methamphetamine into Australia, online drug markets have become an increasing concern for law enforcement agencies in recent years. Various internet forums and sites provide users with access to a range of information on the effects of various substances, the market for such drugs internationally and ways of avoiding detection by law enforcement agencies when importing drugs.

A study was conducted in 2013 of 9,470 drug users from the United Kingdom (n=4313), Australia (n=2761) and United States (2394) who were asked about their consumption of drugs purchased through an online drug marketplace called Silk Road (SR) that has recently been closed. Some of the findings were that:

Cocaine and amphetamine were purchased more commonly in Australia. Globally, the most common reasons for purchasing from SR were wider range, better quality, greater convenience and the use of vendor rating systems. Australians and Americans were more likely to be motivated by SR's lower prices and by inadequate drug access through their own sources, compared to the British. Australians and American were more likely to avoid SR purchase due to the fear of being caught (Barratt, Ferris & Winstock 2013, p.781).

The research also found that in Australia amphetamines including (methamphetamine) were ranked ninth out of twenty different types of drugs purchased online from SR by country of residence. It was determined that MDMA, Cannabis and LSD were the drugs most purchased by Australians using the online drug marketplace. Mr Shane Neilson from the ACC advised the Committee that:

Internationally you can go on the internet. These substances are advertised. You can go and engage with a Chinese company. Sometimes the company will tell you, 'Look, it is probably a good idea if you do this or that or the other to get around Australian customs controls'. All that is part of the service, and then you import it. Both of those scenarios are valid. It is all about your connections. The more sophisticated your local connections, the more likely that you are going and talking directly to a contact in China.⁸⁷⁵

Illicit substances, including methamphetamine and its precursors can be imported with limited chances of detection in small quantities using regular postal services. AFP Assistant Commissioner Jabbour outlined some of the challenges faced by law enforcement agencies in monitoring the use of the internet to source drugs in giving evidence to the Committee:

We are talking about sites such as Silk Road or sites that we commonly referred to as the dark net. The dark net is a site you can access on the internet — and I apologise if I am saying something that you already know about — with total anonymity. It is a bit like eBay but in the dark, if you understand me. So you can access this site and you can make a purchase and remain totally anonymous. Because of the way the site is set up it is nearly impossible to detect who the true supplier is and who made the

875 Mr Shane Neilson, Head of Determination, Australian Crime Commission, Public Hearing, Canberra, 10 February 2014.

request. If you look at Silk Road, for example, that site was effectively shut down by US authorities once we became aware of it. That said, there are other sites out there where you can go online and purchase narcotics from overseas suppliers. Where the site is housed is another issue for us in the wonderful world of cybercrime — it depends on where the server is housed as to who has jurisdiction to be able to take action against the person who established it.

The Committee is also aware of the recent criminological research into online illicit drug trading carried out by Martin in his book *Drugs on the Dark Net* (Martin 2014). The book provides a thorough qualitative study based on an analysis of discussion threads on cryptomarket forums in which illicit substances and other illicit goods are traded. Martin found that following the closure of the Silk Road, a new generation of cryptomarkets has emerged in non-public corners of the internet that use encryption to prevent identification by law enforcement agencies. These encrypted websites facilitate distribution networks that reach around the globe, and are capable of delivering any type of illicit drug directly to purchasers. Martin also undertakes a comparison between conventional drug distribution networks and those facilitated by the dark net. Online networks are seen to be more efficient with improved product quality and less organised crime and violence involvement.

Although the Committee has been made aware of the problems associated with online markets for methamphetamine and other illicit substances, the examination of this problem is beyond the scope of the current terms of reference and entails federally-coordinated action between law enforcement and regulators. Further investigation is clearly needed to explore the most effective ways in which online sales of illicit substances can best be addressed, with particular attention paid to the difficulties associated with attempting to control online content that emanates from overseas sources. Further consideration should also be given to the enhanced scrutiny of the delivery of parcels that could contain illicit substances purchased online. Finally, law enforcement intelligence could be used to assess the extent to which organised crime is involved in online drug sales.⁸⁷⁶

Australia Post

Australia Post and the ACBPS informed the Committee on their current capabilities in screening incoming packages that may contain drugs. Ms Roslyn McCarthy from Australia Post described the current procedures that are in place, without disclosing detailed operational information:

Yes, I liaise with Customs and we have a Memorandum of Understanding with the three agencies, being Australia Post, Australian Customs and Border Protection, and also Department of Agriculture, which was previously known as Australian Quarantine Services. As part of that we have permanent full-time staff that are based there from both Customs and Department of Agriculture around the screening processes that they have in all of the four gateway facilities.⁸⁷⁷

Mr Scott Staunton, General Manager Group Security, Australia Post, also spoke of the capacity of law enforcement agencies to identify and open suspected mail items:

Probably not Customs initially but [by] the Australian Federal Police. The process with the 180 million inbound international articles is essentially that they come off the plane in bags or air containers; however they are delivered to us. They are then taken to Customs before they go anywhere else. So Customs get them first. They do their screening examination to the extent that they are able to or wish to. Then it goes to the Department of Agriculture, Forestry and Fisheries quarantine. When cleared through both of those parties it comes to us. At that point it is cleared from being international and becomes domestic material. We do not then do anything else to those 180 million items in terms of looking at them for evidence that they may contain drugs or prohibited items, but if it does come to

⁸⁷⁶ See also discussion in Chapter 14.

⁸⁷⁷ Ms Roslyn McCarthy, General Manager Last Mile Network, Australia Post, Public Hearing, Melbourne, 24 March 2014.

our attention in the gateway, we will tell Customs and quarantine. If it comes to our attention outside the Gateway, we will tell the Australian Federal Police.⁸⁷⁸

In addition to such cooperative activity, the use of strategic intelligence is critical in screening cargo. A submission from the ACBPS outlined its role and capability:

Our current approach to managing the border seeks to address these challenges through intelligence analysis; risk-based targeting; a range of interventions at airports, seaports and international mail gateways; coordinated operational responses; and joint operations with partner agencies. This approach enables our resources to be used more effectively by intercepting cargo and passengers that are of high risk.⁸⁷⁹

Strategic Intelligence

Recent large-scale detections, such as those described above, indicate that intelligence-led operations can be effective, although adequate resourcing is required to ensure that intelligence is collected and disseminated widely and promptly. Investment in technology to assist with screening procedures is also desirable, particularly as the extent of on-line trade and parcel delivery increases.

Conclusion

Evidence presented to the Committee has stressed the importance of law enforcement agencies employing a multi-agency approach when targeting the importation of illicit drugs and precursors coming into Australia. Although the Committee is unable to present confidential material on the nature of law enforcement intelligence used in detecting illicit drugs, clearly the role of intelligence is important in identifying packages as well as large containers that could contain methamphetamine and its precursors. The Committee understands that it is impossible to screen all materials at the border due to their large and ever-increasing numbers, and that resources must be employed judiciously so as to ensure that high-risk items are able to be examined. Intelligence that makes effective use of technology is likely to be an effective tool in addressing the importation of drugs into Victoria.

878 Mr Scott Staunton, General Manager Group Security, Australia Post, Public Hearing, Melbourne, 24 March 2014.

879 Mr Roman Quaedvlieg, Deputy Chief Executive Officer, Border Enforcement, Australian Customs and Border Protection Service (ACBPS), Submission, 11 April 2014.

Recommendation 20

The Committee recommends that the Australian Crime Commission (ACC) Board consider the establishment of a Special Operation in collaboration with the UNODC into the short and long-term implications for Australia of the substantial growth in the methamphetamine market within the South-East Asian region.

Recommendation 21

The Committee recommends that the Victorian Government in conjunction with the Commonwealth Government examine the issue of precursor control. This should include an examination of new legislation pertaining to precursors used for illicit drug manufacture and the sufficiency of current penalties for the possession and trafficking of precursor materials. Such a working group should include representatives of Victoria Police and the Australian Federal Police and the State and Commonwealth Attorney –General/Justice Departments.

Recommendation 22

The Committee recommends that the Australian Crime Commission Board consider the establishment of a Special Operation to examine organised crime involvement in online illicit drug marketplaces, particularly relating to the sale of methamphetamine including crystal methamphetamine.

Recommendation 52

The Committee recommends that the Law, Crime and Community Safety Council facilitate research into the nature, extent and control of online drug markets including their potential impact on the importation of methamphetamine into Australia.

16. Local Manufacture and Distribution

Introduction

In addition to examining the extent to which methamphetamine and its precursor chemicals are brought into Australia and Victoria, the Committee was also asked to consider how these drugs are manufactured and distributed locally. The evidence suggests that methamphetamine use is particularly problematic in regional and remote communities in Victoria, and questions arise around whether drugs are produced in those communities for local use or whether they are produced elsewhere and transported to locations within the state for domestic use.

The first part of this chapter examines the production line of methamphetamine and crystal methamphetamine. It begins with discussion on the source of ingredients and equipment and how methamphetamine is made, followed by evidence concerning the nature and extent of illicit manufacture in clandestine drug laboratories. In view of the illegal nature of the production of illicit drugs, the chemical production of illicit substances must be undertaken covertly, hence the use of the term 'clandestine' to describe drug laboratories used for production in locations that might be difficult for police to detect. These can include domestic residences, business premises, hotels, vehicles or used shipping containers located on rural properties. The examination of production then focuses on the harms associated with illicit production and the particular risks that children face when they are exposed to chemicals in domestic premises. This part concludes with a discussion on how detected laboratory sites are remediated.

The second part of the chapter considers the distribution of methamphetamine and crystal methamphetamine by examining the networks that operate across state and territory borders in Australia and the evidence of arrests by police in different regional areas in Victoria which indicates the level of regional criminality involved. The role that outlaw motor cycle gang (OMCG) members play in distributing drugs in Victoria, not only using motor cycles as a means of transportation but also in facilitating other avenues of distribution, is discussed in the next chapter. The Committee received evidence of the nature of distribution networks for methamphetamine from academic researchers and members of affected communities as well as from law enforcement agencies. Survey findings identifying the types of individuals from whom users obtain their drugs and research findings on the perceptions of police detainees about the availability of methamphetamine in Victoria are also examined, as is evidence of the incidence of drug users themselves being involved in the distribution of methamphetamine.

The Committee is aware of the need to identify the problems in the areas of manufacture and distribution without facilitating criminal activity by providing precise information on how to source chemicals and produce drugs.

Sourcing ingredients and equipment for production

The production of methamphetamine and ice requires the use of chemicals and equipment that can be used for lawful purposes as well as their illicit, clandestine functions. Precursor chemicals and equipment can be diverted from legitimate sources within Australia, or can be brought into the country covertly (United Nations Office on Drugs and Crime (UNODC) 2014a; Australian Crime Commission (ACC) 2014a). Evidence presented to the Committee demonstrates that the local manufacture of methamphetamine in Victoria is generally undertaken using imported precursor chemicals. In conversation with the Committee, Mr. Shane Nielson from the ACC observed:

There is a whole continuum there. As a starting point I think it is important to understand that large amounts of these substances are moving around the country at any given time; there has to be, for legitimate pharmaceutical industry to work. Sometimes amounts that would be enormously helpful to organised crime groups simply go missing from storage depots and are written off by pharmaceutical companies, for example.⁸⁸⁰

Mr. Shane Nielson from the ACC told the Committee of the industry self-regulation that is in place to prevent diversion of chemicals, and suggested that further investigation of the nature and extent of diversion of substances from industry sources be undertaken.⁸⁸¹

In addition to the theft of precursor chemicals from local wholesale manufacturers, precursor chemicals can be distilled from medicines that are lawfully available to the public from pharmacies. The sourcing of chemicals in this way and the policies used to prevent misuse of legitimate pharmaceutical products are examined in Chapter 15 in the discussion of precursor controls in Australia.

The types of illicit production

Methamphetamine and other amphetamine type stimulants (ATS) can be produced using a variety of techniques. A background paper prepared for the National Amphetamine Strategy 2008–2011 outlined some of these modes of production as being:

- hypophosphorous method which uses hydophoporous acid and iodine;
- red phosphorous method which uses hydriodic acid and red phosphorous;
- 'Nazi' method which uses lithium and sodium with anhydrous ammonia; and
- P2P or Leuckart method which uses phenylacetone or benzyl methyl ketone with formic acid or aluminium amalgam (Department of Health and Ageing (DOHA) 2007, p.117).

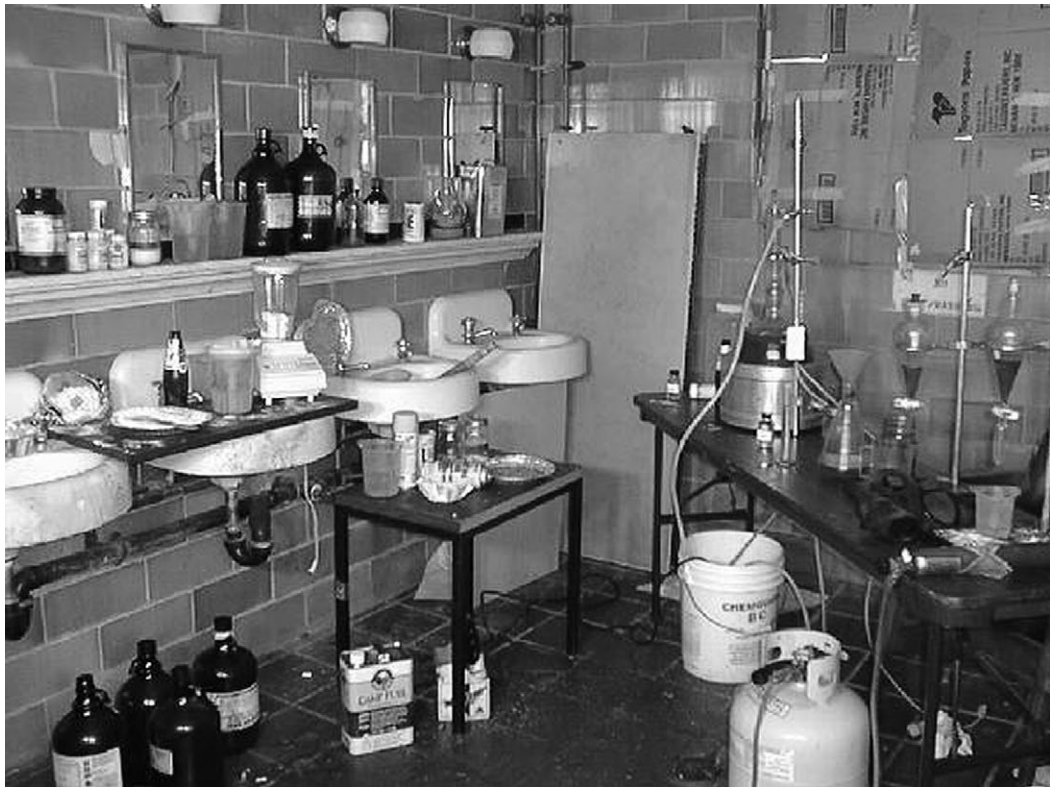
According to Vearrier, Greenberg, Miller, Okaneku & Haggerty (2012), the most common processes for producing methamphetamine are the cold and red phosphorous method and the 'Nazi' or 'Birch' method. The Committee refrains from elaborating on these methods further, in order not to facilitate criminal conduct. See Figure 16.1 for an image of a clan lab.

880 Mr Shane Neilson, Head of Determination, Australian Crime Commission, Public Hearing, Canberra, 10 February 2014.

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Shane Neilson, Head of Determination, Australian Crime Commission, Public Hearing, Canberra, 10 February 2014.

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Figure 16.1: A clandestine laboratory

Source: Penington Institute, Correspondence, 3 August 2014.

The ACC in its submission to the Committee highlighted changes in preferences of production methods in recent years:

As access to pseudoephedrine and ephedrine has become more difficult, there is evidence that some illicit drug producers are reverting to classical phenyl-2-propane (P2P) based techniques for the production of methylamphetamine and are producing ephedrine in clandestine laboratories. While there is a wide range of substances and methodologies available to the producers of P2P, there is a requirement for higher level of technical competence associated with a number of processes.⁸⁸²

Table 16.1 provides a breakdown of ATS production methods based on clandestine laboratory detections by state and territory during 2012-2013. Evidence comes from the Enhanced National Intelligence Picture on Illicit Drugs (ENIPID) project that has extended routine drug profiling capabilities of law enforcement from seizures at the border to include state and territory seizures (ACC 2014a).

882 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

Table 16.1: Methods of ATS (excluding MDMA) production in clandestine laboratory detections, by state and territory, 2012–13

State/ Territory	Hypophosphorous (Iodine)	Red- phosphorus (Hydriotic)	Nazi/Birch (Lithium/ Ammonia)	Phenyl-2- Propanone (P2P)	Other ^a	Total ^b
NSW	81	3	1	3	5	93
Vic	40	1	2	10	0	53
Qld	108	33	0	1	0	142
SA	26	3	1	1	1	32
WA	1	4	130	0	0	135
Tas	7	0	0	1	1	9
NT	1	0	0	0	0	1
ACT	0	0	0	0	0	0
Total	264	44	134	16	7	465

Notes:

- Other includes the detection of other ATS (excluding MDMA) production methodologies.
- Total may not equal the number of ATS (excluding MDMA) clandestine laboratory detections as the method of production may not be identified.

Source: Australian Crime Commission 2014a, *Illicit Drug Data Report 2012-2013*, p.189.

The ENIPID Project is one of two projects that complement the Australian Illicit Drug Intelligence Program (AIDIP) and support the National Illicit Drug Strategy. The ENIPID Project is conducted by the Australian Federal Police (AFP) in partnership with state and territory jurisdictions, to obtain illicit drug samples from seizures within the states and territories. This domestic sampling project extends the type of high-end analysis provided by the AIDIP for border seizures to state seizures. The other project is the National Drug Precursor Risk Assessment Capability (NDPRAC), which identifies where legitimate chemicals (which can also be used as illicit drug precursors) are diverted into the manufacture of illicit drugs. The AFP explains these as follows:

To chemically profile illicit drugs, AIDIP utilises the significant scientific expertise of the National Measurement Institute, and while it remains the only routine drug profiling program within Australia, it networks with other similar initiatives in overseas jurisdictions to track and compare trends. Drugs profiled includes heroin, cocaine, methylamphetamine and 3,4-methylenedioxyethylamphetamine (MDMA, or 'ecstasy'). The program also retains information on drug precursors and analogues which attempt to circumvent existing legislative controls. Through the AIDIP the AIDDC also provides technical assistance to AFP Crime Scene Scientists, as well as responding to drug-related matters raised by external agencies (AFP 2014).

Samples submitted to AIDIP for profiling are primarily from AFP seizures which, owing to the nature of the AFP's responsibilities and casework, are generally from seizures taking place at the Australian border. These provide a snapshot on illicit drugs being smuggled into the country. The AIDIP identifies regions of origin and manufacturing trends among samples collected from seized illicit drugs. Comparisons can also be conducted within and between seizures to identify different batches in a single shipment or potentially demonstrate links between individuals and/or networks (AFP 2014).

Although the hypophosphorous method of production remains the principal production method identified in Australian clandestine laboratories, in Victoria the P2P method was also prevalent, being associated with 10 out of 53 clandestine laboratory detections in that state during 2012-2013. Nonetheless, 'the period between 2010 and 2013,

saw methylamphetamine ENIPID samples primarily manufactured from ephedrine/pseudoephedrine using phosphorous/iodine routes, with quantities also made through Emde method, reductive amination or Leuckart reaction using P2P' (ACC 2014a, p.35).

The extent and nature of clandestine laboratories

Evidence of the extent of domestic production of methamphetamine comes from the National Clandestine Laboratory Database established as part of the national precursor strategy. Law enforcement agencies in states and territories identify and disrupt clandestine laboratories used in the manufacture of methamphetamine using a diverse range of investigative techniques and intelligence-based strategies. The ACC's IDDR 2012-2013 provides information on the number of clandestine laboratories detected during the last 10 financial years based on statistics sourced from all state and territory police. According to the IDDR, there was a 6.4 percent decrease in the number of clandestine laboratories detected in Australia, from 809 in 2011-12 to 757 in 2012-13. Such a trend has not been seen since 2006-07 (ACC 2014a, p.185).

Table 16.2 shows the number of clandestine laboratory detections in all states and territories between 2003-2004 and 2012-2013. Queensland had higher numbers of detections during the 10 years with 379 and 330 clandestine laboratories found in 2011-2012 and 2012-2013, respectively. The highest number of detections in New South Wales occurred in 2012-2013 (105) representing an increase of 16.7% from the 90 detections in 2011-2012.

Table 16.2: Number of clandestine laboratory detections, by state and territory, 2003-04 and 2012-13

Year	Vic	NSW	Qld	SA	WA	Tas	NT	ACT	Total
2003-04	20	61	189	48	33	1	6	0	358
2004-05	31	45	209	25	44	3	21	3	381
2005-06	47	55	161	50	58	5	12	2	390
2006-07	72	49	132	51	37	9	1	5	356
2007-08	76	51	121	69	30	2	1	6	356
2008-09	84	67	148	65	78	0	7	0	449
2009-10	113	82	297	71	118	1	12	0	694
2010-11	63	87	293	75	171	11	2	1	703
2011-12	99	90	379	58	160	15	7	1	809
2012-13	113	105	330	56	136	9	8	0	757

Source: Australian Crime Commission 2014a, *Illicit Drug Data Report 2012-2013*, p.186.

Victoria generally ranks third amongst the various states and territories in terms of the number of detected laboratories, following Queensland and Western Australia. In conversation with the Committee, Ms Judith Lind from the ACC presented evidence of the scale of clandestine laboratory detections in Victoria:

In terms of clandestine laboratories, again this is 10-year data showing detections of clan labs. Victoria had 99 of the 809. The 809 was a record number of clan labs detected in the last 10 years. Victoria does not have a large proportion — it has about 12 percent of the national total — but when you look at the Victorian trend line, apart from 2009-10, where 113 were seized, the last reporting year again shows increases in the number of clandestine labs detected. Most recently out of our Eligo work in October

2013 we detected a commercial-size methylamphetamine laboratory in Sunshine in Melbourne. That came from our following-the-money work.⁸⁸³

The ACC’s National Task Force Eligo was established in 2012 as a special investigation into the use of alternative remittance and informal value transfer systems by serious and organised crime. The alternative remittance sector (ARS) and other informal value transfer systems allow individuals to transfer money or other valuable items within and between countries outside formal financial and banking systems using a set of agreements between individuals. The ACC has found that ARS has been used to transfer the proceeds of crime by organised crime groups (ACC 2014c, n.p.). The Task Force makes use of criminal intelligence to disrupt illicit international money flows, and to ‘harden’ the alternative remittance sector against serious and organised crime. The Task Force comprises the ACC, the Australian Transaction Reports and Analysis Centre (AUSTRAC) and the AFP in partnership with the Australian Customs and Border Protection Service (ACBPS) and State and Territory police (ACC 2014b).

Victoria Police also provided the Committee with recent data on clandestine laboratory detections in Victoria between calendar years 2008 and 2013.⁸⁸⁴ As indicated in Table 16.3, the trends are similar to those shown in Table 16.2 although the total for 2013 is considerably higher than for 2012-13, owing to additional detections occurring after 30 June 2013.

Table 16.3: Number of clandestine laboratory detections by calendar year in Victoria

Year	Number of detections
2008	74
2009	112
2010	86
2011	83
2012	100
2013	142
Total	597

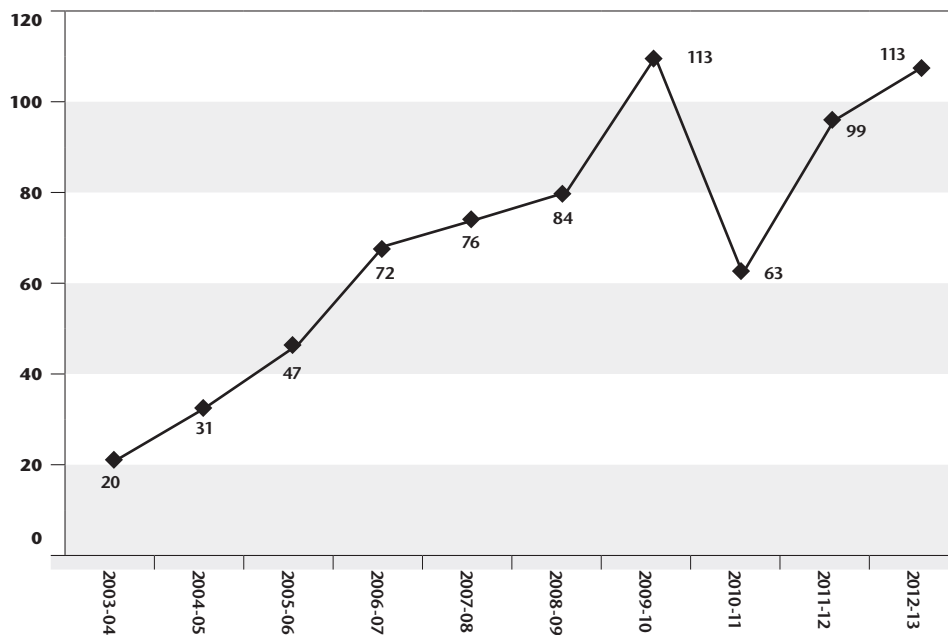
Source: Correspondence with Victoria Police Clandestine Laboratory Unit.

Trends in the number of clandestine laboratories in Victoria between financial years 2003-2004 and 2012-2013 are presented in Figure 16.1. There has been a steady increase in the number of clandestine laboratory detections between 2003-2004 and 2008-2009. However, the number of such detections increased from 99 in 2011-2012 to 113 in 2012-2013, the highest number of detections for the state, which was also reported in 2009-2010.

⁸⁸³ Ms Judith Lind, Executive Director, Australian Crime Commission, Public Hearing, Canberra, 10 February 2014.

⁸⁸⁴ Victoria Police, Correspondence with the Committee, February 2014.

Figure 16.2: Trends in the number of clandestine laboratories in Victoria between 2003-2004 and 2012-2013



Source: Adapted from Australian Crime Commission 2014a, *Illicit Drug Data Report 2012-2013*, Table 36, p.186.

Over the last decade, the number of detections of clandestine drug laboratories in Victoria has increased, although changes over time have fluctuated, unlike in other states where the growth has been more consistent. The Committee notes, however, that data of this kind can reflect the level of resourcing provided to police agencies and may not reflect the underlying incidence of laboratories that exist. In addition, the presence of laboratories is not a direct reflection of the production of methamphetamine and crystal methamphetamine, as they may be used to produce a variety of illicit substances. As the ACC indicated in its submission, 'a record 809 clandestine laboratories were detected in Australia in 2011-12. Of these, 552 (62 percent) were identified as manufacturing ATS (excluding MDMA)'.⁸⁸⁵

Accordingly, the remainder were involved in manufacturing other drugs. In addition, data were not provided to the Committee on the proportion of laboratories that were involved in manufacturing crystal methamphetamine, as opposed to other types of ATS.

Location of clandestine laboratories

During 2011-12 and 2012-13, 68.2 percent of clandestine laboratories were located in residential areas followed by those in vehicles (9%), commercial or industrial areas (8.9%), public places (3.8%), rural areas (2.2%) and other places (7.9%) (Australian Crime Commission (ACC) 2014). According to Victoria Police, there has been a proliferation in small home-based laboratories in Victoria. Of the 108 laboratories located so far in 2013, 75 were in residential premises. Victoria Police also indicated to the Committee that the manufacture of ATS such as methamphetamine and crystal methylamphetamine includes large-scale operations funded by organised crime syndicates both locally and overseas, as well as small home-based laboratories run by individuals.⁸⁸⁶

According to Ms Judith Lind from the ACC, laboratories covertly manufacturing illicit drugs and/or their precursors range from crude, makeshift operations using simple chemical techniques, to highly sophisticated operations using technically advanced equipment and

⁸⁸⁵ Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

⁸⁸⁶ Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

facilities.⁸⁸⁷ According to the Illicit Drug Data Report (IDDR) 2012-13, between 2011-12 and 2012-13, the majority of detected clandestine laboratories were individual, addict-based (58.8%) whereas others were small scale labs (23.5%), medium-sized labs (9.7%) and industrial-scale labs (8%) (ACC 2014a).

The risks of domestic production

Health and safety risks of illicit drug production

As discussed in Chapter 7, clandestine drug laboratories pose risks both to those who manufacture illicit drugs as well as others who may come into contact with them, including people who reside at or visit the sites in question (Edwards 2004; Caldicott et al. 2005). This is particularly important in view of the high proportion of laboratories that are located in residential premises, as noted above, as it is often future tenants or owners who unwittingly suffer the effects of exposure to residual contaminants if they are not removed. The submission from the ACC stated that, 'regardless of their size, the residual contamination arising from illicit drug manufacture presents a serious risk to human and environmental health'.⁸⁸⁸

Hazards also arise for police, forensic chemists and hazardous materials contractors who attend sites that are discovered. Working without proper knowledge of the handling of hazardous materials and without proper equipment and safeguards creates a continuing risk of harm to those involved in the production, as well as others in the nearby environment and law enforcement officers. Risks derive from the chemical hazards that are present including flammable, poisonous, explosive, radioactive and corrosive substances that may be in solid, liquid or gaseous form. These risks may be exacerbated by the way in which illicit operators manage the various chemicals involved. Exposure to the chemicals and by-products of illicit drug manufacture can cause serious adverse health effects, which may be potentially fatal, as noted above. The submission from Victoria Police described the danger of small-scale laboratories:

Recently police and fire services were called in the early hours of the morning to a multi storey block of flats where a fire had broken out during the manufacturing process. Fortunately the unit was fitted with smoke detectors and a sprinkler system and a potential disaster was averted. However, this was not an isolated incident. These incidents require the immediate attendance of CLS investigators, a Forensic Chemist and staff from the Disaster Victim Identification/Chemical, Biological and Radioactive Unit.⁸⁸⁹

Risks for children residing in premises

Children are particularly susceptible to these risks, partly because of their lower tolerance to chemical exposure but also because they are more likely to come into contact with contaminated surfaces through crawling and putting objects in their mouths.

The manufacturing process of methamphetamine involves a range of chemicals, many of which are toxic and hazardous. The process carries the risk of potentially fatal accidents, including explosions and environmental contamination. Many clandestine laboratories are in residential areas, often within homes where children are present. The Victoria Police submission to the Committee noted such concerns:

Children can be exposed to significant contamination from the laboratory site in addition to the chemicals and liquids stored in the home. Liquids are frequently stored in clear plastic drink bottles in refrigerators and freezers where food is also stored. There has been an increase in children located at premises when searches are conducted by Clandestine Laboratory Squad (CLS). In Victoria there is no legislation in place dealing specifically with offenders who are responsible for children being in

⁸⁸⁷ Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

⁸⁸⁸ Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

⁸⁸⁹ Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

laboratory environments. The *Crimes Act 1958* offences of Conduct Endangering Persons and Conduct Endangering Life are not considered appropriate for this situation.⁸⁹⁰

Victoria Police requested the Committee to consider providing recommendations for legislative amendment to overcome this gap in the current legislation. It has been suggested that several mainland states of Australia and New Zealand have specific provisions regarding aggravating circumstances when children are found in these circumstances. These are considered in greater detail below.

The role of the internet in clandestine ATS manufacture

Particular law enforcement and environmental agency concerns about the local manufacture of methamphetamine centre on the experience and knowledge of 'meth cooks' whose knowledge of processes and 'recipes' may come from questionable sources on the internet and be inherently dangerous. Victoria Police in its submission to the Committee raised concerns regarding some of the risks associated with the production process:

Most home based manufacturers are inexperienced, having little knowledge of the chemical process involved having learnt from other inexperienced people or they rely on the internet as the source of instruction. The internet is the most common way inexperienced cooks gather information on manufacturing methylamphetamine. However, there appear to be no restrictions governing the availability of this information. The internet is also used to anonymously purchase glassware and equipment.⁸⁹¹

Risks for the environment

In addition to the hazards posed to humans by the manufacture of illicit drugs, the disposal of hazardous by-products into the environment is also of concern. In the case of methamphetamine, for example, for every kilogram that is produced, between 6 and 10 kilograms of hazardous toxic waste is produced (Caldicott et al. 2005). The precise nature of these by-products and their potential or actual effects on the environment, in both the short and longer term, vary between laboratories. When disposed of in drains or toilets, in backyards, or on the streets, chemical by-products have the potential to seep into waterways.

Remediation of sites used to produce illicit drugs

While the bulk of the chemicals and equipment used to manufacture illicit drugs are usually removed by, or at the request of, investigating police officers or forensic chemists, residual contaminants often remain in properties. Contamination may be located in the air, on surfaces, in fixtures and fittings, in ventilation systems, in walls, soil and in drains. Often contamination can persist indefinitely if not cleaned up, raising both public health and environmental issues for many years.

The risks and hazards posed by such laboratories are of concern as harms could be caused to those involved in the manufacturing process and others living within those premises. In the opinion of Vearrier et al. (2012, p.75):

The manufacture of methamphetamine results in significant morbidity and mortality because of thermal and blast injuries, caustic injury, and other toxicologic exposures.

There is no legal requirement for police to decontaminate or remediate an illicit drug laboratory site. Rather, police are required to gather evidence in connection with the investigation of possible criminal activity. The role of a police officer at a site typically involves securing the site (including removing any people from the site), making an assessment about safety (with the advice of attending chemists), recording and collecting exhibits for

890 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

891 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

evidence, dismantling the laboratory and then handing the site back to the appropriate authority (usually the owner of the property). Depending upon the nature of the laboratory, others normally in attendance include a hazardous materials team, an ambulance and the fire brigade. Police do, however, in conjunction with attending chemists, organise the removal of bulk chemicals and equipment and some assist in placing warning notices on the property alerting people to the potential dangers posed by the site. Nationally, best practice guidelines for the remediation of clandestine laboratories are published by the Australian Government Attorney-General's Department (AGD 2011), although these guidelines deal with the remediation practices rather than determining how the costs of remediation can be recovered. Generally, costs associated with remediation are paid by those authorities who undertake the procedures involved. Compensation may also be sought from offenders using existing criminal laws, or civilly from offenders who may be leasing premises, depending upon the terms of individual tenancy agreements.

Drug markets and distribution

Drug markets operate in many similar ways to legitimate markets with distribution channels focusing on the characteristics and location of interested consumers. If particular regions or demographics demonstrate a demand, then marketing and delivery mechanisms will target those areas of need in priority to others. A study of the Sydney methamphetamine market identified some of the factors that influence the mode of distribution of methamphetamine in Sydney some years ago:

Criminal networks involved in methamphetamine supply had a top-down influence on the market with evidence of 'turf' boundaries at a dealing level. The availability and consumption of base and ice in various regions of Sydney mirrored the involvement of criminal networks supplying these forms of the drug. The distribution of methamphetamine through retail level dealers operated in a similar way to a multi-level marketing scheme, occurring through existing social networks and word-of-mouth (McKetin, McLaren & Kelly 2005, p.xv).

Illicit drug delivery channels are complex and, in recent times, have changed. Traditionally, illicit drugs and precursors were brought into the country using conventional modes of transport such as aircraft, boats and cargo services. Once in Australia, they were moved using road transport or postal services and sold using face-to-face contact between dealers and purchasers. With enhanced air and sea border controls, and the development of online markets, the use of postal and courier delivery has increased, often making face-to-face transactions redundant. As indicated in Chapter 4, the detection of illicit drugs in transit has created considerable challenges for customs, police and postal services personnel. In regard to the distribution within Victoria of illicit drugs obtained overseas, the ACC submission observed:

Ice and precursor chemicals consumed in Victoria are sometimes directly imported into Melbourne, and on other occasions imported into other Australian air and sea ports (for example Sydney and Perth) and then transported to Melbourne. Similarly, ice and precursor imports into Melbourne may subsequently be distributed interstate — the determining factors tend to be demand for the product at the time the importation is arranged and the geographic spread of the criminal connections of the importing network.⁸⁹²

Inter-state distribution

The Committee received evidence that methamphetamine and crystal methamphetamine, as well as precursor chemicals, often emanate from other states and territories and are then brought into Victoria for distribution. Similarly, illicit substances can be manufactured

892 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

within Victoria and transported elsewhere. The ACC, in its submission to the Committee, emphasised the role that cross-jurisdictional trafficking of crystal methamphetamine and its precursors play in Australia:

ACC investigations and file holdings (derived from Commonwealth, state and territory partners) indicate that methylamphetamine and ice is trafficked from Victoria to all other states and territories and from other states into Victoria. Cross-jurisdictional trafficking occurs via motor vehicle, commercial and light aircraft and air freight and, in the case of distribution to Tasmania by ferry.⁸⁹³

The trafficking of methamphetamine across state borders in Australia has been examined in a recent study that sought to explain the domestic supply chain using a hierarchical model (Ritter, Bright & Gong 2012). The model suggested that within domestic markets, precursor chemicals, reagents and equipment from domestic sources are purchased, or diverted, from pharmacies or chemical companies and are then used in the manufacture of illicit substances in clandestine laboratories. Finished products are then distributed using established trafficking networks that involve mid-level distribution channels and finally become part of low-level retail drug dealing (Ritter, Bright & Gong 2012). In this way, methamphetamine manufactured locally in Victoria may be distributed within the state, or across state borders, while, at the same time, products from inter-state as well as those manufactured overseas, may be brought into the local Victorian market. Victoria Police provided evidence to the Committee of inter-state distribution of ATS that had been manufactured in Victoria in clandestine laboratories:

Two examples of large scale laboratories located on rural properties include one discovered in February 2012, where chemicals and equipment capable of producing \$15.4 million worth of ATS were discovered. The syndicate involved had a significant distribution network including an aeroplane used to move product interstate. The second, more recent, discovery had chemicals and equipment capable of producing \$7.5 million worth of ATS. Also at this site were firearms and ammunition.⁸⁹⁴

Submissions presented to the Committee also provided information on inter-state sourcing of drugs. The submission from Gippsland Lakes Community Health Alcohol and Drug Service suggested that some of their clients were involved in the importation of methamphetamine from Sydney:

These individuals would fly to Sydney, receive their shipment, deliver it to Victoria by road transport and distribute it throughout Victoria and in particular to the area around the town of Lakes Entrance in East Gippsland. We can only assume that such operations have links to organised crime organisations.⁸⁹⁵

The challenge for law enforcement lies in understanding where best to target operational activities as some trade occurs on highways, some through the use of aircraft, and other movements take place using courier and postal services. The specific problems that police have found in attempting to charge those alleged to have been in possession of illicit substances found in vehicles and in houses will be examined in subsequent chapters. In such situations the need to prove knowledge and intention can be problematic.

Distribution within Victoria

Victoria Police data

Victoria Police collect a range of statistics that are relevant to the identification of drug distribution pathways within the state. These include the diversion of pseudoephedrine-based medications and amphetamines within Victoria.

893 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

894 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

895 Mrs Sue Medson, Chief Executive Officer, Gippsland Lakes Community Health, Submission, 21 October 2013.

Pseudoephedrine diversion arrests

The Committee was provided with statistics by Victoria Police on the number of arrests made on charges relating to the diversion of pseudoephedrine-based medications in different regions in Victoria. This gives some indication of the state-wide spread of illicit ATS-related activities. Victoria Police regions are shown in Figure 16.2.

Figure 16.3: Victoria Police Regions



Source: Victoria Police.

Table 16.4 shows the number of arrests in Victorian police regions on charges relating to the diversion of pseudoephedrine-based medications between the 2008 and 2013 calendar years. The total number of arrests was higher in the North Western Metro region followed by the Eastern, Southern Metro and Western regions. The highest number of arrests occurred in 2010, which could be due to increased criminal activity or enhanced police attention.

Table 16.4: Number of arrests made by police on charges related to the diversion of pseudoephedrine (PSE) based medications, by State Victoria Police Regions

Year	Eastern Region	North-Western Metro Region	Southern Metro Region	Western Region	Total
2008	2	6	1	0	9
2009	4	7	3	5	19
2010	12	28	7	1	48
2011	1	2	3	4	10
2012	6	6	0	1	13
2013	1	11	5	0	17
Total	26	60	19	11	116

Note: Data provided is for alleged offenders processed for pseudoephedrine related offences.

Source: Correspondence from Victoria Police, Law Enforcement Assistance program (LEAP) data provided, by Victoria Police Corporate Statistics 5 May 2014.

Amphetamine property seizures

Victoria Police also provided the Committee with statistics on the number of amphetamine seizures of different types for state regional categories between 2008 and 2013. Unfortunately,

these data relate to all types of amphetamine as the Law Enforcement Assistance Program (LEAP) does not have either a category of methamphetamine or of crystal methamphetamine which are included in the category 'other'. Table 16.5 shows the number of seized property records as opposed to the quantity of items or weight of drugs seized.

Table 16.5: Number of amphetamine seized property records by region, year and type

Year	Powder		Tablet		Other	
	North-Western Metro Region	Southern Metro, Western and Eastern Regions	North-Western Metro Region	Southern Metro, Western and Eastern Regions	North-Western Metro Region	Southern Metro, Western and Eastern Regions
2008	387	441	19	19	272	272
2009	325	371	14	16	194	215
2010	292	345	11	9	268	265
2011	410	495	19	19	409	432
2012	430	628	28	28	679	793
2013	498	740	35	35	788	1202
Total	2342	3020	126	126	2610	3179

Notes:

LEAP does not have methamphetamine drug type, only amphetamine.

LEAP does not have 'crystal' drug category. Valid LEAP drug forms are: Bag, Block, Buddha Stick, Capsule, Foil, Liquid, Micro Dot, Other Powder, Plant, and Tablet.

All non-powder/tablet drugs will be classified as 'other' for purpose of this Report.

This is a count of seized amphetamine property records, not quantities/weights etc.

Source: Law Enforcement Assistance Program (LEAP) provided to the Committee by Victoria Police.

For all types of amphetamine, and over all regional categories, the number of seizure property records has shown an increase between 2008 and 2013. The highest number of records relate to the 'other' category, which includes ice, with most seizure records for this type occurring in the Southern Metro, Western and Eastern Regions.

National Drug Strategy Household Survey data

Further information on the distribution of methamphetamine in Victoria is available from the responses collected as part of drug use monitoring systems. The National Drug Strategy Household Survey (NDSHS) is conducted by the Australian Institute of Health and Welfare (AIHW). The most recent survey conducted in 2010 had 26,648 respondents, of whom 5,597 were Victorian. The survey participants, in addition to questions on drug use, were asked about their activities in drug markets. The AIHW provided information to the Committee on sources of methamphetamine and the places at which it was obtained.

Sources of methamphetamine

Table 16.6 shows the usual sources of meth/amphetamine as reported in national and Victorian NDSHS surveys conducted in 2004, 2007, 2010 and 2013. A lower proportion of methamphetamine users in Victoria in 2013 sourced their methamphetamine from a friend (51.7%) than did the national sample (57.4%). The proportion of users obtaining their methamphetamine from a dealer has increased over time in both Victoria (from around 17% in 2004 to 35% in 2013) and nationally (from 23% in 2004 to 31% in 2013).⁸⁹⁶ Overall it was found that the methamphetamine market in Victoria as well as nationally was

896 Mr Geoff Neideck, Head, Housing Homelessness and Drugs Group, Australian Institute of Health and Welfare, Submission, 9 April 2014.

operating mainly through close networks, however dealers also represented an important source of supply and the use of dealers has been increasing since 2004.

Table 16.6: Usual source of meth/amphetamine supply, 2004 to 2013

	Victoria				Australia			
	2004	2007	2010	2013	2004	2007	2010	2013
Friend	76.5	63.6	64.9	51.2	69.9	65.9	60.1	57.4
Dealer	16.5*	26.4*	30.8	35.3	22.7	27.0	32.7	30.6
Other	7.0**	10.0*	4.3*	13.6*	7.4	7.1	7.2	12.0

Notes:

Recent user is a person who reported using meth/amphetamines in the last 12 months.

* RSE>25% but <50%, estimate should be interpreted with caution.

** RSE>50% estimate is considered unreliable for general use.

Source: Mr Geoff Neideck, Head, Housing Homelessness and Drugs Group, Australian Institute of Health and Welfare, correspondence, 21 July 2014.

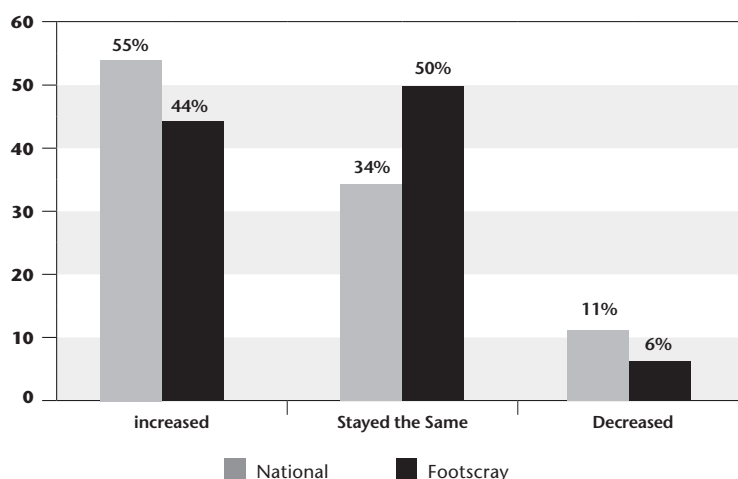
DUMA data

The Drug Use Monitoring Australia (DUMA) research program also provides information on the methamphetamine market, based on responses from police detainees from sites across Australia. During 2012, 569 detainees nationally including 16 detainees interviewed at the police lockup in Footscray, Victoria, responded to the question regarding the number of people selling methamphetamine.

Perceived availability of methamphetamine

Figure 16.3 shows findings for 2012, the most recent year in which data were collected from the Footscray site concerning detainees’ perceptions of the availability of methamphetamine.

Figure 16.4: Comparison between national and Footscray data on perceptions of detainees regarding change in the number of people selling methamphetamine, 2012



Note:

While the DUMA questionnaire asks police detainees about ‘methamphetamine’, the information provided by detainees may also relate to other types of amphetamines. The only DUMA site in Victoria was operational between 2009 and 2012.

Source: AIC DUMA collection 1999–2012 (computer file).

A comparison was undertaken for the Committee between responses from Footscray in Victoria and the national results. DUMA data show that a higher proportion of detainees from the national sample (55%) believed that the sale of methamphetamine had increased than did those from Footscray (44%). The proportion of detainees who believed that the sale of methamphetamine had decreased was also found to be higher in the national sample (11%) compared to those from Footscray (6%). Conversely, a much lower proportion of detainees nationally (34%) perceived that there was no change in the sale of methamphetamine than did the detainees from Footscray (50%).

The information presented in this chapter supports a number of conclusions that can be made about the distribution of methamphetamine in Victoria. First, there appears to be both methamphetamine and precursors available throughout the state. Secondly, it appears that users are increasingly obtaining methamphetamine from dealers rather than from friends. Thirdly, more police detainees in Victoria believe that the number of people selling methamphetamine has stayed the same than do police detainees nationally, who believe that the number of people selling methamphetamine has increased. Together, these findings tend to show that the distribution of methamphetamine, although widespread, is focused on personal contacts.

Distribution by drug users

Finally, as well as groups seeking to make profit from the methamphetamine market in Victoria, drug users themselves can act as distributors within close networks of family and friends. McKetin, McLaren & Kelly, in their research into the Sydney methamphetamine market, concluded that:

Methamphetamine users had limited knowledge of high level supply activities, such as manufacture and importation. However, a small proportion of methamphetamine users had been recruited to undertake miscellaneous tasks related to methamphetamine manufacture and the wholesale distribution of the drug (e.g., obtaining precursors and transporting methamphetamine) (McKetin, McLaren & Kelly 2005, p.38).

Mr John Ryan, Chief Executive Officer of the public health advocacy organisation Anex, in evidence to the Committee, also noted the problem of drug users themselves being involved in the supply and distribution of crystal methamphetamine.

The sad fact of the matter is that most people with a severe drug problem, as in an addiction, are also trading drugs themselves. One of the things that the community needs to better understand is that if you supply methamphetamine to a friend, you are actually committing a criminal offence. At the very local level most of it is through friendship networks. It is not some big bad bokie who is providing it, it is somebody who is connected to somebody who is connected to somebody, and the profit incentive is so high -- the mark up on the drug is so high -- that you can have a number of hands touching it and taking a commission, or a percentage, until it gets to wherever it is going. Whether or not it is 90 percent bokie driven I do not know; the law enforcement agencies would know better than me. But certainly I think there seems to be very strong anecdotal evidence that that is a key part of the distribution, including in country areas. Whether or not it is 90 percent I would not know, but certainly people are getting it mostly at the lower level, at the consumer level, through friendship networks.⁸⁹⁷

⁸⁹⁷ Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

Conclusion

The evidence presented to the Committee shows clearly that a high proportion of methamphetamine and ice are produced locally in clandestine laboratories that range in size and scale from the small to commercial. Although the number of detected clandestine laboratory sites in Victoria is smaller than in some other states in Australia, there has been a general increase in police detections in recent years. The Committee was unable to determine the exact proportion of ice that is produced locally in clandestine laboratories as opposed to being imported from overseas, although it is clear that increasing quantities of both methamphetamine (and ice) as well as precursors are detected at national borders⁸⁹⁸. Of particular concern to the Committee is the evidence of harm to those who may be present at clandestine laboratory sites, or those who may occupy sites that were formerly used to produce drugs. Although it is beyond the remit of the current Inquiry to examine site remediation practices and how they might be improved, the Committee does feel compelled to recommend changes in legislation that will help to protect children who may be exposed to harmful substances.

Whilst the Committee also heard that the drugs produced and their precursors are distributed through channels operating in Victoria which often complement and overlap with each other and involve both networked groups and individuals, it is unable to conclude that any specific group or network has more involvement than others. This conclusion accords with the view of the ACC:

No one criminal syndicate, type of crime group, or ethnicity-based group are dominant in the methylamphetamine market in Victoria. Members of Outlaw Motorcycle Gangs (OMCGs), family groups, ethnic groups and entrepreneurial individuals working alone or in partnership are represented. The methylamphetamine market is sufficiently diverse and profitable to support a large number of competing and sometimes collaborating suppliers, at different levels of sophistication.⁸⁹⁹

The available information on distribution comes predominantly from police activity and although this provides important evidence of how methamphetamine distribution occurs, it does not show how undetected and informal distribution takes place. Individuals who may have further information are often reluctant to report what they have seen through fear of reprisals or in order to protect the confidentiality of their community or family and friends. The evidence presented to the Committee concerning the involvement of organised crime groups is presented in the next chapter.

⁸⁹⁸ See also discussion in Chapter 5.

⁸⁹⁹ Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

17. Involvement of Organised Crime

Introduction

The Terms of Reference of the present Inquiry required the Committee to examine the supply and distribution of methamphetamine and links to organised crime organisations including outlaw motor cycle gangs (OMCGs). During the course of its Inquiry, frequent reference has been made to the role that organised crime groups play in all aspects of the market for illicit drugs, including methamphetamine and crystal methamphetamine. At the outset, it is important to understand the definition of organised crime groups in the present context. Internationally, organised criminal groups are defined in Article 2 of the United Nations (UN) Convention against Transnational Organized Crime:

‘Organised criminal group’ shall mean a structured group of three or more persons, existing for a period of time, acting in concert with the aim of committing serious criminal offences in order to obtain, directly or indirectly, a financial or material benefit (UN 2004, p.5).

According to this definition, an organised criminal activity requires three or more persons to come together for the execution of a common purpose. Organised crime groups are often thought of as traditional criminal organisations such as the Mafia and Yakuza. There is, however, a wide range of other groups that fall within the UN Convention’s definition, including those formed to change government policies as well as those with other specific objectives. In the context of methamphetamine markets, the Committee adopts a broad definition that accords with the terms of the UN Convention and which refers to all groups of three or more persons coming together for the purposes of manufacturing, distributing and selling illicit drugs.

The nature of organised crime in Australia

Types of organised crime groups

Organised crime groups in Australia include ethnicity-based crime groups, family-based crime groups, groups formed on the basis of place of origin such as prisons, and groups with common interests or activities, such as OMCGs (Corruption and Crime Commission of Western Australia (CCC) 2005; Holmes 2007; Lozusic 2002). In terms of their criminality, the Australian Crime Commission (ACC) has noted that:

Although most organised crime activities in Australia are focused on illicit drug markets, organised crime is increasingly diversifying its activities, with convergences being observed between legitimate or licit markets and illicit markets (ACC 2013b, p.7).

Organised criminal activities exist on a continuum of seriousness and complexity of activity. At the lower end of the scale of seriousness are instances of small-scale street crime committed by small groups of individuals, often young people or family members who become involved in low-level property or violent crime, often associated with drug markets (Matrix Knowledge Group 2007). Small groups of individuals can also commit economic crimes such as small-business-related revenue fraud (Lozusic 2002). Other criminal networks are involved in organised cybercrime, including the sale of drugs online

(Choo & Smith 2008). Organised criminal activity may also relate to environmental crime, intellectual property infringement, maritime piracy, organised prostitution and financial crime, which require the presence of multiple players in order for offences to be planned and perpetrated (Morselli 2009). Arguably, at the most serious level are large-scale, organised criminal enterprises related to child exploitation, human trafficking, corporate fraud and illicit drug production and supply (Hobbs 2013).

The groups involved in the illicit drug trade include traditional organised crime groups such as the Mafia or Asian Triads, as well as Middle-Eastern, East-European, West-African and Southeast-Asian organised crime groups, (Le 2013). Members of OMCGs, and small networks of individuals involved in the production, sale and distribution of drugs within communities or online on a local level, are also involved. Like other organisations, effective criminal organisations are those that can adapt to changes in illicit markets (Ayling 2009). In the case of drug-related crime, the availability of new drug types, new techniques of manufacture and new distribution channels all provide opportunities for organised criminal groups to develop their criminal enterprises to generate new sources of income. In the case of amphetamine type stimulants (ATS) production in Australia, a changing mix of criminal elements is present ranging from highly sophisticated and structured criminal organisations to individuals operating within small, local markets and friendship circles (Schloenhardt 2007).

The business model of organised drug-related crime

The business of organised crime in Australia has been characterised by the ACC as:

Those engaged in organised crime energetically, aggressively and innovatively compete for their share of illicit markets, are profit driven, and employ increasingly complex network structures and ways of concealing their activities and their identities — increasingly with the help of professional advisors and facilitators (ACC2013b, p.5).

Prior research into organised crime internationally has emphasised that such criminality is principally driven by the possibility of financial gain (Hobbs 2013; Morselli 2009; Matrix Knowledge Group 2005). Dr Mark Lauchs of Queensland University of Technology described the nature of organised crime groups in the following terms:

The power of an organised crime group is its ability to obtain greater market capture in the same manner as larger businesses in the legitimate economy. They can create economies of scale and take larger share of the market to increase profitability of their enterprise. But these may not be the goals of the small business operators.⁹⁰⁰

In the opinion of Victoria Police, organised crime groups become involved in the methamphetamine trade largely for financial reasons:

Australia is an affluent country. It is targeted by Organised Crime Groups (OCGs) for illicit substances due to the high Australian dollar and the inflated profit margin that Australian customers provide. There are a number of OCGs which emanate from South America, China, Vietnam and Canada which target Australia for these reasons. The illicit substances imported into Australia by OCGs are ATS, cocaine and heroin. They vary in quantity depending on demand.⁹⁰¹

The production and sale of methamphetamine is a lucrative source of income for organised crime groups. Groves & Marmo (2009) argue that 'compared to other illicit drugs, there are numerous incentives associated with the production and distribution of methamphetamine that ensure its prominence within the illicit drug industry and its popularity within organised

900 Dr Mark Lauchs, Senior Lecturer, Faculty of Law, School of Justice, Queensland University of Technology, Submission, 10 April 2014.

901 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

crime’ (p.421). The fact that methamphetamine production does not require any extensive up-front costs and that the drug is relatively easy to produce, increases its profitability.

Similar drivers of organised crime involvement in the methamphetamine market have been identified in other nearby countries. In evidence to the Inquiry Mr Jeremy Douglas from the UNODC observed:

The business model of methamphetamine in South-East Asia and in many other parts of the world is very different from the cocaine business model or the heroin business model, because you can be the manufacturer or the trafficker. It is a very small group involved, it can be a very tight group involved, whereas when you are involved with the heroin trade you have farmers, you have people buying the opium from tens of thousands of farmers, collecting it, then putting it into heroin processing and then trafficking. So you have all these people involved at various points of the supply chain.⁹⁰²

If demand for drugs such as crystal methamphetamine increases in Victoria, organised crime groups will no doubt exploit increased opportunities for financial gain through this market. The diversity and size of the market provides ample opportunities for organised crime groups to maximise profits, as indicated in the ACC’s submission:

No one criminal syndicate, type of crime group, or ethnicity-based group are dominant in the methylamphetamine market in Victoria. Members of OMCGs, family groups, ethnic groups and entrepreneurial individuals working alone or in partnership are represented. The methylamphetamine market is sufficiently diverse and profitable to support a large number of competing and sometimes collaborating suppliers, at different levels of sophistication.⁹⁰³

Organised criminal activity is also not solely confined to one crime type as groups move flexibly and quickly to new markets as they develop. According to the ACC National Criminal Target List (NCTL):

Of the Victoria-based targets recorded on the NCTL, 56 percent are recorded having involvement in the methylamphetamine and precursors market, underlying the primary risks posed by this drug market. The majority of targets recorded as being involved in the Victorian methylamphetamine market are also involved in multiple criminal activities, including multiple illicit drug markets.⁹⁰⁴

Case studies of organised crime in illicit drug markets

In order to illustrate the range of activities crime groups are involved in related to the illicit drug trade in Australia, the Committee presents the following examples derived from recent law enforcement investigations.

Importation of methamphetamine

The involvement of organised crime groups and syndicates in the methamphetamine market has been documented in the successful work of the national multi-agency operation, ‘Taskforce Eligo’, that was established in 2012 by the ACC (see discussion in Chapter 19). This was a special investigation into the use of alternative remittance and informal value transfer systems by serious and organised crime in Australia. Illicit drugs including crystal methamphetamine and its precursors with a combined estimated street value of more than \$530 million have been seized by Taskforce Eligo.⁹⁰⁵ The alternative remittance sector (ARS) and other informal value transfer systems allow individuals to transfer money or other valuable items within and between countries outside formal financial and banking systems

902 Mr Jeremy Douglas, Regional Representative for South-East Asia and the Pacific, United Nations Office on Drugs and Crime, Public Hearing, Canberra, 12 February 2014.

903 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

904 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

905 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

using a set of agreements between individuals. The ACC has found that ARS has been used to transfer the proceeds of crime by organised crime groups (ACC 2014c).

Importation of precursors

One example of organised crime involvement in the importation of precursors concerned a consignment of drugs hidden in multi-threaded rollers used for cricket pitches which was discovered by a law enforcement agency when it arrived in Australia from South Africa. The syndicate attempted to import 44kg of phenylpropanolamine (PPA), enough to produce \$20 million worth of amphetamines. According to the Australian Transaction Reports and Analysis Centre (AUSTRAC):

Two men from the syndicate were recruited as couriers and transported the rollers from Sydney to Melbourne. The rollers were delivered to a pre-arranged location where the suspects later opened the rollers and discovered they were empty. One of the men left the premises and was arrested later that day. He pleaded guilty to one count of attempting to possess a precursor chemical and was sentenced to 15 months imprisonment and fined \$15,000 (AUSTRAC 2013, p.46).

Another recent case concerned the importation into Australia of at least 300kgs of pseudoephedrine concealed in a container of rice from Pakistan and consigned to an established food importing and distribution business. The drugs had been sourced from a Dutch drug syndicate and the shipment facilitated by a corrupt senior investigator with the NSW Crime Commission (CDPP 2012).

Interstate movements

Another recent law enforcement operation involved the seizure of \$1.4 million worth of crystal methamphetamine and the confiscation of approximately \$65,000 in cash, a luxury motor vehicle, motor cycles, jewellery, unlicensed weapons, ammunition and a small quantity of ecstasy tablets. It was alleged that the criminal syndicate travelled to Sydney to purchase drugs and transported them back to Melbourne by motor vehicle, for distribution and sale. The investigation resulted in the interception of two motor vehicles in transit from Sydney to Melbourne, with drugs located during a search of the vehicles. AUSTRAC information established a link between two syndicate members who had both sent \$9,000 on the same day via the same remittance service outlet, to the same beneficiary in Lebanon and that over a six-year period the pair had sent more than \$46,000 to Lebanon (AUSTRAC 2012).

The involvement of outlaw motor cycle gang members

Involvement of members in criminality

In the opinion of the ACC, OMCGs remain one of the most high-profile manifestations of organised crime in Australia, with an active presence in all states and territories (ACC 2013e). The most recent assessment of the activities of gangs identified that there are more than 40 such gangs operating in Australia, with about 600 members, officially permitted to display club insignia (so-called 'patched' members). The ACC believes that the number of gangs and members is on the rise in Australia (ACC 2013e).

The direct involvement of OMCGs in the methamphetamine market is often difficult to establish as they are known to operate within complex social structures involving networks within and beyond their own clubs. One or more OMCG members of a club may choose to be involved in the manufacture, supply and distribution of methamphetamine without the knowledge or consent of other members in their club. They could either be acting as freelancers or participating in the business with individuals who have no connections with any organised crime groups or syndicates.

Victoria Police in a submission to the Committee noted that OMCGs are involved in a combination of legitimate industries including trucking and towing, gyms, licensed premises, security companies and tattoo parlours. Such involvement is intended to blur the lines between licit and illicit activities and to facilitate the distribution of ATS.⁹⁰⁶ The submission from the ACC also explained the collaborative activities of those involved in the ATS market:

It is not unusual for persons of different ethnic or criminal backgrounds to collaborate at different stages of the methamphetamine supply chain, or to collaborate on an importation or local supply. In some cases the collaboration lasts for only a small series of transactions, but in other cases the relationship is more enduring.⁹⁰⁷

In discussing the involvement of OMCG members, some have suggested that 'outlaw' motor cycle gangs need to be distinguished from motor cycle 'clubs', and that even amongst gangs it may be only some individual members who become involved in criminality, and that often the gang entity itself has less direct involvement. This point has been emphasised by Von Lampe:

Outlaw motorcycle gangs are not necessarily criminal organisations themselves...it is more characteristic that some of their members are engaged in criminal activities, most notably drug trafficking and extortion. Still, being a member of an outlaw motorcycle club provides protection and a web of contacts that can potentially be used for criminal endeavours (Von Lampe cited in Ayling 2011, p.260).

The relevance of the distinction between the gang and its membership has taken on some importance in connection with legislation that seeks to prohibit membership of specified groups, such as OMCGs. Arguably this could be seen as being over-inclusive, targeting individuals who may be group members who have no involvement in criminal activities (Mann & Ayling 2012). Mann and Ayling argue that:

Anti-association measures have been designed to prevent criminal conspiracies among OMCG members. However, research emerging from Canada by Morselli (2009) suggests that the criminal activities of members and their associates may operate largely independently from the formal structure of the organisations that are targeted by this legislation (2012, p.5).

The use of anti-association legislation will be examined further in Chapter 19 on responses to organised crime.

Connections with legitimate business interests

Victoria Police's Submission to the Committee indicated that many OMCG members are involved in various legitimate industries that they use in connection with the distribution of ATS.⁹⁰⁸ These include the transport industry, tattoo parlours, gyms, and nightclubs that allow for the distribution of methamphetamine to a wider drug market.⁹⁰⁹ There is also some evidence of criminal gangs infiltrating chemical and pharmaceutical companies to facilitate the diversion of ATS precursors (Schloenhardt 2007). By using legitimate business interests, OMCGs can make detection of their illegal activities more difficult. Victoria Police has also found evidence that such groups engage in acts of intimidation in regional areas to facilitate the distribution of ATS, and that OMCG members involved in the methamphetamine trade make use of the transport industry:

Many members of OMCGs are known to own, have involvements in, (including silent partners/financiers) or exploit their relationship with associates who own or who are involved with trucking and

906 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

907 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

908 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

909 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

towing (heavy haulage) companies. Involvement in the transport industry allows for ready access to both inter and intra state distribution routes and networks.⁹¹⁰

The involvement of OMCG members in the ATS market

There is a lack of information available to quantify precisely the extent of OMCG members’ involvement in the methamphetamine market. This was noted by Dr Terry Goldsworthy of Bond University in evidence to the Committee:

It was interesting to note that the acting director of the ACC, when asked to put a percentage on how much organised crime OMCGs are involved in, would not or could not do it. I am not surprised by that, because in most of the [ACC’s] data they put out they do not quantify how much [OMCGs] are involved. The [ACC] merely say that [OMCGs] are part of the larger organised crime picture and just one group that operates within it.⁹¹¹

The extent of OMCG involvement in the ATS market in Victoria is revealed to some extent in Victoria Police statistics provided to the Committee. The Law Enforcement Assistance Program (LEAP) database contains information on ATS-attributable offences associated with OMCG members between 2010 and 2013. These data are collected by police making an assessment that individual suspects have some degree of association with OMCGs. This is then recorded in LEAP under the ‘Person of Interest’ database flag. Between 2010 and 2013, there has been an overall increase in the number of arrests, with most taking place in non-northern metropolitan regions. Again, this may be due to enhanced police activity rather than an increase in the underlying incidence of criminality. Due to the small number of arrests, it is difficult to demonstrate statistical significant of these trends. However, it should be recalled that in 2011-12, 4,494 ATS arrests were made in Victoria, which increased to 6,762 in 2012-13 (ACC 2014a). Accordingly, the number of OMCG ATS-related arrests in Victoria is exceedingly small.

Table 17.1: Number of ATS-attributable offences alleged against OMCG members by year and location

Year	OMCG ATS-related arrests		
	Northern Metropolitan Region	Southern, Eastern, Western Regions	Total
2010	8	12	20
2011	14	16	30
2012	7	20	27
2013	13	21	34
Total	42	69	111

Notes:

OMCG suspects were identified via ‘Person of Interest’ flag in LEAP.

Data provided are for ‘Alleged Offenders processed for amphetamine/methamphetamine offences’, who have OMCG affiliation.

Source: Victoria Police correspondence. Data extracted from LEAP database 5th May 2014, by Corporate Statistics.

Anecdotal evidence presented in submissions to the Committee indicated that OMCG members have involvement in all aspects of the ATS market.⁹¹² This includes the importation

910 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

911 Dr Terry Goldsworthy, Assistant Professor, Faculty of Society and Design, Bond University (via teleconference), Public Hearing, Canberra, 11 February 2014.

912 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014; Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

of precursors, robbery of pharmacies to procure pseudoephedrine, manufacture of ATS in clandestine laboratories, infiltration of the security industry to facilitate distribution and sales, and recruitment of drug users to settle debts. The Committee heard, in particular, of how those in rural and regional communities have been affected.

In criminal proceedings against members of a drug syndicate being heard in the County Court of Victoria in May 2014, evidence was given of the use of 'gangster-style violence in small country Victorian towns' (Mills 2014, p.9):

A young butcher was shot in his home, Molotov cocktails were thrown into two houses where children slept, a car was set alight and another run off the road and into a tree. There were numerous assaults as the syndicate wrestled for control and recovered drug debt. "This drug seems to bring about quite extreme acts of intimidation, violence; uncontrolled onto the innocent", Judge Bourke said (Mills 2014, p.9).

It has also been reported that OMCG members are involved in recruiting young people in rural towns to distribute crystal methamphetamine. On 1 November 2012, for example, *ABC News Online* reported that:

Police in a rural Victorian town say an outlaw motorcycle gang is recruiting young people to distribute the drug ice through the nightclub scene. The region's police chief, Simon Clemence said "we have some fairly specific information that an outlaw motorcycle group, who I can't name at this point in time, is working within the Mildura community to try and get young people hooked on the drug ice" (King 2012).

The report alleged that members of OMCGs are giving young people some free samples to test the drug. When they become addicted, the OMCG members create a 'tab' for the individual. This inevitably results in large debts being incurred which can only be settled through involvement in distribution activities.

Similar claims were made to the Committee by witnesses to the Inquiry.⁹¹³ Further, many witnesses would have liked to provide evidence to the Committee in this regard but feared recrimination.

The information collected as part of this Inquiry demonstrates some possible links in some areas of Victoria between OMCG members and illicit drug trade. This information is mainly supported by anecdotal evidence and law enforcement intelligence, however quantitative evidence of the extent of direct involvement in the methamphetamine trade in Victoria is very limited. The Committee believes that further intelligence is needed to quantify the level of involvement of organised crime groups in the distribution of methamphetamine within Victoria and interstate.

The involvement of Asian organised crime groups

The UNODC (2013a) has found evidence that Asian organised crime groups such as the Chinese triads, Japanese Yakuza, and Vietnamese gangs are involved in the illicit trade in heroin, cocaine as well as ATS. There is, however, limited literature in Australia to indicate the level of association of such groups. As Schloenhardt (2007) observed:

In contrast to purely local, small scale ATS production and distribution, larger operations which involve the importation of precursor substances or finished products into the region require the involvement of persons in multiple locations and invite for the creation or use of transnational criminal networks (Schloenhardt 2007, p.58).

913 See, for example, evidence from Superintendent Paul Naylor, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013.

Le & Lauchs (2012), in a study of models of South-East Asian organised crime drug operations in Queensland, described a categorisation of such groups developed by Ruggiero and Khan as:

A “family network” whose structure was not rigid or hierarchical; a “mono-ethnic network” comprising of individuals with the same ethnic background; “issue-specific networks” comprised of an “executive layer, middle management and a number of employees” that actively recruit members from diverse background; and, “value adding networks” which also recruits members from diverse backgrounds and establish alliances with any networks that can potentially benefit from their own enterprise (Le & Lauchs 2012, p.12).

Ayling and Broadhurst (2013, p.2) also stated that ‘a shift has been detected away from strongly hierarchical crime groups based on ethnicity, place or activity towards more flexible, entrepreneurial groups that are open to instrumental associations across ethnicities and operate in multiple criminal markets and across jurisdictions’.

Interception of ATS and precursor chemicals from the ‘Golden Triangle’ countries of Myanmar, Laos and Thailand has been well-documented for many years (UNODC 2013a). In 2011-2012, importations from India, and China (including Hong Kong) accounted for more than 24 percent of the amphetamine group substances detected at Australian borders (UNODC 2013a). Substantial amounts of final products and precursor chemicals used to manufacture methamphetamine are intercepted at the Australian border coming from South-East Asian countries including Singapore, Indonesia, Cambodia, Laos, Malaysia, Thailand, Myanmar and Vietnam. Le (2013) conducted a study of the operational structure of South-East Asian drug trafficking groups in Australia and found that such groups had an extensive involvement in the illicit drug market as users, dealers and importers.

Case study — ATS importation by Asian organised crime

The involvement of Asian-based organised crime is also evident from the results of a joint law enforcement investigation into suspected large-scale importations of methamphetamine by Hong Kong and Sydney-based individuals who were linked to Asian organised crime syndicates. During the investigation, it was established that a suspect based in Sydney was operating on behalf of a Hong Kong-based syndicate member and may have been in control of up to 100 kilograms of methamphetamine stored at a location in Sydney. AUSTRAC financial intelligence was used to link large transactions involving up to \$500,000 in cash that were carried out by a Sydney-based Chinese money remitter. The AUSTRAC Report found:

These funds were believed to be payments for the ‘ice’ importations. After the cash was collected by the associates, it was immediately broken up into smaller amounts and deposited into the bank accounts operated by the remitter and related businesses. The cash deposits were made via various banks and branches. The remitter made no attempt to structure the cash deposits below the \$10,000 cash transaction reporting threshold, and the funds were simply rolled into the general cash deposits of the remittance business. Once the funds were deposited into the remitter’s accounts, the remitter then transferred the funds domestically to the account of a Chinese-based foreign exchange trading platform. The remitter then used this trading platform to transfer the funds overseas to other related remittance and foreign exchange businesses, where the funds were available to overseas-based members of the syndicate (AUSTRAC 2011, p.30).

Four men arrested were charged with trafficking a commercial quantity of controlled drugs contrary to the *Criminal Code Act 1995* (Cth). It was estimated that the 50 kilograms of methamphetamine seized by law enforcement had a street value of \$20 million (AUSTRAC 2011, p.30). This investigation clearly shows the benefits of using financial intelligence collected by AUSTRAC, and made available to law enforcement agencies, in uncovering organised crime involvement in illicit drug markets.

Conclusion

On the basis of the evidence received by the Committee, it may be concluded that organised crime groups have some level of involvement in all aspects of the methamphetamine market in Australia, and in Victoria in particular. The market, however, operates using a number of other participants including individuals who participate principally to raise funds to support their own use of illicit drugs. Although addressing the part played by organised crime would interfere with the functioning of the ATS market considerably, there are many other participants whose activities also need to be addressed.

There has been considerable media attention given to the alleged participation of members of OMCGs in the illicit drug market in Victoria, and law enforcement provided anecdotal evidence and some police intelligence to the Committee to support this view. Further law enforcement intelligence is, however, needed to quantify the true extent of the involvement of organised crime groups in the illicit drug trade, particularly in relation to methamphetamine production and distribution by the members of OMCGs. Much of the evidence is general in nature, and fails to explore the involvement of organised crime, and OMCG members, in the specific operation of the methamphetamine and ice market in Victoria.

Recommendation 53

The Committee recommends that Victoria Police collaborate with the Australian Crime Commission to obtain more conclusive evidence of the extent of the involvement of organised crime groups in the distribution of methamphetamine within Victoria and interstate.

