



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

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

Final Report

VOLUME 2 of 2

September 2014

ORDERED TO BE PRINTED

**by Authority
Government Printer for State of Victoria**

The Report was prepared by the Law Reform, Drugs and Crime Prevention Committee.

Law Reform, Drugs and Crime Prevention Committee
Inquiry into the Supply and Use of Methamphetamines, particularly 'Ice', in Victoria — Final Report
Parliament of Victoria

ISBN:

Volume One - 978-0-9804595-9-3

Volume Two - 978-0-9941543-0-9

Law Reform, Drugs and Crime Prevention Committee

Parliament House, Spring St
Melbourne VIC 3002

Phone: (03) 8682 2810

Fax (03) 8682 2808

Email: lrdcpc@parliament.vic.gov.au

Website: <http://www.parliament.vic.gov.au/lrdcpc>

Contents

Law Reform, Drugs and Crime Prevention Committee — 57th Parliament	iii
Functions of the Law Reform, Drugs and Crime Prevention Committee	iv
Terms of Reference	iv
Chair’s Foreword	v
Acknowledgements	vii
Executive Summary and Recommendations	ix
Introduction	ix
Key Findings on the Use and Supply of Methamphetamine	ix
Statement of Principles underlying the Recommendations	xiv
Recommendations	xv
List of Tables and Figures	liii
List of Abbreviations	lvii
VOLUME ONE	
Section One — Contextualising the Supply and Use of Methamphetamine	1
PART A Background and History	3
1. Scope of the Inquiry: History and Background	5
Introduction	5
Background	5
The nature of methamphetamine and ice	6
This inquiry	10
Structure of the Report	16
2. National and State Policy Responses to Methamphetamine Use	19
Introduction	19
Australia’s national drug policy	19
National amphetamine-specific policies and initiatives	26
Drug policy in states/territories other than Victoria	30
Victorian drug policy	32
The specific versus general drug policy debate	34
Conclusion	35
PART B The Nature and Extent of Methamphetamine Use	37
3. Understanding Methamphetamine — the Drug and its Use	39
Introduction	39
A history of amphetamines and methamphetamine	39
Pharmacology of methamphetamine	44
Terminology	45
Form and composition	46
Price	48
Purity	51
Access and availability	57
Route of administration	61
Poly-drug use	63
Conclusion	64

4. International Perspectives	65
Introduction	65
A global problem	65
Asia and Oceania	66
Europe	67
United Kingdom	69
North America and Mexico	71
Australia	73
Conclusion	74
5. Prevalence and Extent of Harm	75
Introduction	75
Sources of information	75
Section One: Prevalence — Drug use in Victoria and Australia	76
Section Two — The extent of methamphetamine-related harm	105
Discussion and findings	121
PART C Effects of Methamphetamine — Physical, Psychological and Social	125
6. Medical and Psychological Consequences of Methamphetamine Use	127
Introduction	127
The effects of methamphetamine depend on numerous factors	127
Psychological and behavioural consequences of methamphetamine use	142
Conclusion	149
7. The Social and Environmental Impacts of Methamphetamine Use	151
Introduction	151
Family stress and breakdown: The social impact of methamphetamine	151
Violence, crime and (meth)amphetamine use	172
Environmental hazards and consequences associated with methamphetamine production	173
Economic and financial costs of methamphetamine use	177
Conclusion	182
8. Methamphetamine Use and Links to Crime	183
Introduction	183
Violence observed by emergency and health-care professionals	183
The Goldstein Tripartite Conceptual Framework	186
Statistical evidence on methamphetamine and related crime	187
Academic research	196
Conclusion	201
PART D The Patterns, Culture and Profiles of Methamphetamine Use	203
9. The Patterns of Methamphetamine Use	205
Introduction	205
Patterns of methamphetamine use	205
Conclusion	212
10. Poly-Drug Use: Compounding the Issues	211
The prevalence of poly-drug use	212
The experience of agencies	224
The reasons for poly-drug use	226
Medical and physical effects of poly-drug use	229
Conclusion	230

11. Methamphetamine use in Rural and Regional Victoria	233
Introduction	233
The diversity of regional Victoria	233
Methamphetamine use in rural and regional Victoria — A new problem?	234
Partnerships to address methamphetamine use in rural and regional communities	239
Conclusion	245
12. Methamphetamine Use and its Effect on Aboriginal communities	247
Introduction	247
Aboriginal Victorians — A snapshot	248
The extent of the problem in Aboriginal communities	249
Access and availability of methamphetamine in Aboriginal communities	252
Patterns of use	252
Reasons for methamphetamine use in Aboriginal populations	254
The impact of methamphetamine on the health and wellbeing of Aboriginal Victorians	257
The need for culturally appropriate service provision	265
Conclusion	269
13. Methamphetamine Use by Young People	271
Introduction	271
The prevalence of methamphetamine use amongst young people	271
Why young people use methamphetamine	273
Problematic methamphetamine use	282
Young people in out-of-home or residential care	286
Conclusion	289
14. Methamphetamine Use in Specific Populations	291
Introduction	291
General profiles of methamphetamine users	291
Functional use of methamphetamine	292
The use of methamphetamine by women	297
Methamphetamine in the gay, lesbian, bisexual and transgender communities	301
Inter-generational users	304
Methamphetamine users with pre-existing mental illnesses	304
Prisoners	305
Culturally and linguistically diverse communities	311
The use of methamphetamine as a therapeutic drug	316
Methamphetamine use amongst the homeless and poor	317
Methamphetamine use in sport	318
Conclusion	322
PART E Manufacture, Supply and Distribution of Methamphetamine	323
15. Direct Importation	325
Introduction	325
Law enforcement drug seizures	325
Precursor chemicals and ingredients	330
Final methamphetamine product	334
Online drug markets	335
Conclusion	337

16. Local Manufacture and Distribution	339
Introduction	339
Sourcing ingredients and equipment for production	340
The types of illicit production	340
The extent and nature of clandestine laboratories	343
The risks of domestic production	346
Drug markets and distribution	348
Inter-state distribution	348
Distribution within Victoria	349
Distribution by drug users	353
Conclusion	354
17. Involvement of Organised Crime	355
Introduction	355
The nature of organised crime in Australia	355
Case studies of organised crime in illicit drug markets	357
The involvement of outlaw motor cycle gang members	358
The involvement of Asian organised crime groups	361
Conclusion	363
VOLUME TWO	
SECTION TWO Strategies and Approaches to Address Methamphetamine Use	365
PART F Law, Law Enforcement, Policing and Supply Control	367
18. The Law Pertaining to Methamphetamine	369
Introduction	369
International law	369
Domestic law	370
Federal law	370
General legal issues pertaining to all states and territories	372
Overview of drug laws in the states and territories	375
Victorian law	381
Drug laws in other state jurisdictions	395
Conclusion	396
19. Responses to Organised Crime	397
Introduction	397
International Conventions	398
Domestic law pertaining to organised crime	399
Special techniques of investigation	408
Commonwealth entities involved in responding to organised crime in Australia	408
Victorian responses to organised crime	415
Administrative approaches to controlling organised crime	431
Conclusion	432
20. International and Domestic Precursor Controls	435
Introduction	435
International precursor controls	435
National precursor controls	438
Conclusion	448

21. Addressing Methamphetamine through Law Enforcement: Local level Policing, Alternative Justice and Diversion	451
Introduction	451
Policing methamphetamine use	451
Alternative criminal justice approaches	456
Diversion and alternative justice programs in Victoria	458
The New South Wales Compulsory Drug Treatment Correctional Centre and Program	481
Justice reinvestment	483
Conclusion	485
PART G Prevention, Education, Training and Information Provision	487
22. Prevention Strategies to address Methamphetamine Use — Promoting Resilience and Reducing Risk Factors	489
Introduction	489
Levels of prevention	489
Approaches to drug prevention	491
Prevention for young people — Schools and engagement	500
Providing alternatives — Connecting to the community	507
Conclusion	516
23. Education, Information and Support for Young People and Families	517
Introduction	517
A definite lack of knowledge	518
Drug education for young people	519
Education and support for families	549
Conclusion	552
24. Methamphetamine Awareness Campaigns and Community Education Strategies	555
Introduction	555
Community awareness and engagement	555
Mass media campaigns	562
The media and the reporting of methamphetamine	575
Conclusion	579
25. The Need for Workforce Development and Training for Professionals	581
Introduction	581
The need for a highly trained and supported workforce	582
The need for a national strategic approach to workforce development and training	583
Victoria’s Alcohol and Drug Workforce Framework and Implementation Plan	584
The need for a better trained and resourced workforce in the context of methamphetamine	584
Conclusion	597
26. Harm Reduction Approaches to Methamphetamine Use	601
Introduction	601
Harm reduction as part of an education model	602
Harm reduction and methamphetamine use — What is possible?	602
Barriers to using harm reduction approaches	609
Harm reduction: An essential component of addressing methamphetamine abuse	611
A contentious issue — the use of ‘ice pipes’	612
Conclusion	614
PART H Treatment Issues	617
27. Barriers to and Challenges for Treatment	619
Introduction	619
Extent and needs of users seeking or in treatment	619
Barriers to people seeking treatment	622
Challenges for treatment services	628
Conclusion	637

28. Best Practice Treatment and Service Provision	639
Introduction	639
Characteristics of the general population of methamphetamine users	639
Patterns of methamphetamine use and models of care	640
Effective treatment and evidence-based practice	642
A specialist treatment service model from Victoria	661
Residential rehabilitation	662
Management of mental health symptoms	664
Alternatives to face-to-face treatment: The case for online self-help and treatment opportunities	669
Need for follow-up and aftercare services	671
Adjusting treatment to better suit the needs of methamphetamine users	672
Family-centred practice	673
Conclusion	676
29. Treatment Needs of Specific Populations	679
Introduction	679
Treatment and service provision in rural and regional communities	679
Treatment needs for Aboriginal people	684
Treatment for young people	690
Treatment needs of other specific populations	693
Conclusion	698
SECTION THREE — The Way Forward	701
PART I Future Directions	703
30. The Supply and Use of Methamphetamine: A Call for Further Research and Evaluation	705
Introduction	705
The current framework for research into drug issues	705
The need for further research on methamphetamine	706
Gaps in the research on methamphetamine	708
Conclusion	719
31. The Development and Implementation of a Proposed Strategy to Address Methamphetamine Use	723
Introduction	723
The national framework	724
The need for state and local policies	725
Lessons from New Zealand: The ‘Tackling Methamphetamine Action Plan’	728
What type of model for Victoria?	734
Conclusion	739
32. Addressing Methamphetamine: Final Thoughts and Concluding Remarks	743
Introduction	743
Concerns with regard to methamphetamine use in Victoria	743
Key findings on methamphetamine in Victoria	744
The importance of harm minimisation	749
Developing and implementing policy	753
Final remarks	757
Appendices	759
Bibliography	817
Extract of the Proceedings	853
Minority Report	855

List of Tables and Figures

Tables

Table 2.1	Timeline of ATS policy initiatives in Australia	29
Table 3.1	Forms of methamphetamine available on the illicit drug market in Australia	48
Table 3.2	Average purity of methamphetamine samples 2008-2013	53
Table 3.3	Change in percentage of average purity of methamphetamine by location and year	53
Table 3.4	Participant reports of current methamphetamine purity, 2013	54
Table 3.5	Participant reports of methamphetamine purity change, 2013	55
Table 3.6	Availability of crystalline methamphetamine (ice/crystal), 2013	58
Table 3.7	Last source, purchase location and use location of crystalline methamphetamine (ice/crystal), 2013	59
Table 4.1	DEA domestic drug seizures of methamphetamine (kgs), 1986 to 2012	71
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	72
Table 5.1	Prevalence of recent illicit drug use, by drug type, Victoria and Australia, people aged 14 years or older, 2013 (percentage)	79
Table 5.2	Recent use of methamphetamine, persons aged 14 years or older, Victoria and Australia, 2001 to 2013	80
Table 5.3	Recent use of meth/amphetamines by remoteness area, 2004 to 2013	80
Table 5.4	Average age of initiation of lifetime methamphetamine use, people aged 14–24 years, 2001 to 2013 in Australia	81
Table 5.5	Recent use of meth/amphetamine, persons 14 years or older, by age category Victoria and Australia, 2004 to 2013	81
Table 5.6	Recent use of methamphetamine, people aged 14 years or older, by gender, Victoria and Australia, 2010 (percentage)	82
Table 5.7	Main form of meth/amphetamines used, population prevalence, Victoria and Australia, 2007 to 2013 (percentage)	83
Table 5.8	Summary tobacco, alcohol and recent illicit drug use, people aged 14 years or older, Australia, 1993 to 2013 (percentage)	85
Table 5.9	Percentage of students using amphetamines in the past month in 2005, 2008 and 2011, Australia (sample) and Victoria (sub-sample)	87
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	90
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	90
Table 5.12	Patterns of methamphetamine use (any form), 2013, Australia	96
Table 5.13	Patterns of methamphetamine use (any form), 2013, Victoria	97
Table 5.14	Proportion of IDUs who reported use of ice/crystal methamphetamine in the preceding six months, 2003 to 2013	97
Table 5.15	Prison entrants, illicit drug use in the 12 months preceding 2012 for selected drugs, by sex, age group and Indigenous status	106
Table 5.16	Use of illicit drugs during the last 12 months, prison entrants (percentage)	107
Table 5.17	Characteristics of crystal methamphetamine-related Ambulance attendances, 2011-12 and 2012-13	108
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	111
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	112
Table 5.19	Frequency of hospital-treated methamphetamine-related injury and poisoning cases by intent and age group, Victoria, 2008-09 to 2012-13	114
Table 5.20	Frequency of hospital-treated methamphetamine-related injury and poisoning cases by intent and cause, Victoria, 2008-09 to 2012-13	114

Table 5.21	Number of calls where amphetamines were cited as drugs of concern	117
Table 5.22	DirectLine 2013 — Amphetamine related calls	117
Table 5.23	Age and gender of callers 2013	118
Table 5.24	Annual frequency of deaths where methamphetamine was present by age group and sex, Victoria, 2009 to 2013	119
Table 5.25	Annual frequency of deaths where methamphetamine was present by location of usual residence, Victoria, 2009 to 2013	120
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	121
Table 6.1	Dose-related effects of methamphetamine use	128
Table 2.2	Major psychological harms associated with methamphetamine use	143
Table 7.1	Number (n) of methamphetamine positive roadside tests by gender and region	166
Table 7.2	Number (n) of positive roadside tests by age and year	167
Table 7.3	Detection rates (%) by year and region	167
Table 7.4	Victorian road fatalities 2009–2013 involving methamphetamine	171
Table 8.2	Amphetamine-type stimulants (ATS), number and percentage of consumer and provider arrests, by state and territory, 2012-2013	189
Table 8.3	Percentage of different types of offences that were attributable to ATS in 2012-13.	195
Table 8.4	Number of different types of offences that are attributable to ATS (by year), 2008–2013	196
Table 8.5	Criminal activity among regular psychostimulant users (RPU), 2013	198
Table 9.1	Patterns of methamphetamine use	206
Table 9.2	Places at which recent users usually use meth/amphetamine, 2004 to 2013	208
Table 10.1	Poly-drug uses, recent drug users aged 14 years or older, Australia, 2013 (percent)	215
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	216
Table 10.3	Drugs used at the same time when using meth/amphetamines, 2004 to 2013	217
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	218
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 (%)	219
Table 10.6	Comparison between national and Victorian lifetime and recent (last six months) poly-drug use of RPU, 2013	220
Table 10.7	Drug use among the national sample in the six months preceding interview, 2013	221
Table 13.1	Factors influencing first use of an illicit drug, lifetime users aged 14 years or older, by sex, 2007 and 2010 (percent)	273
Table 13.2	Risk and protective factors associated with youth substance abuse and antisocial behaviour	285
Table 15.1	Number and weight of amphetamine-type stimulants and crystal methamphetamine (ice) detections at national borders	327
Table 15.2	National Border Methamphetamine and Amphetamine Type Stimulant (ATS) Precursor Seizures	328
Table 15.1	Victoria border methamphetamine and amphetamine type stimulant (ATS) precursor seizures	329
Table 15.2	Methods of manufacture of methylamphetamine samples as a proportion of analysed AFP border seizures classified by precursor, 2010–June 2013	332
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	332
Table 16.1	Methods of ATS (excluding MDMA) production in clandestine laboratory detections, by state and territory, 2012–13	342
Table 16.2	Number of clandestine laboratory detections, by state and territory, 2003-04 and 2012-13	343
Table 16.3	Number of clandestine laboratory detections by calendar year in Victoria	344

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	350
Table 16.5	Number of amphetamine seized property records by region, year and type	351
Table 16.6	Usual source of meth/amphetamine supply, 2004 to 2013	352
Table 17.1	Number of ATS-attributable offences alleged against OMCG members by year and location	360
Table 18.1	Trafficable threshold quantities (in grams) in Australia by drug type, system (purity or mixed based), and jurisdiction	374
Table 18.2	Commonwealth, State and Territory Drug Offences and Penalties as of May 2014	376
Table 18.3	Maximum penalties for Victorian drug offences under the DPCSA 1981	386
Table 19.1	<i>Crimes Legislation Amendment (Serious and Organised Crime) Act 2010 (Cth) and Crimes Legislation Amendment (Serious and Organised Crime) Act (No. 2) 2010 (Cth)</i> amendments from existing legislation	401
Table 19.2	<i>Criminal Code Act 1995 (Cth)</i> organised crimes and maximum penalties	403
Table 19.3	Summary of asset recovery measures in Australia**	406
Table 20.1	Pharmacy registrations, instructions kits sent and uptake by jurisdiction in February 2010	442
Table 21.1	Rewards and sanctions that can be applied by the Drug Court Magistrate	471
Table 22.2	Definitions of prevention strategies	497
Table 23.1	Principles for School Drug Education	522
Table 23.2	Simple Dos and Don'ts when providing information about drug use	527
Table 24.1	Ice forum participant responses to the question, 'What would you like more information about?'	561
Table 24.2	Methamphetamine and ICE in the news, 3 September 2013–2 July 2014	575
Table 27.1	Comparison of methamphetamine treatment outcomes to that of other main drug types	621
Table 27.2	Resources currently available on methamphetamine treatment	636
Table 31.1	Action — Improving routes to treatment	732
Table 31.2	Progress Report 2014 — Improving routes to treatment	733

Figures

Figure 2.1	Main components of Australia's National Drug Strategy	22
Figure 2.2	Availability of amphetamine inhalers on Pan Am flight menu in the 1940s	25
Figure 2.3	Victoria's 15-point alcohol and drug plan	33
Figure 3.1	Magazine advertisements for amphetamine products from the 1950s and 1960s	41
Figure 3.2	Chemical structure of phenethylamine and typical amphetamine type stimulants	44
Figure 3.3	Annual median purity of methamphetamine samples, 2003–04 to 2012–13	52
Figure 5.1	Recent use of meth/amphetamines by gender and age, Victoria, 2010	83
Figure 5.2	Percentage of students who have ever used amphetamines (for non-medical reasons) in their lifetime, by age and sex, 2011	86
Figure 5.3	Percentage of students who believe it is very dangerous to use amphetamines occasionally, by age and sex, 2011	88
Figure 5.4	Recent methamphetamine use by form of drug used among national EDRS participants, 2003 to 2013	91
Figure 5.5	Recent methamphetamine use by form of drug among Victorian EDRS participants, 2008 to 2013	92
Figure 5.6	Proportion of participants reporting methamphetamine use in the past six months, National, 2001 to 2013	95
Figure 5.7	Proportion of participants reporting methamphetamine use in the past six months, Victoria, 2001 to 2013	96
Figure 5.8	National data on the proportion of detainees who tested positive to methamphetamine, National, 1999 to 2012	99
Figure 5.9	Detainees testing positive to methamphetamine, Victoria, 2006 to 2012	100
Figure 5.10	National trends on perceived change in quality of methamphetamine, 2009 to 2012	101
Figure 5.11	Comparison between national and Footscray data on perceptions of detainees regarding change in quality of methamphetamine, 2012	101

Figure 5.12	National trends on perceived change in price of methamphetamine, 2009 to 2012	102
Figure 5.13	Comparison between national and Footscray data on perceptions of detainees regarding change in price of methamphetamine, 2012	103
Figure 5.14	National trends on perceived change in the availability of methamphetamine, 2009 to 2012	104
Figure 5.15	Comparison between national and Footscray data on the perceptions of detainees on availability of methamphetamine, 2012	104
Figure 5.16	Frequency of hospital admissions for psychostimulant-related injury and poisoning by financial year, Victoria 1998-99 to 2012-13	110
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	111
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	111
Figure 5.18	Frequency of hospital-treated methamphetamine-related injury and poisoning cases by age group and sex, Victoria, 2008-09 to 2012-13	112
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	113
Figure 5.20	Age Distribution of clients receiving treatment for their own amphetamine use	116
Figure 7.1	Estimated financial burden on a 21-year-old methamphetamine user at Junction Support Services	178
Figure 7.2	Interventions required for a drug user	181
Figure 8.1	Amphetamine-type stimulants: consumer and provider arrests, 1999/00–2011/12	187
Figure 8.2	Percentage of charges by offence classification for Australian police detainees who tested positive to methamphetamine, 1999–2012	191
Figure 8.3	Percentage of charges by offence classification for Footscray detainees who tested positive for methamphetamine, 2006-2012	192
Figure 8.4	Percentage of charges by offence classification for Footscray and National methamphetamine using detainee samples, 2012	193
Figure 8.5	Percentage of charges by offence classification for Footscray and National heroin using detainee samples, 2012	194
Figure 10.1	Proportion of detainees from the all sites who tested positive for methamphetamine and another drug in 2012	223
Figure 15.1	National ATS seizures, by number and weight, 2003–04 to 2012–13	326
Figure 16.1	A clandestine laboratory	341
Table 16.1	Methods of ATS (excluding MDMA) production in clandestine laboratory detections, by state and territory, 2012–13	342
Table 16.2	Number of clandestine laboratory detections, by state and territory, 2003-04 and 2012-13	343
Table 16.3	Number of clandestine laboratory detections by calendar year in Victoria	344
Figure 16.2	Trends in the number of clandestine laboratories in Victoria between 2003-2004 and 2012-2013	345
Figure 16.3	Victoria Police Regions	350
Figure 16.4	Comparison between national and Footscray data on perceptions of detainees regarding change in the number of people selling methamphetamine, 2012	352
Figure 22.1	A Systems model for the prevention of alcohol and other drug problems	493
Figure 27.1	Temporal relationship between methamphetamine use and first drug treatment	622
Figure 28.1	Typical course of methamphetamine withdrawal, and potential for enduring sub-acute symptoms	651
Figure 28.2	Potential symptomatic relief for symptoms of amphetamine withdrawal	654
Figure 28.3	Temporal relationship between methamphetamine use and mental health symptoms	664
Figure 31.1	The three pillars of the National Drug Policy (Ministry of Health (NZ) 2013)	729
Figure 31.2	New Zealand Action Plan Overview	731
Figure 31.3	Suggested methamphetamine strategy	735

SECTION TWO

Strategies and Approaches to Address Methamphetamine Use

PART F

Law, Law Enforcement, Policing and Supply Control

18. The Law Pertaining to Methamphetamine

Introduction

The legislative framework with regard to illicit drugs in all Australian states is for the most part prohibitionist, depending on the drug in question. However, increasingly criminal justice responses are recognising that some drug use practices are less deserving of punitive legal sanctions than others. For example the possession of small amounts of drugs is being dealt with by way of cautions and diversionary processes rather than being dealt with by criminal sanctions such as fines or imprisonment.⁹¹⁴ Similarly, the law reflects the notion that some drugs are less inherently dangerous or deserving of sanction than others. Thus offences and penalties for cannabis will be of a different severity than those for heroin and methamphetamine and these variations in penalty that apply will relate to the gravity with which the drug class is viewed.

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.

This chapter examines the domestic criminal laws with regard to methamphetamine and where necessary for comparative reasons, other illicit drugs. It concentrates primarily on the law in Victoria but also canvasses briefly the main aspects of drugs law in each of the states and territories of Australia.⁹¹⁵ To put these domestic laws in context, it is also necessary to briefly examine how international conventions direct and shape Australian drug law.⁹¹⁶

International law

A brief account of the main international conventions to which Australia is a signatory will serve to contextualise the following discussion on Commonwealth, State and Territory laws. This chapter is not primarily concerned with international law as it applies to domestic drug regulation,⁹¹⁷ for example, precursor control.

International conventions and provisions shaping Australian drug laws

International law pertaining to the control of illicit drugs, including methamphetamine is governed by a number of conventions to which Australia is a signatory. These include:

- ◆ The United Nations Single Convention on Narcotic Drugs (1961);
- ◆ The United Nations Convention on Psychotropic Substances (1971); and
- ◆ The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).

Subject to the 1971 Convention, drugs are scheduled depending on their public health risk or therapeutic potential. Four schedules classify the drugs, with those in Schedule

914 See discussion in Chapter 21.

915 Given the length of the chapter, most discussion of interstate law is located in Appendix 11.

916 The law cited is correct as of August 2014.

917 This is more properly the province of Chapters 19 and 20.

One having the greatest public health risk and those in Schedule Four having the most therapeutic potential.

Schedule One drugs are generally outlawed for general consumption. Meth/Amphetamines are usually placed in the first schedule.

Once a drug is placed on the Convention's schedule, signatories to the convention then adopt these schedules and their content within their own legislation. In Australia, methamphetamine is a listed drug on both Commonwealth and all state and territory drugs schedules.

Of particular importance in the area of methamphetamine and methamphetamine manufacture is the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Subject to this Convention, an international control regime has been established to prevent precursor chemicals being used to make illicit amphetamines. This will be discussed in Chapter 20.

Subject to the international Conventions, the Commonwealth has also enacted the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990*.⁹¹⁸

Domestic law

As Australia is a federation with a division of constitutional responsibility between the states and the Commonwealth, Australian law concerning drugs is divided between state and federal jurisdictions. Under Australian constitutional law criminal offences that fall solely within the boundaries of the states or territories fall under that state or territory's jurisdiction. Thus with some exceptions, theoretically Australia has eight different sets of domestic criminal laws pertaining to illicit drugs. These exceptions pertain primarily to extra-territorial and cross-border importation/exportation offences and laws enacted as a result of international convention obligations. When the responsibility for drug law enforcement falls solely within the state's responsibility, there is no legal requirement for consistency across the several jurisdictions. Should a state enact a drug-related law that the Commonwealth considered breached its international obligations, that law could be rendered invalid under Section 109 of the Constitution.⁹¹⁹

Subject to the United Nations treaties outlined above, particularly the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, amphetamine, amphetamine analogues and derivatives, methamphetamine and its analogues have been scheduled as prohibited drugs under state legislation.⁹²⁰

Federal law

The relevant federal legislation is the Commonwealth Criminal Code; the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* and the *Customs Act 1901*. The Commonwealth Constitution has no specific head of responsibility for drugs law. It can, however, enact laws with regard to drugs and drug policy pursuant to its external affairs power in Section 51 (xxix) of the Australian Constitution and its concomitant obligations under international conventions to which it is a signatory.

918 This will be discussed below under the section on federal law.

919 Sec 109 states:

'When a law of a State is inconsistent with a law of the Commonwealth, the latter shall prevail, and the former shall, to the extent of the inconsistency, be invalid'.

920 An exception is dexamphetamine which under Commonwealth law is classified by the Therapeutic Goods Administration as a Schedule 8 Controlled Substance given its (limited) therapeutic use in the treatment of narcolepsy, ADHD and similar disorders.

Commonwealth Criminal Code

Offences under the Commonwealth Criminal Code (the Code) primarily concern conduct relating to the import and export of drugs. These offences were previously found in the *Customs Act* and versions of these have been updated and moved into the Code through the passage of the *Law and Justice Legislation Amendment (Serious Drug Offences and other measures) Act 2005*.

The main drug offences under the Code are found in Part Nine and include:

- ◆ Trafficking controlled drugs (Division 302)
- ◆ Commercial manufacture of controlled drugs (Division 305)
- ◆ Pre trafficking controlled precursors (Division 306)
- ◆ Import and export offences (Division 307)
- ◆ Possession offences (Division 308)
- ◆ Drug offences involving or harming children (Divisions 309, 310).

The offences in each category are tiered according to the quantity of the drug involved. As with most jurisdictions, greater penalties apply to commercial or marketable quantities of the drug in question.⁹²¹

The main offences relate to the import and export of border controlled drugs or the possession and supply of controlled drugs. Methamphetamine and its analogues are listed as both border controlled drugs and controlled drugs. The distinction relates to whether they are import/export offences, that is, into or out of Australia (border controlled drugs), or crossing borders within Australia (controlled drugs).

The applicable penalty for bringing a commercial quantity of methamphetamine (0.75kgs or more) into Australia is life imprisonment, 7500 penalty units⁹²² or both. Whilst for the importation or exportation of a marketable quantity of methamphetamine (2 grams or more) the penalty is 25 years imprisonment, 5000 penalty units or both. Lesser quantities of the drug being supplied for a commercial purpose may attract a penalty of 10 years, 200 penalty units or both. In addition there is an offence that applies to lesser amounts of the drug without an intention to supply for a commercial purpose (ie. simple possession). This attracts a penalty of two years imprisonment, 400 penalty units or both.⁹²³

Precursors

Division 307 also allows for offences pertaining to the importation and exportation of border controlled precursor chemicals with the intention of manufacturing a controlled drug. The applicable penalty where a marketable quantity is involved is 15 years imprisonment or 3000 penalty units or both. This penalty increases to 25 years imprisonment and 5000 penalty units or both for the importation/exportation of commercial quantities. The commercial and marketable quantities are based on the amount of precursor necessary to manufacture the corresponding amount of border controlled drugs.

Offences relating to children

Special provisions apply under Division 309 of the Code for adults who involve children younger than 18 years of age in drug offences. These include offences pertaining to supplying

921 Commercial and marketable quantities of border controlled drugs are listed in Schedule 4 of the Commonwealth Criminal Code Regulations 2002. Current quanta are 0.75 kilograms for a commercial quantity and 2 grams for a marketable quantity.

922 One Commonwealth penalty unit is equal to \$170.00.

923 See Division 308.1 *Criminal Code*.

a child with a controlled drug,⁹²⁴ procuring a child to import controlled drugs and precursors or supplying a child with a drug with the intention that the child traffics it.⁹²⁵ There are also provisions pertaining to procuring children to 'pre traffic' in controlled substances and precursors. 'Pre traffic' in this context means procuring the child to sell the substance knowing that the person to whom it is sold intends to use it to manufacture a controlled drug.⁹²⁶ Finally, under Division 309.10 child endangerment laws have been enacted penalising offenders who expose a child to danger or harm through their manufacturing of illicit drug activities.⁹²⁷

Customs Act 1901

Most of the provisions of the *Customs Act* pertaining to illicit drug crime have been repealed and replaced by the relevant sections of the Code. However, case law decided under the equivalent repealed sections of the *Customs Act* may still provide guidance in interpreting the Code provisions. Moreover the powers of arrest, detention, search and seizure still extant under the *Customs Act* are still applicable to procedural law applicable to the Code and the investigation of federal drug offences.⁹²⁸

Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990

The Commonwealth has enacted the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* pursuant to its obligations under United Nations drug treaties, namely the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988.

This Act needs to be read in conjunction with the Criminal Code. It primarily concerns drug offences having extra-territorial effect and drug offences committed on Australian aircraft or shipping.

General legal issues pertaining to all states and territories

Before discussing the drug laws of each state and territory, it is important to canvass briefly issues which apply across all jurisdictions: specifically, the Model Code on Drug Laws and the concept of legal drug thresholds.

Model Code on drug laws

Recognising the practical problems arising from having multiple criminal codes across the country, a Model Criminal Code Committee (MCCC) of the Standing Committee of Attorneys-General was established to try and reach agreement on uniform model laws to address illicit drug use and supply. Its Report on Model Serious Drug Offences was published in 1998. The Report recognised that in Australia organised crime involving illicit drugs transcends state and national boundaries and that a diversity of laws in different jurisdictions could lead to different and inconsistent outcomes for alleged traffickers. Given this, the MCCC argued that there was 'a persuasive case for uniformity in the definition of serious offences such as drug trafficking' (Model Criminal Code Offences Committee 1998, p.ii in Makkai & Beattie 2012, p.164).

Consequently, some jurisdictions have in part enacted similar legislation to adopt the model legislation from the Code.⁹²⁹ Provisions, offences and penalties are therefore approximately

924 See Division 309. 2 *Criminal Code*.

925 See Division 309. 3 and 309.4 *Criminal Code*.

926 See Division 309. 10–12 *Criminal Code*.

927 In such cases the offender will be subject to a maximum penalty of 9 years imprisonment and/or 1800 penalty units.

928 See generally *Customs Act 1901*, Section 219.

929 This has not been part of a formal process whereby the suggested Code legislation has been adapted uniformly across the country.

comparable in Victoria, Tasmania, South Australia and the Commonwealth and not overly dissimilar from the other states and territories.⁹³⁰

A note on drug thresholds and deeming provisions

Most jurisdictions in Australia incorporate different drug threshold quantities which are used to measure the gravity of the offence. Usually three different thresholds will be employed to distinguish the seriousness of drug use. Whilst the terminology may differ between states these are generally:

- ◆ A small quantity — the possession of which will usually constitute personal use
- ◆ A commercial quantity; and
- ◆ A large commercial quantity.

The latter two quantities form the basis of trafficking or supply offences. Each threshold triggers increasingly severe penalty ranges.⁹³¹

In addition to these thresholds most jurisdictions employ the mechanism of the trafficable quantity.

A trafficable quantity is the amount of illicit drug, the possession of which will be deemed to be trafficking as opposed to personal use and thereby attract more severe maximum penalties.⁹³² Whilst there may be no external or additional evidence of drug trafficking, the mere possession of the trafficable amount will be *prima facie* evidence that the drug was in the defendant's possession for the purposes of trafficking.

In many jurisdictions, including Victoria, it will be incumbent upon the defendant to show that the drug was not in his or her possession for the purposes of trafficking but for personal use only. This is a reversal of the traditional onus of proof by which the prosecution must prove the charge. The standard of proof, however, in most jurisdictions is that the defendant must show on the balance of probabilities that the drug amount was in his or her possession for personal use only. This is a lesser standard to meet than the traditional beyond reasonable doubt, the standard the prosecution must meet to secure a conviction with regard to most criminal cases.

The quantity of drug that constitutes a trafficable amount, thereby triggering the deeming provisions, is found in the Schedules of most state and territory legislation. For methamphetamine the prescribed trafficable amount in most jurisdictions is between 2 and 3 grams. Recognising the reality that most illicit drugs sold and seized contain substances other than the pure drug, most jurisdictions define their threshold quantities in terms of total weight or mixed substances including admixtures.⁹³³ See Table 18.1.

930 There are still some notable dissimilarities and gaps particularly in the area of child endangerment laws. See discussion later in this chapter.

931 See Table 18.2.

932 Queensland has a slightly different system whereby rather than being deemed a trafficker for possessing a trafficable amount, the possession of a prescribed amount will result in penalties equal to trafficking rather than an actual charge as a drug trafficker. See *Drug Misuse Act 1986* (Qld) and the discussion in Hughes et al. 2014.

933 Again Queensland is the exception defining its threshold quantities in terms of pure substance only.

Table 18.1: Trafficable threshold quantities (in grams) in Australia by drug type, system (purity or mixed based), and jurisdiction

	Heroin	Meth/amph	Cocaine	MDMA	Cannabis (leaf)
Purity based system					
Qld	2	2	2	2	500
Mixed based system					
ACT	5	6	6	10	300
NT	2	2	2	0.5	50
NSW	3	3	3	0.75	300
SA	2	2	2	2	250
Tas	25	25	25	10	1000
Vic	3	3	3	3	250
WA	2	2	2	2	100

Source: Adapted from Hughes et al. 2014, p.13.⁹³⁴

Criticism has been made of utilising trafficable quantity mechanisms as a measure for determining criminal liability. The rationale for their use is that it is unlikely the possession of a trafficable amount could be for personal use only and they are thereby a useful tool with which to address drug traffickers who may otherwise only be sanctioned for simple possession offences.

Some academics have argued, however, that the current amounts set as trafficable quantities (3 grams in the case of methamphetamine in Victoria) are too low and that there could be conceivable cases where a person may have that amount in their possession for personal use. One such example could be the perceived need by the user to stockpile an amount over the trafficable quantity whilst prices are low. In such cases it is argued that the user may be unjustly at risk of receiving the far greater penalties for trafficking when there was in fact no intention to do so; alternatively, there may be cases where the amount of drug used in a heavy session of drug use for personal consumption also exceeds the trafficable minimum. In Victoria this could mean a maximum sentence of 15 years compared to one year for possession for personal use.⁹³⁵

The issue of legal drug thresholds was examined by a research team headed by Dr Caitlin Hughes of the University of New South Wales. Dr Hughes gave evidence to the Committee on the content and findings of this research. She emphasised how the settings of the thresholds could be arbitrary and anomalous and not necessarily correlate with the seriousness or conversely relative harmlessness of the drugs used:

One interesting quandary is how the quantities get set and how they have come about. Regardless of whether you are looking in Australia or internationally, we really have very little knowledge, but it is clear they were devised many years ago and often based on assumptions or ad hoc rationale with very little use of research. Often this was because research was not available at the time that these laws were being devised. This has raised some concerns about whether the thresholds have been appropriately designed. The research we have been conducting in recent years has been trying to look at the design

934 Note: In April 2014, the Australian Capital Territory amended its legislation to increase the threshold quantity amounts. The trafficable amount for methamphetamine is now 6 grams mixed. To some extent this legislative change was based on the evidence based findings coming out of the work of Dr Hughes and her colleagues on drug threshold quantities discussed above.

935 For a discussion of these arguments, see Hughes et al. 2014.

and use of an evidence-informed approach to see whether the thresholds are designed to do what they are supposed to. By that I mean whether the thresholds sufficiently differentiate intentional traffickers from those who use or purchase illicit drugs for their own personal consumption and, if they do that, whether they then enable the judiciary to provide a sanction according to the seriousness of the particular drug-trafficking offence that has been committed... For Victoria specifically, we found most illicit drug users consume about 0.1 to 1 gram, which is well under the trafficable amounts; however, we found that when undertaking heavy or binge sessions regular illicit drug users can consume more than the trafficable amounts for different drugs — for example, we found regular users of cocaine in Victoria can consume up to 1.6 times the current trafficable threshold, regular users of ecstasy can consume up to 1.9 times the current trafficable threshold and regular users of methamphetamine can consume up to 2.3 times the current trafficable threshold.⁹³⁶

Whilst the Model Criminal Code (MCC) recommended a set of uniform drug threshold quantities for each Australian jurisdiction; on the surface a sensible reform, Hughes et al. are critical of such a proposal given that the original proposed thresholds were not necessarily based on any rational or evidence-based formula and in some cases were even lower than those set in most jurisdictions today.⁹³⁷ Moreover, whilst the Commonwealth Government has pushed for the states to adopt the proposed thresholds set by the MCC in 1998, the amounts and their suitability to the realities of drug use and supply or the relative harms that flow from this have not since been revisited or reassessed:

In recent times there has been renewed attention to the inconsistency of Australian drug trafficking schedules and threshold quantities. Concerns that this may reduce the capacity to respond effectively to drug trafficking have led to increased pressure for jurisdictions to maintain and harmonise their thresholds (Attorneys-Generals Department, 2011; Ministerial Council on Drug Strategy, 2007, 16 May) in line with quantities outlined in the 1998 Australian Model Criminal Code for serious drug offences (MCCOC, 1998). Yet, a rational basis for whether these recommendations ought to be adopted, that is whether they will serve jurisdictions to respond to drug trafficking, has been ignored. Moreover, given the proposed threshold quantities are lower than currently used in many jurisdictions, there is a real need to refocus policy and legislative reform debates on whether current or proposed drug trafficking thresholds are fit for purpose (Hughes et al. 2014, p.18).

Overview of drug laws in the states and territories

Although the content of the state and territory drug legislation can vary in each jurisdiction the central themes are the same. 'Penalties are higher for those found to be dealing in drugs than for those possessing them for their own use, and people convicted of trafficking large amounts of drugs are liable for a greater penalty than lower level dealers' (Makkai & Beattie 2012, p.164).

The possession of cannabis is uniformly treated more leniently just as drug trafficking particularly of 'heavier' drugs such as heroin and methamphetamine is viewed as a very serious offence and conviction in most jurisdictions may result in a maximum penalty of life imprisonment where large quantities are involved.

Table 18.2 compares the various drug offences that can be charged in each of the states and territories and the maximum penalties they attract.

936 Dr Caitlin Hughes, Research Fellow, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of New South Wales, Public Hearing, Melbourne, 5 May 2014.

937 For example, in the case of methamphetamine the trafficable quantity was proposed at 2 grams (Hughes et al. 2014, p.17). In some states the trafficable quantity for methamphetamine today is 3 grams.

Table 18.2: Commonwealth, State and Territory Drug Offences and Penalties as of May 2014

	Commonwealth	Victoria	New South Wales	Queensland	South Australia	Western Australia	Tasmania	Australian Capital Territory	Northern Territory
	Criminal Code 1995	Drugs, Poisons and Controlled Substances Act 1981	Drug Misuse and Trafficking Act 1985	Drugs Misuse Act 1986	Controlled Substances Act 1984	Misuse of Drugs Act 1981	Misuse of Drugs Act 2001	Drugs of Dependence Act 1989 Criminal Code 2002	Misuse of Drugs Act
	<p>Note: Offences under the Code are divided into Border Controlled Drugs and Controlled Drugs. Although the drugs in question are the same [eg: methamphetamine], the circumstances in which the drug charges are used differ. BCD are used for import/export to/from Australia offences. Controlled drugs are used for offences crossing state borders.</p>								
Use	State or territory charges are used	Section 75 (b) 30 p.u and/or 1 year	Sec 12 20 p.u 2 years	See possession offences	Sec 33L \$2000 2 years	See Simple Possession	Sec 24 50 p.u. 2 years	Sec 169 DDA 50 p.u. 2 years	Sec 13 Administering a dangerous drug to self 17 p.u. 2 years
Possession	Division 308.1 Possessing controlled Drugs 400 p.u. and/or 2 years Div 307.7 Possessing unlawfully imported BCD 400 p.u. and/or 2 years	Not related to trafficking Sec 73(1)(b) 30 p.u. 1 year	Sec 10 20 p.u 2 years	Sec 9 If Schedule 4 amount (200 gms +) 25 years If Schedule 3 amount (2gms +) and person drug dependent 20 years If not — 25 years Lesser amounts 15 years	Sec 33L \$2000 2 years	Sec 6(2) Simple Possession \$2000 2 years	Sec 24 50 p.u. 2 years	Sec 169 DDA 50 p.u. 2 years	Sec 9 Less than trafficable amounts in a public place 85 p.u 5 years Less than trafficable amounts in a private place 40 p.u. 2 years

Note the penalties listed are in maxima

PU = Penalty Units

* These maximum penalties apply to all offences pertaining to drugs of dependence, including methamphetamine, other than cannabis which attracts lesser penalties.

	Commonwealth	Victoria	New South Wales	Queensland	South Australia	Western Australia	Tasmania	Australian Capital Territory	Northern Territory
Possession Related to Trafficking	Division 307.5 Possessing commercial quantities of border controlled drugs reasonably suspecting to be unlawfully imported 7500 p.u. and/or Life imprisonment Div 307.6 Possessing marketable quantities of border controlled drugs reasonably suspecting to be unlawfully imported 5000 p.u. and/or Life imprisonment	Sec 73(1)(c) 400 p.u. 5 years	Sec 29 If a trafficable amount deemed to be possession for supply and charged accordingly	See Sec 9	Sec 331 \$50,000 10 years	Sec 6(1) Possession with intent to sell \$100,000 25 years Unless for an amount that can be heard summarily (less than 4 gms) in which case \$5,000 4 years	Sec 12 Possessing a trafficable amount deemed to constitute offence of trafficking 21 years (20 individual packages or 25 grams)	Sec 164 DDA 500 p.u. 5 years	Sec 9 (2)(b) Possession of trafficable quantity in a public place 14 years Otherwise 7 years Sec 9 (2)(a) Possession of commercial quantity 25 years
Trafficking Large Commercial Quantity	Not applicable	Sec 71 5000 p.u. Life imprisonment	Sec 33 5000 p.u. Life imprisonment		Sec 32 \$500,000 Life imprisonment	See Sec 6(1) and provisions of Sec 32A re Declaration of drug traffickers		Crim Code Sec 603 Life imprisonment	
Trafficking Commercial Quantity	Division 302 Controlled Drugs. 7500 p.u. and/or Life imprisonment Division 307 BCD. 7500 p.u. and/or Life imprisonment	Sec 71AA 3000 p.u. 25 years	Sec 25(2) 3500 p.u. 20 years		Sec 32 (2) Basic offence \$200, <?> **** \$500,000 Life imprisonment	See Sec 6(1) and provisions of Sec 32A re Declaration of drug traffickers		Crim Code Sec 603 2500 p.u. 25 years	Sec 5 Unlawful supply – not a commercial quantity 25 years
Trafficking Other Quantity	Division 302.3/302.4 Controlled Drugs Division 307 BCD 5000 p.u. and/or 25 years 200 p.u. and/or 10 years	Sec 71AC 1800 p.u. 15 years	Sec 25 2000 p.u. 15 years Sec 25A Special Offence of ongoing supply ('3 strikes' law) 3500 p.u. 20 years	Sec 5 General trafficking provision Sec 6(1)(c) Other supply 20 years	Sec 32 (3) Basic offence \$50,000 10 years Aggravated offence**** \$7 <?> ^^^ Basic offence \$7,5000 15years<?>**** \$200,0000 25 years	Sec 32A -Declarations of drug traffickers Where a person is declared a drug trafficker, they firstly face the penalty for the offence which caused the declaration (usually an offence of possession of drugs with intent to sell or supply). In case of methamphetamine more than 28 grams Where a declaration is made under s32A of the <i>Misuse of Drugs Act</i> , section 8 of the <i>Criminal Property Confiscation Act 2000</i> (WA) is triggered. Where this occurs, all property owned by the person at the time of the declaration and all property given away before or after the declaration can be confiscated	Sec 26 Selling or supplying a controlled drug less than trafficable amount 100 p.u. 4 years Sec 12 Trafficking a controlled substance 21 years	Crim Code Sec 603 1000 p.u. 10 years	Sec 5 Unlawful supply –not a commercial amount 14 years

**** In South Australia aggravated offence means when the offender committed the offence for the benefit of or for at the request of a criminal organisation.

^^^ In South Australia prescribed areas include licensed premises and their environs and areas of public entertainment including queues and car parks.

**** In South Australia aggravated offence means when the offender committed the offence for the benefit of or for at the request of a criminal organisation.

Commonwealth	Victoria	New South Wales	Queensland	South Australia	Western Australia	Tasmania	Australian Capital Territory	Northern Territory
<p>Child endangerment offences</p> <p>Div 310.2 Danger from exposure to unlawful manufacturing 1800 p.u. 9 years</p> <p>Div 310.3 Harms from exposure to unlawful manufacturing 1800 p.u. 9 years</p>		<p>Child exposure and endangerment offences Sec 24 (1A) Non-commercial amount 2400 p.u. 18 years</p> <p>Sec 24 (2A) Commercial quantity 4200 p.u. 25 years</p>	<p>See Supply — Sec 6</p>		<p>Sec 34(5) Maximum penalties as per 6(1)(b) Manufacture However judge must impose a mandatory minimum of no less than 12 months or other minimum penalties if offence involves endangering child's life or causing harm to a child</p>	<p>Sec 13 Procuring a child to traffic 21 years</p>	<p>Sec 624 Procuring a child to traffic (commercial quantity) Life imprisonment Other quantities 2500 p.u. 25 years</p>	
<p>Traffic or Supply to a Child</p> <p>Division 309.2 Supplying a child with a controlled drug 3000 p.u. and/or 15 years</p> <p>Division 309.3 Supplying marketable quantities of drug to a child for the child to traffic. 7500 p.u. and/or Life imprisonment</p> <p>Division 309.4 Supplying less than marketable amounts to a child for trafficking 5000 p.u. and/or 25 years</p>	<p>Sec 71AB Trafficking to a child 20 years</p> <p>Sec 71B Supply to a child 1000 p.u. 15 years</p>	<p>Sec 25 (1A) Non-commercial amount 2000 p.u. 15 years</p> <p>Sec 25 (2A) Commercial amount 4200 p.u. 25 years</p> <p>Sec 33 Large commercial quantity 5000 p.u. Life imprisonment</p>	<p>Sec 6(1)(a) Supply to a child under 16 Life imprisonment</p> <p>Sec 6(1)(aa) Supply to a minor over 16, intellectually impaired and other categories 25 years</p>	<p>Sec 33F Sale or supply to a child or possession with intent to so sell or supply \$1,000,000 Life imprisonment</p> <p>Sec 33G Sale or supply in a school zone or possession with intent to so sell or supply \$1,000,000 Life imprisonment</p>		<p>Sec 14 Supplying a controlled drug to a child 21 years</p>	<p>Sec 625 Supplying a controlled drug to a child 2000 p.u. 20 years</p>	<p>Sec 5 Unlawful supply to a child –any amount Life imprisonment</p>
<p>Possession of Documents</p> <p>Div 308.4 (Controlled Drugs) 1400 p.u. 7 years</p>	<p>With intention of trafficking Section 71A 10 years</p>	<p>Sec 11C (Summary Offence) 20 p.u. 2 years</p>	<p>Sec 8A 25 years</p>	<p>Sec 33LAB \$10,000 2 years</p>			<p>Sec 614 Possession of substance, equipment or instructions to manufacture a controlled drug 500 p.u. 5 years</p>	<p>Section 8B (1)(3) Possession of documents specifying manufacture of precursors or drugs if found together with equipment to manufacture 7 years</p>

	Commonwealth	Victoria	New South Wales	Queensland	South Australia	Western Australia	Tasmania	Australian Capital Territory	Northern Territory
Possession of Equipment (Including Ice Pipes)	Div 308.4 (Controlled Drugs) 1400 p.u. 7 years	With intention of trafficking Section 71A 10 years	Sec 11 (Summary Offence) 20 p.u. 2 years	Sec 10(1) 15 years Sec 10(2) In connection with use or administration 2 years	Sec 33LA \$10,000 2 years	Sec 5(1) Owner or lessee allowing premises to be used for purposes of illicit drug manufacture, preparation or use etc \$3000 3 years Sec 5(1)(e) Owner or lessee allowing premises to be used for purposes of use etc \$2000 2 years Sec 7B Possession of drug paraphernalia \$10,000 Unless sold to a child then: \$24,000 2 years	Sec 23 Possession of thing to administer a controlled drug. 50 p.u.		Sec 12 Possessing things to administer dangerous drugs. 17 p.u. 2 years
Possession of Precursors	Division 308.2 (Controlled Drugs) 400 p.u. or 2 years	Sec 71D 600 p.u. 5 years	Sec 24A 2000 p.u. 10 years	Sec 9A 15 years	Sec 33LB \$10,000 3 years See also Sec 33A [Next row]	Sec 14(2) \$12,000 3 years 14(1) If exceeds simple amount (37gms pseudoephedrine for example) If heard summarily \$12,000 3 years Otherwise \$20,000 5 years	Sec 12 Possessing a trafficable amount deemed to constitute offence of trafficking 21 years (20 individual packages or 25 grams)	Sec 612(1) Possession of large commercial amount with intention to manufacture or sell 2500 p.u. 25 years Sec 612(3) Commercial quantity 1500 p.u. 15 years Sec 612(5) Other amount 700 p.u. 7 years	Sec 8A 7 years

	Commonwealth	Victoria	New South Wales	Queensland	South Australia	Western Australia	Tasmania	Australian Capital Territory	Northern Territory
Trafficking of Precursors	(Border controlled drugs) Division 30711 5000 p.u. (commercial) and/ or 25 years Division 30712 3000 p.u. (marketable) and/ or 15 years Division 30713 (lesser amounts) 1400 p.u. 7 years	With intention of trafficking Section 71A 10 years		Sec 9D 20 years	Sec 33A Sale or possession of large commercial quantity of precursors \$200, <?>**** then \$500,000 Life imprisonment Sale or possession of commercial quantity of precursors \$75,000 15 years Unless aggravated offence**** then \$200,000 25 years Other quantity - 500,00 10 years unless aggravating circumstances**** then 750,00 15 years	Sec 6(1)(b) Sec 6(1) \$100,000 25 years Unless for an amount that can be heard summarily (less than 4gms methamphetamine) in which case \$5000 4 years	Section 27A Unlawful importation of controlled substances 50 p.u. 2 years Sec 12 Trafficking a controlled substance 15 years 21 years Trafficable amount of pseudoephedrine =(200gms)	Sec 610(1) Large commercial quantity of controlled precursor 2500 p.u. 25 years Sec 610 (3) Commercial quantity 1500 p.u. 15 years Sec 610(5) Other amount 700 p.u. 7 years	Sec 8D Supplying precursors knowing to be used to manufacture dangerous drug. 7 years
Manufacture of Drugs of Dependence	Division 305 Manufacturing commercial quantities of controlled drugs. 7500 p.u. or Life imprisonment Manufacturing marketable quantities of controlled drugs. 5000 p.u. or 25 years Manufacturing lesser amounts 2400 p.u. or 12 years	For the purposes of trafficking Sec 71A 10 years	Sec 24 (1) Non-commercial amount 2000 p.u. 15 years Sec 24 (2) Commercial amount 3500 p.u. 20 years Large commercial amount 5000 p.u. Life imprisonment	Sec 8 If Schedule 4 amount (200 gms +) 25 years If Schedule 3 amount (2gms +) And person drug dependent 20 years If not — 25 years Lesser amounts 15 years	Sec 33j Manufacture not for sale \$35,000 7 years Sec 33 Manufacture for sale — large commercial quantity \$500,000 Life imprisonment for sale — commercial quantity \$200,000 25 years unless aggravating circumstances**** -then 500,000 Life imprisonment Other quantity - 500, <?>**** then 750,00 15 years	Sec 6(1)(b) Sec 6(1) \$100,000 25 years Unless for an amount that can be heard summarily (less than 4gms methamphetamine) in which case \$5000 4 years	Sec 21 Manufacturing a controlled drug 50 p.u. 2 years Sec 20 Manufacturing a controlled precursor 50 p.u. 2 years Sec 6 Manufacturing trafficable amounts	Sec 607 (1) Manufacturing large commercial quantities Life imprisonment Sec 607 (3) Commercial quantity 2500 p.u. 25 years Sec 607 (5) Other quantity with intention to sell 1500 p.u. 15 years Sec 609 Simple manufacture 1000 p.u. 10 years	Sec 8 Manufacture commercial quantity Life imprisonment Manufacture non-commercial quantity 25 years

**** In South Australia aggravated offence means when the offender committed the offence for the benefit of or for or at the request of a criminal organisation.

Victorian law

The Victorian *Drugs, Poisons and Controlled Substances Act 1981* (DPCSA) covers mostly drug offences occurring within the jurisdictional boundaries of Victoria. These include offences pertaining to:

- ◆ Use
- ◆ Possession
- ◆ Cultivation⁹³⁸
- ◆ Trafficking

Methamphetamine and its derivatives are listed in Schedule 11 as drugs of dependence to which the DPCSA offences will apply.

Use

The use of a drug of dependence other than cannabis⁹³⁹ is a summary offence that provides for a maximum penalty of 30 penalty units or imprisonment of one year or both (Section 75(b) *Drugs, Poisons and Controlled Substances Act 1981*).⁹⁴⁰ Use is defined under Section 70 as including smoking, inhaling the fumes of or introducing a drug of dependence into one's body.

A variety of diversion programs are available for people charged with non-violent drug use offences who can show that they have a 'drug problem'. These include the Court Referral and Evaluation for Drug Intervention and Treatment program, the Court Integrated Services Program, the Criminal Justice Diversion Program and Drug Treatment Orders under the Drug Court. A discussion of these diversion programs is found in Chapter 21.

Possession

Possession is an indictable offence under Section 73 of the Act. Winford explains the relevant law as follows:

Under common law, a person is in possession of a drug if he or she has physical control or custody of the drug to the exclusion of others not acting with the person. The prosecution must prove knowledge by the person of the presence of the drug and an intention by the person to possess the drug. In many cases, custody of a drug may supply sufficient evidence of possession, including the necessary mental element. This is because the inference of knowledge may often be drawn from the surrounding circumstances.

As well as its common law meaning, possession has an extended meaning under the *Drugs, Poisons and Controlled Substances Act 1981*: section 5 states that a person is in possession of drugs if he or she is in possession of drugs that are:

- On any land or premises occupied by the person; or
- Used, enjoyed or controlled by the person in any place whatsoever, unless the person satisfies the court to the contrary.⁹⁴¹

Deeming provision

The legislation also contains a deeming provision which in effect changes prima facie accounts of possession into trafficking or supply charges.

If the court is satisfied that the:

938 These laws will not be discussed as cultivation is not applicable to methamphetamine.

939 Use and possession of cannabis attracts lesser penalties including the use of a cautioning scheme.

940 A penalty unit in Victoria is currently worth \$144.36.

941 Fitzroy Legal Service 2014, *Law Handbook*, Chapter 4.1, 'Drug offences', at www.lawhandbook.org.au/handbook/ch04s01.php. Chapter written by Stan Winford.

- ◆ Substance found on premises is an illegal drug; and
- ◆ The premises were occupied by the accused

The accused is prima facie guilty of possession unless he or she can prove on the balance of probabilities that they were not in common law possession of the drug as defined above. In other words, a reverse onus of proof applies, albeit on the lesser standard of proof of the balance of probabilities. The burden of proof can be satisfied by the accused when he or she can lead evidence that they did not know the drug was on the premises, or even if they did, they had no intention to possess it.⁹⁴²

With the exception of cannabis, the penalties relating to possession of a drug that is not related to trafficking is 30 penalty units and/or one year's imprisonment (Section 73(1)(b)).

Possession of a trafficable quantity

If the prosecution can prove:

- ◆ The requisite elements of possession
- ◆ Of an identifiable illegal drug
- ◆ That is of a trafficable quantum (3 grams in the case of methamphetamine)

This will constitute prima facie evidence of trafficking (Section 73 (2)).

Prima facie evidence of trafficking means that a court or jury may be satisfied that the offence has been committed unless the defendant can lead evidence to the contrary. If the offence of possession for trafficking is substantiated the defendant will be convicted and penalised of a trafficking offence.⁹⁴³ In other words, if the court is not satisfied that the possession of the drug was not for the purposes of trafficking, a higher maximum penalty of up to 400 penalty units or imprisonment for five years or both will apply (Section 73(1)(c)).

Trafficking

The law of trafficking is complex. In simple terms, if the prosecution proves the following matters:

- ◆ The accused was in possession⁹⁴⁴
- ◆ Of a scheduled drug
- ◆ Of a quantity that is a *trafficable quantity*

then this will be prima facie evidence of the crime of trafficking in the particular drug. Similar to federal law, a trafficable amount is determined by reference to a prescribed weight listed for that drug in the Eleventh Schedule of the *Drugs, Poisons and Controlled Substances Act 1981*.

Victoria has implemented threshold quantities for drug trafficking, as have most other states and territories. The purpose of which is to differentiate 'traffickers' from those who purchase drugs for their own personal use and consumption and who therefore should be sentenced more leniently (Hughes et al. 2014). These legal thresholds specify the quantities of drugs over which offenders will be presumed to have possessed the drugs for the purposes

942 Fitzroy Legal Service 2014, *Law Handbook*, Chapter 4.1, 'Drug offences', at www.lawhandbook.org.au/handbook/ch04s01.php. Chapter written by Stan Winford.

943 The penalties for which are detailed below.

944 Section 5 of the Act outlines the physical requirements for a person to be deemed in possession as follows:

'Any substance shall be deemed for the purposes of this Act to be in the possession of a person so long as it is upon any land or premises occupied by him or is used, enjoyed or controlled by him in any place whatsoever, unless the person satisfies the court to the contrary.'

The use of the phrase 'any place whatsoever' would extend to drugs found in cars and other vehicles.

of supply and consequently sentenced as drug traffickers. In Victoria the trafficable amount for methamphetamine is set at 3 grams (mixed amount).⁹⁴⁵

Extended meaning of trafficking

Under Section 70(1) of the Act, the definition of trafficking has been extended to include preparing or manufacturing a drug of dependence for trafficking, in addition to sale or possession for sale of the drug. Thus in effect, trafficking also extends to manufacture even where no actual trafficking has occurred. Under Section 71A of the *Drugs, Poisons and Controlled Substances Act*:

A person who, without being authorised by or licensed under this Act or the regulations to do so, possesses a substance, material, document containing instructions relating to the preparation, cultivation or manufacture of a drug of dependence or equipment with the intention of using the substance, material, document or equipment for the purpose of trafficking in a drug of dependence is guilty of an indictable offence and liable to level 5 imprisonment (10 years maximum).

Such an extended definition of trafficking dispenses with the common law interpretation of trafficking as requiring some form of ‘movement from source to ultimate user in the course of trade.’⁹⁴⁶

Thus the manufacture or ‘cooking’ of methamphetamine may constitute trafficking even though no actual trafficking has yet occurred as long as it can be proven that the manufacture was intended to be for the ultimate purpose of trafficking.

The following are some scenarios which if proven would result in successful trafficking convictions under the extended definition:

1. Preparing a drug for trafficking — thus a person who dries cannabis or packages heroin is guilty of trafficking, provided that the preparation was intended for trafficking; this is so even though no actual trafficking has occurred;
2. Manufacturing or making a drug, even though no actual trafficking has occurred;
3. Selling or exchanging a drug for something;
4. Agreeing to sell, even though the actual sale does not occur;
5. Offering to sell a drug to another, whether or not the offer is accepted or the sale takes place. Even if the substance turns out not to be a drug of dependence on analysis, the mere belief by an accused that they were selling a drug of dependence is sufficient to come within the ambit of “offering to sell” (*Gauci v Driscoll* [1985] VR 428). The case of *Pierce v The Queen* [1996] 2 VR 215 extends offering to sell to include a “rip-off”, so that even where there is no proof that there is an intention to complete the offer or that the accused was even in a position to complete such, they may be found guilty of trafficking. In the *Pierce* case, the court only required proof that the accused intended the offer to sell to be taken seriously;
6. Possessing a drug together with an intention to sell it, even though there is no sale. It is common to find persons telling the police that the reason for their possession is that they intend to sell some of the drug, but that confession is accompanied by a vehement denial that any sale has taken place. These persons are guilty of trafficking;
7. Buying drugs for a friend from a third person if that friend has given you the money to buy the drugs, even if a profit is not made from the transaction;
8. Arranging for one party to sell to another party, even if no profit is made.⁹⁴⁷

⁹⁴⁵ For a critical analysis of the drug threshold provisions across Australia and whether such laws may result in some users being sentenced as traffickers unjustly or inappropriately, see Hughes et al. 2014.

⁹⁴⁶ See *R v Clarke and Johnstone* [1986] VR 643 at 659.

⁹⁴⁷ Fitzroy Legal Service 2014, *Law Handbook*, Chapter 4.1, ‘Drug offences’, at: www.lawhandbook.org.au/handbook/ch04s01.php. Chapter written by Stan Winford.

Drug amounts

The DPCSA allows for a range of penalties depending on the amount of drug in question. Under the Act the following amounts are relevant:

- ◆ Small quantity⁹⁴⁸
- ◆ Trafficable quantity⁹⁴⁹
- ◆ Commercial Quantities⁹⁵⁰
- ◆ Large Commercial quantity.⁹⁵¹

Of particular importance is the fact that at state level the trafficable amount of the drug is no longer weighed as pure amounts. The relevant weight is now the weight of the whole mixture, including substances other than the drug. Thus, for example, the trafficable amount of methamphetamine, currently listed as 3.0g, could in appropriate circumstances include a compound mixed of pure methamphetamine and talcum powder, baking soda, sugar, or other substances.

In addition to trafficable quantities, as with the federal law, a person may also be convicted of the more serious crime of trafficking in a commercial quantity. Commercial quantities and large commercial quantities for drugs of dependence are found in Part Three of Schedule Eleven of the Act.

These latter two categories are still differentiated between pure amounts of the drug and where the drug may be mixed with other compounds or additives. The current commercial quantity of methamphetamine is 100 gms (pure amount) and 500gms (mixed amount). The current large commercial quantity of methamphetamine is 750 gms (pure) and 1kg (mixed amount). Methamphetamine precursors such as pseudoephedrine and phenyl-2-propanone (P2P) are also listed in Part Three of Schedule Eleven.

Finally, the legislation allows for aggregated quantities of drugs for commercial or large commercial amounts. In other words, these amounts can be comprised of an aggregate of two or more drugs of dependence when the quantity of each drug alone does not constitute a commercial or large commercial quantity.⁹⁵²

Case law on trafficking and evidential problems

Two case law decisions have established some important precedents with regard to trafficking. First, in *R v Pierce*⁹⁵³ the Supreme Court of Victoria found that to offer a drug for sale without any intent to produce that drug is still trafficking. In *Gauci v Driscoll*⁹⁵⁴ the Court held that a mistaken belief by the vendor that a substance is a drug when it is offered for sale is still evidence of trafficking (for example a person believing they are selling speed when the substance is actually baking powder).

Nonetheless, evidence given to the Committee has indicated that notwithstanding these laws, it is not always easy to secure trafficking convictions due to evidential requirements. For example Detective Inspector Paul Maher from Victoria Police told the Committee:

948 For methamphetamine 0.75gms under Schedule 11, Part 3, Column 4 of the Act.

949 For methamphetamine 3gms under Schedule 11, Part 3, Column 3 of the Act.

950 For methamphetamine 100gms pure or 500gms mixed under Schedule 11, Part 3, Columns 2 and 2A of the Act.

951 For methamphetamine 750gms pure or 1kg mixed under Schedule 11, Part 3, Columns 1A and 1B of the Act.

952 The quite complex formulae and equations for working out the aggregates of various combined drugs is set out in Section 70 of the Act.

953 1996 2 VR 215.

954 1985 VR 428.

At the moment in Victoria if you are in possession of more than 3 grams of an amphetamine-type substance — being methylamphetamine or amphetamine — that is classed as a prima facie trafficable quantity. On the face of it that is a trafficable quantity, but it is for the police to prove they have it in their possession for trafficking. We would also need other evidence such as text messages on the person's phone indicating transactions; what we refer to as 'tick sheets' — people's names with amounts and numbers next to them of what they owe; scales; or plastic bags. If we can get all those items with that 3 grams, we will then have enough evidence to charge them with that.

The problem we have is, for example, if they are in possession of 50 grams of ice, it is still a prima facie trafficable quantity; it is not until it gets to 100 grams pure or 500 grams mixed [that it can be charged as a commercial quantity]. Someone may have 50 grams of ice on them, which is potentially \$35 000 worth, walking down the streets of Shepparton, but unless we have these other bits of evidence such as tick sheets, text messages and scales we are having trouble getting support from the courts to convict those people with trafficking. If someone is in possession of 50 grams of ice compared to 3 grams, it is a huge difference and something that could be looked at legislatively.⁹⁵⁵

As such, Victoria Police has made a recommendation to the Inquiry with regard to possession of certain substances by virtue of weight alone to automatically constitute trafficking. Using the example raised by Inspector Maher, if a person is found in possession of 50 grams of methamphetamine this should constitute trafficking without the need for any other evidence to be led by the police. It would be up to the defendant to disprove that he or she was not in possession of the drug for trafficking.⁹⁵⁶

Penalties for trafficking offences

Trafficking offences of non-commercial amounts attract a maximum penalty of 15 years' imprisonment.⁹⁵⁷ These sentences increase to 20 years' imprisonment when the person is convicted of trafficking to a person under the age of 18.⁹⁵⁸

A conviction for trafficking in a commercial quantity results in a maximum penalty of 25 years' imprisonment.⁹⁵⁹ If the person is convicted of trafficking in a large commercial quantity, the penalties are even more severe — maximum of life imprisonment and in addition up to 5000 penalty units.⁹⁶⁰ Table 18.3 sets out the penalties for the major drugs offences under the DPCSA.

955 Detective Senior Sergeant Paul Maher, Detective Acting Inspector, Goulburn Valley Division 3, Victoria Police, Public Hearing, Shepparton, 25 February 2014.

956 Detective Senior Sergeant Paul Maher, Detective Acting Inspector, Goulburn Valley Division 3, Victoria Police, Public Hearing, Shepparton, 25 February 2014.

957 Section 71AC DPCSA (Vic).

958 Section 71AB DPCSA (Vic).

959 Section 71AA DPCSA (Vic).

960 Section 71. Note these penalties are concurrent not disjunctive, ie. if found guilty the defendant is subject to imprisonment *and* a hefty fine.

Table 18.3: Maximum penalties for Victorian drug offences under the DPCSA 1981

Offence	Jurisdiction (indictable or summary)	Penalty section	Imprisonment (years)	Fine (number of penalty units)
Use				
Cannabis	Summary	75(a)	-	5
Other drug	Summary	75(b)	1	30
Possession				
Cannabis not related to trafficking	Indictable offence, triable summarily	73(1)(a)	-	5
Other drug not related to trafficking	Indictable offence, triable summarily	73(1)(b)	1	30
Other possession	Indictable offence, triable summarily	73(1)(c)	5	400
Cultivation				
Not related to trafficking	Indictable offence, triable summarily	72B(a)	1	20
Other	Indictable offence, triable summarily	72B(b)	15	1800
Commercial quantity	Indictable	72A	25	3000
Large commercial quantity	Indictable	72	Life	5000
Trafficking				
Large commercial quantity	Indictable	71	Life	5000
Commercial quantity	Indictable	71AA	25	3000
Other quantity	Indictable offence, triable summarily	71AC	15	1800
Supply of drug to a child	Indictable offence, triable summarily	71B	15	1000
Trafficking to a child of a non-commercial quantity of a drug	Indictable offence, triable summarily	71AB	20	2400
Possession of substance, <i>material</i> , documents or equipment for <i>trafficking</i> in a drug of dependence	Indictable offence, triable summarily	71A	10	
Conspiracy to				
Traffic	Indictable offence, triable summarily	79(1)	As for trafficking	
Cultivate	Indictable offence, triable summarily	79(1)	As for cultivation	
Possess	Indictable offence, triable summarily	79(1)	As for possession	
Introduction of a drug into the body of another	Summary	74	1	30
Forging, altering, or uttering prescription	Summary	78	1	20
False representation to obtain drug, injection or prescription	Summary	78	1	20

Source: Winford 2014.

Offences relating to children

There are a number of offences in the Act that reflect the particular gravity of acts that involve children and minors in the use or trade of illicit drugs. For the purposes of these sections, a child is defined in Section 70 as a person under the age of 18 years.

The primary offence relating to children is that of trafficking to a child a non-commercial quantity of an illegal drug (Section 71AB).⁹⁶¹

An offence of supplying a drug of dependence to a child for either that child's own use or for the child to supply the drug to another person is also found in Section 71B of the Act. In this case the term 'supply' has been interpreted as including 'those circumstances where the drug is simply given to the child or is bought for the child and then given to the child without a profit being made' (Winford 2014). It is a defence to the charge if the person supplying the drug to the child believes on reasonable grounds that the child is 18 years or more of age.⁹⁶² Maximum penalties on conviction for this offence are a fine of 1000 penalty units and/or 15 years imprisonment.

Prescribed precursor chemicals

As described in Chapter 16, a person in possession of precursor chemicals prescribed in Schedule 11 of the Act is guilty of an indictable offence and liable for a maximum penalty of 600 penalty units, five years imprisonment or both.⁹⁶³ Other offences relating to precursors and precursor apparatus are found in Part VB of the Act. These relate primarily to bookkeeping, transaction and supply records, storage and proof of identity provisions for legitimate suppliers and receivers. Under Section 80N of the Act end user declarations for precursor chemicals must be kept for at least five years after the date of supply.⁹⁶⁴

Miscellaneous offences

There are a variety of other miscellaneous drug-related offences under the Act. These include:

- ◆ Introducing a drug of dependence into another person's body⁹⁶⁵
- ◆ Forging a prescription for a drug of dependence⁹⁶⁶
- ◆ Making false representations to obtain drugs of dependence⁹⁶⁷
- ◆ Possessing a substance, material, documents or equipment for trafficking in a drug of dependence⁹⁶⁸
- ◆ Possessing a tablet press without lawful excuse.⁹⁶⁹

One important miscellaneous law in the context of this Inquiry however, is the ban on selling 'ice pipes' as implements used to smoke methamphetamine.

Prohibition of ice pipes — Part VAB

In 2004, the Victorian Government legislated to ban the sale of 'ice pipes', that is apparatuses through which drugs such as methamphetamine can be smoked. Theoretically, however,

961 The maximum penalty for this offence is 20 years imprisonment as indicated earlier.

962 Section 71B (4) DPCSA (Vic).

963 Section 71D. DPCSA (Vic).

964 See Chapter 20 for further discussion of supply control of precursor chemicals.

965 Section 74 DPCSA (Vic).

966 Section 77 DPCSA (Vic).

967 Section 78 DPCSA (Vic).

968 Section 71A DPCSA (Vic).

969 Section 71C DPCSA (Vic).

this does not make the *use* of such apparatuses illegal. As one senior police officer told the Committee:

At the moment it is only an offence to sell the implements, so a shop cannot have a smoking implement in possession for sale. In other jurisdictions it is an offence to be in possession of a smoking implement, so you have your crack pipe or ice pipe as they are referred to and even a bong which is used to smoke cannabis. If we intercept someone with that in their car, it is no offence at the moment.⁹⁷⁰

Interestingly, evidence has been given to the Committee that because the use/possession of ice pipes is not illegal in Victoria but incurs a \$2000 fine in New South Wales,⁹⁷¹ some people particularly in border areas⁹⁷² such as Albury will drive across the border into Victoria to have ‘their night out’ with the smoking pipe.⁹⁷³

Some witnesses have given evidence that the ban on the sale of ice pipes should be rescinded. Their rationale for this position is that making it difficult to obtain smoking implements may result in users shifting to the arguably more dangerous mode of injecting.⁹⁷⁴

Regulations prescribing drugs of dependence

As a result of amendments made to the parent Act by the *Drugs Poisons and Controlled Substances Act Amendment (Drugs of Dependence) Act 2011* the Governor-in-Council, on advice from the Minister, may make regulations prescribing a substance as a drug of dependence; specifying which part of Schedule 11 listing drugs of dependence it is to be listed under; and specifying quantities in relation to the drug for the purposes of Schedule 11. Such a provision facilitates the easier listing of new drugs (for example synthetic cannabinoids or amphetamine type precursors) as they emerge in Victoria.⁹⁷⁵ In recommending a substance to be listed under the section, the Minister must be satisfied that the substance represents a significant risk to the health of consumers; or a significant risk to public safety.⁹⁷⁶

The Severe Substance Dependence Treatment Act (SSDTA) 2010

The SSDTA is civil legislation that allows in certain circumstances a person to be detained and provided with treatment for their drug dependence. Under Section 3 of the Act such detention and treatment should only be initiated when it is necessary to save the life of a person with severe substance dependence or to prevent serious damage to that person’s health. Under the objectives of the Act, such a measure is to be considered a ‘last resort’ and only applicable if there is no less restrictive means reasonably available to ensure the person receives required treatment.⁹⁷⁷ Any person over the age of 18 may make an application to a Victorian Magistrates’ Court for a detention and treatment order enabling the person subject to the order to be taken to a designated treatment centre for up to 14 days. The application must be accompanied by a recommendation from a medical practitioner who has examined the person for whom the order is intended and agrees in his or her expert opinion that such compulsory treatment is required.⁹⁷⁸

The merits or otherwise of involuntary treatment of people with severe substance dependence including methamphetamine dependence is discussed in Chapter 27 of this Report.

970 Detective Acting Inspector Paul Maher, Goulburn Valley Division 3, Victoria Police, Public Hearing, Shepparton, 25 February 2014.

971 Or a maximum penalty of 2 years imprisonment. See Section 11 *Drug Misuse and Trafficking Act 1985* (NSW).

972 For a discussion of cross-border issues in policing drug-related crime, see Chapter 21.

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

974 The merits or otherwise of such a position are discussed in Chapter 26 in the context of harm reduction interventions.

975 Section 132AA, DPCSA (Vic).

976 Section 132AA, (2) DPCSA (Vic).

977 Section 8, SSDTA (Vic).

978 Sections 10, 12 and 20, SSDTA (Vic).

Sentencing provisions

As indicated throughout this chapter, the DPCSA imposes a complex series of penalties depending on the nature of the substance, the purpose for which it is possessed and the quantum of the drug in question.⁹⁷⁹ With the exception of cannabis, penalties for the most part do not discriminate between illicit drugs. Thus the penalties for trafficking methamphetamine will attract the same penalty as the same quantum of heroin. The penalties in the DPCSA are maximum not mandatory penalties, unlike the provisions in some other state drug legislation.⁹⁸⁰

The penalties in the DPCSA need to be read in conjunction with the *Sentencing Act* 1991. Drug offences in the DPCSA are for the most part indictable (more serious) although some of them may be heard summarily. If they are heard in a summary jurisdiction the magistrate is limited to imposing a maximum penalty to a fine of 500 penalty units or two years imprisonment for a single offence.⁹⁸¹

The dispositions available to a judge or magistrate under the Sentencing Act in decreasing order of severity are:

- ◆ Prison sentences;
- ◆ Drug treatment orders;
- ◆ Suspended prison sentences;
- ◆ Detention in a youth training centre (for young people);
- ◆ Community correction orders (with or without conviction);
- ◆ Fines (with or without conviction);
- ◆ Adjourned undertakings — also known as “good behaviour bonds” (with or without conviction); and
- ◆ Charges proven and dismissed without penalty.

Some of these penalties can have conditions attached to them, requiring assessment, supervision and treatment for drug or alcohol addiction. Such conditions can only be attached if the *offender* agrees to comply with them (Winford 2014).

It should be noted that the Victorian Parliament recently enacted the Sentencing Amendment (Baseline Sentences) Bill 2014 to amend the parent *Sentencing Act* 1991 and *Drugs, Poisons and Controlled Substances Act* 1981. The purpose of this Bill was to increase baseline/median sentences for a range of indictable offences. This is not to be confused with the *maximum* sentences applicable for indictable crimes which will remain the same. In the area of drug law, a new median sentence for trafficking in a *large commercial quantity* is being proposed. It is envisaged if passed this will increase the median penalty from a 7 to a 14 year period of imprisonment. The rationale for, and mechanics of, the Bill were discussed by the Assistant Treasurer, the Hon. Gordon Rich-Phillips in the Second Reading Speech of the Bill in the Legislative Council.⁹⁸²

Adjourned bonds

Under Section 76 of the DPCSA, first-time drug offenders charged with the use or possession of any ‘small quantity’ of drug found in Part 3 of Schedule 11 (most ‘street drugs’ including

979 Fitzroy Legal Service 2014, *Law Handbook*, Chapter 4.1 ‘Drug offences’, at www.lawhandbook.org.au/handbook/ch04s01.php. Chapter written by Stan Winford.

980 For example the sentencing options for the judiciary in Western Australia have been curtailed with the introduction of mandatory penalties for certain drug offences related to or affecting children. See discussion in Appendix 11.

981 Sections 112A and 113, *Sentencing Act* 1991.

982 See Sentencing Amendment (Baseline Sentences) Bill 2014 Second Reading, The Hon. Gordon Rich-Phillips, Hansard (Council) 26 June 2014, p.2195.

methamphetamine) may receive at the discretion of the sentencing judge or magistrate an adjourned bond. In doing so the court must be satisfied that the drug was not possessed for the purposes of *trafficking*.

Where a section 76 bond is given for an offence involving a drug other than cannabis, the bond must include a condition that the offender undertakes to complete an approved drug education and information program.

Serious and significant drug offenders

A serious drug offender is a person other than a young offender (ie. under the age of 21 at the time of sentencing) who has been convicted of a drug offence for which they have been sentenced to a term of imprisonment.

For a person to be described as a serious drug offender, they must have committed one of the offences listed in Clause 4 of Schedule 1 of the *Sentencing Act*. These are largely trafficking and trafficking-related offences. In addition, the offence must relate to an amount of the drug not less than the commercial quantity where the offence is a DPCSA offence, or a marketable or commercial quantity where the offence is a Commonwealth Criminal Code offence (see discussion above). Significant drug offences are trafficking a large commercial quantity of a drug of dependence (s 71 DPCSA), or trafficking a commercial quantity of a drug of dependence (s 71AA DPCSA).

The court can sentence a serious drug offender to a term of imprisonment longer than the offence itself warrants. This is based on the principle that once a person is regarded as a serious offender the overriding concern in determining the sentence is the protection of the community.

In addition, recent amendments to the *Sentencing Act* mean that suspended sentences are not available to offenders who have committed a 'serious offence' or a 'significant offence' after 19 April 2011.⁹⁸³

Drug Treatment Orders

Another separate sentencing option for people who have been convicted of drug-related offences (theft, burglary etc) is the making of a Drug Treatment Order supervised by the Drug Court of Victoria (DCV). The operations of the DCV are discussed in detail in Chapter 21.

Adequacy of sentencing

Evidence was given to the Inquiry that either the penalties available for sentencing ice offenders were inadequate or lenient or that the magistrates and judges were not taking sufficient advantage of the sentences available. This was particularly the case compared to New South Wales⁹⁸⁴ where it was perceived, not in all cases correctly, that penalties were harsher.⁹⁸⁵

983 Fitzroy Legal Service 2014, *Law Handbook*, Chapter 4.1 'Drug offences', at www.lawhandbook.org.au/handbook/ch04s01.php. Chapter written by Stan Winford.

984 This was mentioned by Detective Leading Senior Constable Jason Bray, Victoria Police, in Wodonga across the border from NSW. Presumably he was referring to the supply of prohibited drugs on an ongoing basis, provisions of the *Drug Misuse and Trafficking Act 1985* (Section 25A). This section which imposes severe penalties for people who supply prohibited drugs for reward on three separate occasions within a 30-day period is discussed in Appendix 11.

Detective Leading Senior Constable Jason Bray, Wangaratta Criminal Investigation Unit, Victoria Police, Public Hearing, Wodonga, 24 February 2014.

985 See for example:

Detective Leading Senior Constable Jason Bray, Wangaratta Criminal Investigation Unit, Victoria Police, Public Hearing, Wodonga, 24 February 2014; Detective Acting Inspector Paul Maher, Goulburn Valley Division 3, Victoria Police, Public Hearing, Shepparton, 25 February 2014; Superintendent Michael Sayer, Eastern Region, Victoria Police, Public Hearing, Shepparton, 25 February 2014; Mr Gilbert Freeman, Counsellor, Ngwala Willumbong Co-operative Ltd, Public Hearing, Melbourne, 24 March 2014.

Certainly members of the police force who gave evidence to the Committee have been critical of past sentencing practices of imposing suspended sentences on convicted drug offenders. However, for most serious drug offences this is no longer an option. It may not be an option for other offenders in the magistrates' courts subject to changes to sentencing law foreshadowed by the government for later in 2014.

For example, a submission from the Northern Mallee Community Partnership was particularly critical in this respect stating:

The Justice Department continues to hand repeat offenders of ice related crimes extremely light sentences, or community based orders, which far from being a deterrent, encourages offenders to continue drug-related activities.⁹⁸⁶

Other witnesses made the point that the justice/treatment system infrastructure was insufficiently resourced for magistrates to take advantage of the therapeutic oriented dispositions that were available, for example the fact that only one catchment area is able to refer to the Drug Court of Victoria.⁹⁸⁷ Acknowledging these views Magistrate Clive Alsop noted that given the nature of ice addiction, sentencing in this area was extremely difficult:

Under the Sentencing Act magistrates and judges are required to take into account a number of factors, including the entitlement of an accused and the ability of a court to resort to therapeutic assistance to try and assist them in dealing with, particularly, addiction processes. So there can be...a heavier emphasis on the therapeutic aspect, because there may be a diminution of the actual culpability caused by addiction to ice which would warrant therapeutic approaches as opposed to serious punishment, including taking away somebody's liberty.

The nature of the drug...makes the disposition choice difficult. For example, to put a person on an order that requires them to obey the law, and that includes not taking drugs or using drugs or selling drugs — in some cases of addiction it is heart-breaking to have to impose that sort of penalty, because you know very well that Little Johnny is not going to be able to comply because to say, 'Don't use ice', or, 'Don't use drugs', is a bit like saying, 'Would you mind not breathing for three months'. I am not trying to be flippant about it, but that is how hard it is for a lot of addicted users. If people at large think it is easy to sit in judgment, as I do and my colleagues do every single day, and send young people to gaol while they and their families are crying their eyes out, it is not easy. I still sometimes have nightmares about it.⁹⁸⁸

The difficult and sometimes conflicting aims of law enforcement and therapeutic justice as they relate to drug-related offending are discussed in greater detail in Chapter 21.

Victoria Police proposals for legislative changes

Throughout the course of this Inquiry there have been suggestions and recommendations made by Victoria Police and other witnesses as to how the law and particularly the Victorian legislative framework and its application pertaining to methamphetamine could be improved.⁹⁸⁹

The Victoria Police's submission to this Inquiry contained the following recommendations for changes to the legislative framework pertaining to illicit drugs:

Prima facie provisions

As discussed earlier, trafficking charges in general (including for crystal methamphetamine) often involve reliance on prima facie provisions in respect of trafficable quantities. Victoria Police stated:

The charges can be very difficult to prove. Persons found in possession of amounts of prima facie trafficable quantity generally offer personal use as a defence. They are often well prepared, and so have

986 Mr Rob McGlashan, Executive Officer, Northern Mallee Primary Care Partnership, Submission, 21 October 2013.

987 See Ms Lynne Macdougall, Manager, Alcohol, Tobacco and Other Drugs, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014. See also the discussion in Chapter 21 for a discussion of diversion options and 'therapeutic justice'.

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

989 The proposal for a reverse onus of proof made by Detective Inspector Paul Maher outlined earlier in this chapter was a recommendation made by the Officer as an individual and did not form part of the formal Victoria Police submission.

no mobile phones, records of transactions, scales, or large quantities of cash which could be used as corroborating evidence.

Legislative changes which would allow possession of certain substances by virtue of weight alone to automatically constitute trafficking would assist prosecutions.⁹⁹⁰

Possession and knowledge

Victoria Police argued that possession cases involving the use of hire cars by accused persons is problematic when drugs are found under the bonnets or in the boots of vehicles. They stated that cases are being reported where the driver asserts the drugs must have been in the vehicle at a time prior to their possession of the vehicle, and the passenger claims no knowledge of the drugs. Rented hotel rooms with numerous persons present also create difficulties in proving possession and/or knowledge of the drugs.

Prosecutions may be assisted by a deeming provision in the Drugs, Poisons and Controlled Substances Act 1981 regarding drugs in vehicles/premises. For example, in the absence of evidence to the contrary, drugs found in a vehicle/premises are deemed to be in the possession of the driver/owner. Victoria Police accepts, however, this would be difficult to construct legislatively without implicating innocent parties.⁹⁹¹

Presence of children in laboratory environments

Victoria Police also had particular concerns with regard to the perceived lack of provisions to safeguard children who live in or near clandestine laboratories or are otherwise exposed to the dangers with which they are associated.⁹⁹²

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. Several mainland states of Australia and New Zealand have specific provisions of aggravating circumstances which cover children found in these circumstances. The Committee may wish to consider recommending legislative amendment to overcome this gap in Victorian law.⁹⁹³

The submission from Victoria Police also discussed and made recommendations with regard to precursor chemicals and unexplained wealth provisions.⁹⁹⁴ These issues are dealt with separately in Chapter 19.

Drug driving laws

It is only relatively recently that (western) legislatures have enacted laws and procedures that penalise drivers who drive with either any or a specified amount of illicit (and licit pharmaceutical) drugs in their system, in ways comparable to driving under the influence of alcohol provisions (see Gliddon 2002; Godfrey & Phillips 2003).

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 and passed the *Road Safety (Drugs) Bill 2006* that proposed amendments to the *Road Safety Act 1986*. The primary purpose of this bill was to authorise the

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

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

992 For a discussion of this issue, see Chapter 16.

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

994 Recommendations from individual officers from Victoria Police have also been suggested in evidence. For example, Superintendent Don Downes recommended that a legislative provision with regard to designating drug transit routes similar to that in South Australia, discussed later in this chapter, be enacted. It should be noted that this recommendation is that of an individual officer and does not form part of the formal Victoria Police submission.

See Superintendent Don Downes, Western Region, Division 2, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

implementation of a program that randomly selected motorists for mandatory roadside drug tests. 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.

The rationale behind such enactments was clearly the dangers associated with drug driving and the increasing incidence of drug-related motor accidents in those years. Peter Bachelor, the then Minister for Transport, highlighted these dangers in the second reading speech as follows:

Drug-driving is now as much a factor in driver fatalities on Victoria's roads as drink-driving.

Research by the Victorian Institute of Forensic Medicine shows that in 2002, drugs other than alcohol were detected in the blood of 27 percent of fatally injured drivers, almost as many as the 29 percent who had a blood alcohol concentration above the legal limit of .05 grams per 100 millilitres. The corresponding figures in 2001 were even higher for drugs at 29 percent, compared to 22 percent for alcohol.

Over 16 percent of drivers killed in road crashes in 2001, and over 20 percent in 2002, tested positive to delta-9-tetrahydrocannabinol (often abbreviated to THC), which is the active component of cannabis, or to amphetamines and other stimulant drugs. In 2002, the use of these drugs was associated with almost 50 driver deaths.

Despite an 11 percent reduction in the overall road toll in 2002 compared with 2001, there were a similar number of drug-related road deaths in each of those years. In a 10-year study of truck driver fatalities in Australia, the Victorian Institute of Forensic Medicine found that 25.8 percent of truck drivers killed on the roads tested positive to drugs that could impair driving. Ninety-seven percent of these drug-positive fatalities tested positive to THC or to stimulants. The majority of these tested positive to either THC or to the illicit stimulant, methylamphetamine (also known as methamphetamine).⁹⁹⁵

Drug is defined in the parent Act as: a substance that is a drug for the purposes of this Act by virtue of a declaration under sub-section (3) or any other substance (other than alcohol) which, when consumed or used by a person, deprives that person (temporarily or permanently) of any of his or her normal mental or physical faculties (Section 3, *Road Safety Act 1986*).

Methamphetamine along with cannabis was one of the original drugs selected for random roadside testing because:

- ◆ There is clear evidence that drivers using these drugs are at increased risk of causing crashes;
- ◆ They are the impairing substances with the highest incidence, after alcohol, in the blood of fatally injured drivers;
- ◆ Neither THC nor methylamphetamine are found in any Australian prescription medicines; and
- ◆ They can be reliably detected in oral fluid samples of drivers at the time that they will adversely affect a driver's ability to drive safely.⁹⁹⁶

There is no legally permitted amount for these prescribed illicit drugs for the purposes of the RSA. Even very low levels of these drugs have been shown to have an adverse effect on the abilities necessary to drive safely.⁹⁹⁷

The relevant offence under the legislation is to drive or be in charge of a motor vehicle while prescribed illicit drugs are present in the person's oral fluid or blood (Sections 49, 55A). Forensic

995 The Hon Peter Bachelor, Minister for Transport, *Road Safety (Drug Driving) Bill*, Second Reading Speech, October 30, 2003. Hansard (Legislative Assembly), p.1418.

996 The Hon Peter Bachelor, Minister for Transport, *Road Safety (Drug Driving) Bill*, Second Reading Speech, October 30, 2003. Hansard (Legislative Assembly), p.1419.

997 The Hon Peter Bachelor, Minister for Transport, *Road Safety (Drug Driving) Bill*, Second Reading Speech, October 30, 2003. Hansard (Legislative Assembly), p.1419.

technology allows for preliminary roadside saliva testing by police or authorised officers and follow-up laboratory tests that will be able to prove the presence of such drugs.⁹⁹⁸ The main intervention target groups for random testing from a police operational perspective are:

- ◆ Motorists in areas of high drug use prevalence
- ◆ High risk drug users associated with the road transport industry
- ◆ High risk drug users associated with raves, dance parties and the night time economy.

Testing procedures closely follow the established random breath-testing model. The preliminary screening test will be conducted by requiring a person to suck or chew an absorbent pad or other oral fluid receptacle. The oral fluid sample will then be tested using a prescribed oral fluid screening device, which will provide a result within a few minutes.

If the test indicates the presence of illicit drugs such as THC or methamphetamine, the driver may be required to provide a further sample of oral fluid. This sample will also be tested on an oral fluid screening device. Before enforcement action can be taken the saliva sample must be confirmed by laboratory testing. Blood samples can be taken only by registered medical practitioners or approved health professionals. Only police members and authorised officers who have been appropriately trained will be able to take a sample of oral fluid for the second confirmatory test and evidential analysis.

Both monetary penalties and cancellation of driver licences may apply in the case of proven infringements.⁹⁹⁹

Recent amendments to the *Road Safety Act* have also allowed for the introduction of ‘cocktail’ laws whereby a driver may 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.¹⁰⁰⁰

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*.¹⁰⁰¹

It remains to be seen how effective such measures will prove.¹⁰⁰² The success of roadside testing can be gauged to some extent by seeing what its general deterrent effect is. For a random roadside operation to be a deterrent it must, it is argued, be highly visible and frequent enough to create a sense of certainty of being detected and punished (Vos 2010).

998 For an account of this technology and the process of testing for methamphetamine see Professor Theo Vos, *Random Roadside Drug Testing Program in Victoria* 2010, Briefing Paper at http://www.sph.uq.edu.au/docs/BODCE/ACE-P/ACE-P_briefing_Roadside_drugtest.pdf. See also Baldock and Wooley 2013. Criticisms have been made that the process for drug testing is substantially longer than that for alcohol.

999 See *Road Safety Act* Section 49 (2)(3)(3A)(3b) for a list of both monetary and imprisonment penalties.

1000 See Second Reading Speech, *Road Safety Amendment Bill* 2014. The Hon Matthew Guy, Minister for Planning, 26 June 2014, *Hansard*, (Council) p.2172.

1001 See *Road Safety Amendment Act* 2014, inserting Section 49(1)(bc) in the *Principal Road Safety Act* 1986.

See also Chapter 7 for a discussion of road trauma as it relates to methamphetamine use.

1002 For an evaluation of random roadside drug testing, particularly for the purposes of general and specific deterrence see: *Random Roadside Drug Testing Program in Victoria* — www.sph.uq.edu.au/docs/...P/ACE-P_briefing_Roadside_drugtest.pdf and Boorman and Owens 2009.

It has been posited that the test of the random drug testing program should not be evaluated so much on the number of drug drivers it picks up as the incremental level of deterrence it attains (Boorman & Owens 2009, p.22. See also Owens & Boorman 2011).

It should ideally also be accompanied by a media campaign that alerts the public to the existence of the program and the dangers of drug driving (Vos 2010; Hall & Homel 2007).

Such laws have been viewed favourably in jurisdictions where they have been enacted, as Neale states in the British context:

For those who use their car on a regular basis, loss of licence is extremely inconvenient and potentially very expensive. Likewise, having a criminal record is likely to be stigmatising and to have social and employment consequences. Certainly, there are many difficulties involved in securing drug-driving convictions. Nonetheless, more overt policing — including routine spot checks at peak drug driving times — would help to improve road safety by countering the dangerous belief that driving after drugs is acceptable simply because the chances of being caught seem very remote (Neale 2001, p.324).

For further discussion of the offence of drug driving in the context of methamphetamine, see Chapter 7.

Drug transit routes

One of the concerns of Victoria Police has been the use of motor vehicles to traffic methamphetamine across state borders using interstate highways and other transit routes. One South Australian intervention to address this has been the declaration of drug transit routes under the *Controlled Substances Act 1984 (SA)*.¹⁰⁰³

A unique feature of the search and seizure provisions of 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'.¹⁰⁰⁴ In the exercise of such a power a police officer may under Section 52B (5) accordingly:

- (a) 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
- (b) 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
- (c) 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
- (d) 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.¹⁰⁰⁵

Drug laws in other state jurisdictions

Criminal law generally and drug law particularly, is for the most part the province of the individual states and territories unless the offences have cross-border or extra-territorial consequences. Notwithstanding this legal and constitutional position, much of the law pertaining to illicit drugs in the country is becoming comparable. An overview of these laws can be seen in Table 18.2 in this chapter. A more comprehensive account of the legal

¹⁰⁰³ See also Appendix 11 for an account of other relevant drug laws in South Australia.

¹⁰⁰⁴ Such an area may only be subject to an authorisation as a drug transit route if:

- (a) the whole of the area is situated more than 30 kilometres from the General Post Office at Adelaide; and
- (b) the total size of the area is not more than 5 square kilometres (Sec 52B(4)).

¹⁰⁰⁵ See for example the comments of Superintendent Don Downes in the context of the interstate drug trade between the western district of Victoria and Mt Gambier in South Australia. Superintendent Don Downes, Western Region, Division 2, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

provisions pertaining to illicit drugs, including methamphetamine for each Australian state and territory is given in Appendix 11 of this Report.

Conclusion

Throughout this Inquiry concern has been expressed by some witnesses that other states and territories are ‘tougher’ on drug use, and particularly drug trafficking than Victoria. The reality is, however, somewhat different. With a few exceptions the law pertaining to drug offences and the penalties which apply to them are fairly standardised throughout Australia despite the Commonwealth Model Offences Code not having been formally adopted by most states. For example, in each state and territory, cannabis is seen as an illicit drug meriting lesser penalties for use, possession and trafficking than other illicit drugs. For most states and territories there are comparable provisions whereby if a person is found in *possession* of a *trafficable* amount of a prohibited drug, such as methamphetamine, it will be deemed that this drug is in his or her possession for the purposes of *trafficking*. In most jurisdictions there is a reverse onus of proof whereby the accused will need to lead evidence to rebut this presumption. With regard to penalty, there is a significant degree of uniformity between the states. Whilst it is true that penalties for simple possession of illicit drugs tend to be lower in Victoria than many other states,¹⁰⁰⁶ trafficking offences in Victoria receive either equivalent or greater maximum penalties than in the other states and territories.¹⁰⁰⁷ Finally, all states have enacted some form of extra protection for children who have somehow been involved in or affected by drug use and trafficking. A significant gap in the law is that Victoria does not have a specific child endangerment offence that addresses situations where children are injured by being subjected to the dangers associated with clandestine methamphetamine manufacture. As such, the Committee supports the recommendation of the Victoria Police that the Victorian Government enact a specific offence of child endangerment for children injured or otherwise put in danger when they are found in or near clandestine drug laboratories.

Despite the technical aspects of the drug law regime, law and law reform does not consist solely of the written law, regulations, offences or proscriptions. An essential aspect of the administration of the criminal law is the investigation and the policing of those offences and how an offender is dealt with once she or he has pleaded or is found guilty. This is especially true of drugs law and policy. The problems associated with policing methamphetamine and the involvement of the criminal justice system is the subject of Chapter 21.

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.

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.

¹⁰⁰⁶ One year’s imprisonment (maximum) in Victoria compared to two years in most other states.

¹⁰⁰⁷ For example trafficking in a commercial quantity attracts a maximum penalty of 25 years imprisonment in Victoria compared to 20 years in New South Wales. Trafficking in a large commercial quantity attracts a maximum penalty of life imprisonment in most states including Victoria. See Table 18.2.

19. Responses to Organised Crime

Introduction

The association between organised crime groups and the illicit drug trade is well-documented, as noted by the Australian Crime Commission (ACC): 'crime groups thrive on profits generated through the illicit drug market and accordingly continue to be a key focus of ACC's response' (ACC 2014, p.2). Although anecdotal evidence from law enforcement agencies has shown that outlaw motor cycle gangs (OMCGs) participate in the methamphetamine market in Victoria and elsewhere in Australia, they are not the only groups involved. Also, individuals with no connection to organised crime groups may participate in aspects of the methamphetamine market, often to support their own personal drug use.

This chapter presents information on the range of legislative and policy responses that have been adopted at both the federal level and in Victoria to respond to organised crime. In presenting this material, it focuses on strategies that have particular relevance to the ice problem in Victoria.

Criminal justice approaches

In general, the range of legislation relevant to organised crime can be categorised as follows:

- Hold individuals responsible by way of offences relating to their behaviour or to their participation in criminal organisations.
- Attribute responsibility for organised crime to criminal groups in one of three ways:
 - ♦ by prohibiting them;
 - ♦ by targeting patterns of criminal activities in which such groups engage;
 - ♦ by targeting the structure of criminal groups.
- Deal with the economic, physical and psychological impacts of crime through provisions relating to, for example, asset forfeiture (economic), sentence enhancement for group violence (physical), and witness protection (psychological).
- Target the facilitating circumstances for crime, and the people involved in them (situational crime prevention) (Ayling 2014, p.81).

Aspects of each approach have been adopted in Australia to varying extents, and Victoria has made use of a number of these interventions to date, although not all. According to Ayling, 'the dominant approach in Australia is one of seeking to disrupt the structure of criminal groups through anti-associations provisions, supplemented by an ad hoc recourse to addressing facilitating circumstances. The main target of this approach has been outlaw motorcycle gangs' (Ayling 2014, p.81). In addition, policies to deal with the economic impact of organised crime, through asset confiscation and anti-money-laundering controls, have been a central feature of the response in Australia.

There are numerous Commonwealth entities responsible for responding to organised crime, and an extensive set of policy frameworks in place at the federal level as well as in Victoria. Many initiatives arise from international obligations on Australia to implement international normative approaches to the control of transnational and organised crime. Australia's federal

implementation of these norms is contained in the *Criminal Code Act 1995 (Cth)*; *Crimes Act 1914 (Cth)* and *Crimes Legislation Amendment (Serious and Organised Crime) Act 2010 (Cth)* and other pieces of legislation dealing with proceeds of crime, money laundering, extradition, mutual legal assistance and special techniques for investigation, as described below. Such measures play a role, not only in relation to illicit drugs, but also in connection with other types of organised crime, particularly those motivated by financial gain.

In Victoria, a range of specific legislative measures have been adopted to deal with aspects of organised crime. These include organised crime control orders, anti-fortification laws, proceeds of crime and asset confiscation legislation, and anti-money laundering provisions. AFP Assistant Commissioner Jabbour, in evidence to the Committee, also noted the establishment in October 2013 of a National Anti-Gang Squad that comprises the AFP and the Australian Taxation Office working with Victoria Police to combat OMCG involvement in the methamphetamine trade.¹⁰⁰⁸

International Conventions

Australia's legislative response to the control of transnational and organised crime is derived from a number of international Conventions. Those of principal relevance to organised crime are the *United Nations (UN) Convention against Transnational Organized Crime (UNTOC)* (UNODC 2004b) and the *United Nations Convention Against Corruption (UNCAC)* (UNODC 2004a), and the *OECD Convention Against the Bribery of Foreign Public Officials in International Business Transactions*.

United Nations (UN) Convention against Transnational Organized Crime

The *United Nations (UN) Convention against Transnational Organized Crime (UNTOC)* was developed to promote cooperation to prevent and combat organised crime more effectively (UNODC 2004b). Article 2 of the convention defines organised criminal groups as:

- (a) 'Organised criminal group' shall mean a structured group of three or more persons, existing for a period of time and acting in concert with the aim of committing one or more serious crimes or offences established in accordance with this Convention, in order to obtain, directly or indirectly, a financial or other material benefit;
- (b) 'Serious crime' shall mean conduct constituting an offence punishable by a maximum deprivation of liberty of at least four years or a more serious penalty;
- (c) 'Structured group' shall mean a group that is not randomly formed for the immediate commission of an offence and that does not need to have formally defined roles for its members, continuity of its membership or a developed structure (UN 2004b, n.p.).

Australia, along with 122 other member states of the UN, signed the convention in Palermo, Italy in December 2000. It was the first legally-binding treaty aimed at responding to transnational organised crime. It came into force on 29 September 2003. The Convention has been designed as the international community's response to the increasing globalisation of organised crime.

As a ratifying state of these treaties, Australia has to comply with relevant obligations.¹⁰⁰⁹ An essential element of this includes streamlining Australian legislation with the relevant

¹⁰⁰⁸ Assistant Commissioner Ramzi Jabbour, National Manager, Serious and Organised Crime, Australian Federal Police, Public Hearing, Canberra, 10 February 2014.

¹⁰⁰⁹ United Nations Information Service 2005. *United Nations Convention against Transnational Organized Crime Receives 100th Instrument Ratification*. UN website, viewed 12 June 2014. <http://www.unis.unvienna.org/unis/en/pressrels/2005/uniscp510.html>

convention or protocol, to which Australia has committed. In addition, under Article 27 of the *UNCTOC*, member states are required to assist neighbouring states to introduce domestic policies and legislation to assist in regional activities against transnational organised crime.

United Nations Convention against Corruption

Following the successful implementation of the *UNCTOC*, the *United Nations Convention against Corruption (UNCAC)* was adopted by the General Assembly of the United Nations on 31 October 2003 in New York.¹⁰¹⁰ According to Article 1 of the convention (UNODC 2004a), the statement of purpose is:

- (a) To promote and strengthen measures to prevent and combat corruption more efficiently and effectively;
- (b) To promote, facilitate and support international cooperation and technical assistance in the prevention of and fight against corruption, including asset recovery;
- (c) To promote integrity, accountability and proper management of public affairs and public property.¹⁰¹¹

Australia signed the *UNCAC* in 9 December 2003 and finalised the process of ratification, acceptance, approval, accession and succession by 7 December 2005. As at 2 April 2014, 140 member states are signatories to that convention.¹⁰¹² As a signatory to these UN conventions and others related to organised crime activities, such as trafficking of people and illicit goods (see above), Australia is committed in combating organised crime and corruption and receives international cooperation in connection with cross-border operations. The *Convention against Corruption* obliges Nation States to share profits of crime where assistance in the recovery of those profits contributes to legal enforcement cooperation (Attorney-General's Department 2013).

OECD Convention against the Bribery of Foreign Public Officials in International Business Transactions

In addition to the *UNCAC*, Australia is a party to the Organisation for Economic Cooperation and Development (OECD) *Convention against the Bribery of Foreign Public Officials in International Business Transactions* (OECD 1997), and actively participates in the convention's review framework. Further, Australia has endorsed the Asian Development Bank/ OECD *Anti-Corruption Plan for Asia and the Pacific*. Australia also has a chapter of Transparency International with state and territory representatives, and is a member of the Financial Action Task Force (FATF), an inter-governmental body established in 1989 to set standards and promote effective implementation of legal, regulatory and operational measures for combating money laundering, terrorist financing and other related threats to the integrity of the international financial system.

Together these international conventions establish the requirements that legislation in Australia must adhere to in order to respond effectively to criminal activities relating to each of the areas in question.

1010 United Nations Office on Drugs and Crime 2014. *United Nations Convention against Corruption Signature and Ratification Status as of 2 April 2014*. <https://www.unodc.org/unodc/en/treaties/CAC/signatories.html>

1011 United Nations Office on Drugs and Crime 2014. *United Nations Convention against Corruption Signature and Ratification Status as of 2 April 2014*. <https://www.unodc.org/unodc/en/treaties/CAC/signatories.html>

1012 United Nations Office on Drugs and Crime 2014. *United Nations Convention against Corruption Signature and Ratification Status as of 2 April 2014*. <https://www.unodc.org/unodc/en/treaties/CAC/signatories.html>

Domestic law pertaining to organised crime

Commonwealth legislation against transnational organised crime

Commonwealth offences are generally prosecuted in the courts of the various states and territories. Because of this, the prosecution of Commonwealth offences involves a complex mix of federal and state or territory law. The two key federal pieces of legislation relevant to organised crime are the *Criminal Code Act 1995* (Cth) and the *Crimes Act 1914* (Cth).

The *Criminal Code Act 1995* (Cth) is fundamental to the operation of Commonwealth criminal law. It was designed to achieve consistency and equity in the operation of the Commonwealth criminal law throughout Australia. The *Crimes Act 1914* (Cth), on the other hand, deals directly with a number of evidentiary and procedural matters. In addition to these two Acts, there are a number of other Commonwealth Acts that are relevant to transnational and organised crime.

The Australian suite of transnational organised crime legislation was enhanced in 2010 with the enactment of the *Crimes Legislation Amendment (Serious and Organised Crime) Act 2010* (Cth) and *Crimes Legislation Amendment (Serious and Organised Crime) Act (No. 2) 2010* (Cth). The *Crimes Legislation Amendment (Serious and Organised Crime) Act 2010* (Cth) created a new regime in order to target the leaders of organised crime who shield themselves from the reach of the law. It created 'unexplained wealth' orders, which allow the Commonwealth to confiscate the assets of particular individuals who cannot explain how they afforded their assets (Croke 2010). The amendments to the *Crimes Legislation Amendment (Serious and Organised Crime) Act 2010* (Cth) and *Crimes Legislation Amendment (Serious and Organised Crime) Act (No. 2) 2010* (Cth) are listed in Table 19.1.

Table 19.1: Crimes Legislation Amendment (Serious and Organised Crime) Act 2010 (Cth) and Crimes Legislation Amendment (Serious and Organised Crime) Act (No. 2) 2010 (Cth) amendments from existing legislation

Legislation	Amendments
<i>Proceeds of Crimes Act 2002 (Cth)</i>	Amended in relation to criminal asset confiscation and money laundering.
<i>Crimes Act 1914 (Cth)</i>	Amended to enable seized material to be used by, and shared between, Commonwealth, state and territory law enforcement agencies; allow law enforcement agencies to access and search electronic equipment; and preserve the right of a person accused of a federal offence in Victoria to appeal a finding that he or she is unfit to plead.
<i>Witness Protection Act 1994 (Cth)</i>	Amended to clarify the application of the Act to witnesses involved in state and territory matters; update the concept of identity; extend protection to former participants and related persons; and update and extend the scope of non-disclosure offences.
<i>Criminal Code Act 1995 (Cth) and Telecommunications (Interception and Access) Act 1979 (Cth)</i>	Amended to introduce offences into the <i>Criminal Code</i> to target persons involved in serious and organised crime; and ensure that telecommunications interception warrants are available for the investigation of the new offences.
<i>Criminal Code Act 1995 (Cth) and Anti-Money Laundering and Counter-Terrorism Financing Act 2006 (Cth)</i>	Amended to extend the geographical jurisdiction and the scope of money laundering offences; and expand AUSTRAC's ability to take enforcement action against non-complying reporting entities.
<i>Australian Crime Commission Act 2002 (Cth)</i>	Amended to expand the ACC's powers to deal with uncooperative witnesses; clarify procedural powers for issuing summons and notices to produce; and require a five-yearly review of the operation of the Act.
<i>Administrative Decisions (Judicial Review) Act 1977 (Cth), Surveillance Devices Act 2004 (Cth) and Telecommunications (Interception and Access) Act 1979 (Cth)</i>	Amended to make consequential amendments.
<i>Criminal Code Act 1995 (Cth)</i>	Amended to increase the penalties for bribing foreign and Commonwealth public officials; and provide that drug importation offences apply to offenders engaged in activity connected to the importation of drugs into Australia. Also amends 23 Acts consequent upon the joint commission offence being included in the <i>Criminal Code</i> ; and amends 20 Acts consequent on provisions of the <i>Crimes Act 1914</i> being repealed.

Despite the introduction of the *Crimes Legislation Amendment (Serious and Organised Crime) Act 2010 (Cth)* and *Crimes Legislation Amendment (Serious and Organised Crime) Act (No. 2) 2010 (Cth)*, there remains a lack of a unified definition of organised crime. Instead, organised crime is defined by relevant agencies for the purposes of their own jurisdiction and operations. For example, the *Australian Crime Commission Act 2002 (Cth)* defines 'serious and organised crime' as an offence in sub-section 1 of section 4 of the Act as a crime:

- (a) that involves two or more offenders and substantial planning and organisation; and
- (b) that involves, or is of a kind that ordinarily involves, the use of sophisticated methods and techniques; and

- (c) that is committed, or is of a kind that is ordinarily committed, in conjunction with other offences of a like kind; and
- (d) that is a serious offence within the *Proceeds of Crime Act 2002 (Cth)*, an offence of a kind prescribed by the regulations or an offence that involves any of the following:
 - (i) theft;
 - (ii) fraud;
 - (iii) tax evasion;
 - (iv) money laundering;
 - (v) currency violations;
 - (vi) illegal drug dealings;
 - (vii) illegal gambling;
 - (viii) obtaining financial benefit by vice engaged in by others;
 - (ix) extortion;
 - (x) violence;
 - (xi) bribery or corruption of, or by, an officer of the Commonwealth, an officer of a State or an officer of a Territory;
 - (xii) perverting the course of justice;
 - (xiii) bankruptcy and company violations;
 - (xiv) harbouring of criminals;
 - (xv) forging of passports;
 - (xvi) firearms;
 - (xvii) armament dealings;
 - (xviii) illegal importation or exportation of fauna into or out of Australia;
 - (xix) cybercrime.

Sub-section 2 of section 4 of the Act provides that:

If the head of an ACC operation/investigation suspects that an offence (the incidental offence) that is not a serious and organised crime may be directly or indirectly connected with, or may be a part of, a course of activity involving the commission of a serious and organised crime (whether or not the head has identified the nature of that serious and organised crime), then the incidental offence is, for so long as the head so suspects, taken, for the purposes of this Act, to be a serious and organised crime.

In addition to the *Crimes Legislation Amendment (Serious and Organised Crime) Act 2010 (Cth)* and *Crimes Legislation Amendment (Serious and Organised Crime) Act (No. 2) 2010 (Cth)*, there are a number of other Commonwealth Acts that are important in the transnational organised crime space. The offences relevant to transnational organised crime contained within the *Criminal Code Act 1995 (Cth)* are shown in Table 19.2 along with their associated penalties.

Table 19.2: Criminal Code Act 1995 (Cth) organised crimes and maximum penalties

Act	Selected Offences	Maximum penalty
Division 390 — Criminal associations and organisations	390.3 Associating in support of serious organised criminal activity	3 years imprisonment
	390.4 Supporting criminal organisations—	5 years imprisonment
	390.5 Committing an offence for the benefit of, or at the direction of, a criminal organisation—	7 years imprisonment
	390.6 Directing activities of a criminal organisation	10 years imprisonment
Division 400 — Money laundering	400.3 (s1) Dealing in proceeds of crime etc.—money or property worth \$1,000,000 or more	25 years imprisonment
	400.4 Dealing in proceeds of crime etc.—money or property worth \$100,000 or more	20 years imprisonment
	400.5 Dealing in proceeds of crime etc.—money or property worth \$50,000 or more	5 years imprisonment
	400.6 Dealing in proceeds of crime etc.—money or property worth \$10,000 or more	10 years imprisonment
	400.7 Dealing in proceeds of crime etc.—money or property worth \$1,000 or more	5 years imprisonment
	400.8 Dealing in proceeds of crime etc.—money or property of any value	12 months imprisonment
	400.9 Dealing with property reasonably suspected of being proceeds of crime etc.	3 years imprisonment

In recent years, key policy initiatives and legislative reforms have also taken place in order for Commonwealth law enforcement agencies to respond more effectively to organised crime. These include ‘the *Customs and AusCheck Legislation Amendment (Organised Crime and Other Measures) Act 2013 (Cth)* that was passed by Parliament on 16 May 2013 which amends the *Customs Act 1901 (Cth)* and the *AusCheck Act 2007 (Cth)* to mitigate vulnerabilities at Australia’s borders’ (ACC 2013b, p.71).

Proceeds of crime

The Proceeds of Crime legislation aims to deter crime by reducing the financial motivations for offending, thus making acquisitive property offending less profitable. This was explained by Mr Sabin, Director of MethCon Group Ltd, when giving evidence to the Committee:

My strongly held view in terms of where you need to spend your resources in the criminal justice system is getting to the real kingpins and the traffickers and ensuring that you have proceeds of crime legislation and the ability to absolutely strip them of their assets and their finances. Those are the ones who should be doing some serious time because ultimately they are the ones who are profiting the most. Usually they are many steps removed from the average trafficker, who is simply a mule trying to sustain his own habit and doing the dirty work for the big guys.

The big guys definitely need to be taken down at every level. Going to prison is one thing, but I am telling you that taking all their assets — everything they own; everything they have earned — hurts them equally as much, probably more in many respects. This is in addition to having effective proceeds of crime legislation that actually says to organised crime, ‘We will do everything we can to target you

financially as well as criminally and, if you are in that net, it's gone. Everything that you have worked for, everything that you actually care about — the proceeds of crime and money — goes back into your prevention, your education, your treatment and so forth'. There is a great ironic synergy in doing that. That is certainly something that New Zealand has picked up on, and I think it is a very effective tool because essentially what you get is a situation that is almost parasitical, where the drug user uses the proceeds of their own crime and diminishes their own ability to make more money.¹⁰¹³

At the Commonwealth level, the *Proceeds of Crime Act 2002* (Cth) (POCA) provides a scheme to trace, restrain and confiscate the proceeds of crime committed against Commonwealth laws. In some circumstances it can also be used to confiscate the proceeds of a crime against state and foreign laws. The Act provides for recovery on the basis that there has been a conviction (conviction-based forfeiture) or on the basis that a court is satisfied, on the balance of probabilities, that a crime has been committed (civil-based forfeiture).

The POCA includes both conviction-based and non-conviction based streams of confiscation and action can be taken against either the criminal conduct of the person (action *in personam*) or against property being the proceeds or instrument of certain offences (action *in rem*). Proceedings are usually initiated by way of an application for a restraining order, which restrains specified assets.

Under the *Proceeds of Crime Act 2002* (Cth), there are five main types of final orders that are available to a court:

- conviction-based forfeiture;¹⁰¹⁴
- non-conviction based forfeiture, which allows confiscation action to be taken independently of the prosecution process, where a court is satisfied that a person has committed a serious offence,¹⁰¹⁵ or that the property is the proceeds of an indictable offence or the instrument of a serious offence;¹⁰¹⁶
- pecuniary penalty orders, which require a person to pay an amount based on the benefits the person has derived from his or her criminal conduct;¹⁰¹⁷
- literary proceeds orders, which require a person to pay an amount based on the literary proceeds that he or she has derived from commercial exploitation of his or her criminal notoriety (e.g. through paid media interviews or book deals);¹⁰¹⁸ and
- unexplained wealth orders, which require a person to pay a proportion of their wealth, where they cannot satisfy a court that that wealth was legitimately acquired.¹⁰¹⁹

Proceeds of crime actions are civil proceedings¹⁰²⁰ and orders under the Act are made by a court, which ensures that orders are only made after receiving independent consideration by a judicial officer. Applications for proceeds of crime orders are brought by the Commissioner of the AFP or the Commonwealth Director of Public Prosecutions (CDPP) (Goldsmith, Gray & Smith 2014).

Unexplained wealth

The Commonwealth's *Crimes Legislation Amendment (Serious and Organised Crime) Act 2010* (Cth) also introduced unexplained wealth provisions at the federal level:

1013 Mr Mike Sabin MP, Member for Northland, New Zealand Parliament, Public Hearing, Melbourne, 5 June 2014 (see footnote in Chapter 31, No.16)

1014 *Proceeds of Crime Act 2002* (Cth) ss 48 and 92.

1015 s 47, *Proceeds of Crime Act 2002*

1016 s 49, *Proceeds of Crime Act 2002*

1017 s 116, *Proceeds of Crime Act 2002*

1018 s 152, *Proceeds of Crime Act 2002*

1019 s 179B, *Proceeds of Crime Act 2002*

1020 s 315, *Proceeds of Crime Act 2002*

Under these provisions, if a court is satisfied that there are reasonable grounds to suspect that a person's total wealth exceeds the value of the person's wealth that was lawfully acquired, the court can make an order compelling the person to attend court and prove, on the balance of probabilities, that their wealth was not derived from offences falling under a Commonwealth head of power. In their purest form, unexplained-wealth provisions do not require a link to an offence (Goldsmith et al. 2014).

Two distinct remedies are available to deal with unexplained wealth. First, section 20A allows for the making of restraining orders that prevent dealings with particular property, and second, the Act creates a regime of confiscation orders termed 'unexplained wealth orders' (Croke 2010).

These provisions are specifically aimed at those who remain at arm's length from the commission of offences and who are not always able to be directly linked to specific offences. In particular, 'unexplained wealth orders are designed to target senior organised crime figures who fund and benefit from organised crime groups, but seldom carry out the physical elements of crimes' (Goldsmith et al. 2014, p.16).

Approximately a year after the Commonwealth provisions had been enacted, on 13 July 2011, the Parliamentary Joint Committee on Law Enforcement commenced an inquiry into Commonwealth unexplained-wealth legislation and arrangements. The reasons for the Inquiry were canvassed in the Attorney-General's Department's submission to the Inquiry in 2012:

No proceedings have been brought under the Proceeds of Crime Act seeking an unexplained wealth order, although the AFP are investigating two cases. Accordingly, there has not yet been an opportunity to test the effectiveness of the provisions in practice.

The inclusion within the Commonwealth unexplained wealth provisions of links to offences within Commonwealth constitutional power places some limitations on the operation of those provisions as compared to similar State and Territory regimes.

The ability of a person to dispose of property to meet legal costs may weaken the effectiveness of the provisions by allowing the wealth which law enforcement agencies suspect to have been unlawfully acquired to be used to contest the proceedings. By contrast, those who are subject to other proceeds of crime orders have access to legal aid and the legal aid costs are met from the value of confiscated property.

A court's power to make costs orders in relation to unexplained wealth proceedings is more onerous than is the case for other types of orders under the Proceeds of Crime Act. This may create a disincentive to seek unexplained wealth orders.

In addition, a court has general discretion as to whether to make an unexplained wealth order, even when it is satisfied that the relevant criteria have been met. This is in contrast to other types of proceeds of crime order, which a court must make if it is satisfied that the criteria have been met (Parliamentary Joint Committee on Law Enforcement 2012, p.vii).

On 19 March 2012, the Committee handed down its final report (Parliamentary Joint Committee on Law Enforcement 2012). The Government accepted 15 of the Committee's 18 Recommendations (either wholly or in part) (Australian Government 2013). Of particular relevance to the situation in Victoria is Recommendation 14, 'that the Commonwealth Government take the lead in developing a nationally consistent unexplained wealth regime' and Recommendation 15, 'that the Australian Government seek a referral of powers from the states and territories for the purpose of legislating for a national unexplained wealth scheme, where unexplained wealth provisions are not limited by having to prove a predicate offence' (Australian Government 2013). The Government supported the development of a nationally consistent unexplained wealth regime and decided that the most effective way for this to be achieved is through a referral of powers. The Attorney-General has raised a possible referral of powers from the states with state and territory counterparts at meetings of the Standing Council on Law and Justice on 13 April 2012 and 5 October 2012 (Australian Government 2013).

On 6 March 2014, the Senate referred the provisions of the Crimes Legislation Amendment (Unexplained Wealth and Other Measures) Bill 2014 to the Legal and Constitutional Affairs Legislation Committee (2014) for inquiry and report. On 5 June the Committee’s Report dealt with a number of concerns raised by the Parliamentary Joint Committee on Law Enforcement, namely, to:

- remove the discretion of the court to decide whether or not to make an unexplained wealth order where certain criteria are satisfied;
- prevent restrained assets from being used to meet legal expenses;
- streamline affidavit provisions;
- enable the making of an unexplained wealth order in the absence of the person who is the subject of the order;
- ensure evidence relevant to unexplained wealth proceedings can be seized under a search warrant; and
- extend the disclosure of information regime (Legal and Constitutional Affairs Legislation Committee 2014).

After examining these issues, the Committee recommended that the Senate pass the Bill and the Bill is currently before the House of Representatives.

Victoria Police, in its submission to the Committee, recommended that unexplained wealth legislation be introduced in Victoria.¹⁰²¹ Subsequent to this submission on 19 August 2014, the Victorian Parliament passed the *Criminal Organisations Control and Other Acts Amendment Bill 2014*. The new legislation introduced unexplained wealth provisions into Victoria’s asset confiscation laws. The Committee supports the introduction of these laws but also notes the ACC’s view that there is a need for harmonised unexplained wealth laws throughout Australia.¹⁰²² This would facilitate the ability of law enforcement to confiscate the proceeds of crime held by organised crime groups engaged in various criminal activities including illicit drug trade. The Committee believes that Victoria should actively participate in any future discussions with the Standing Council on Law and Justice or elsewhere regarding the achievement of harmonised laws in this area.

By way of summary, Table 19.3 compares the various asset recovery measures that are currently in place throughout Australia (Goldsmith et al. 2014).

Table 19.3: Summary of asset recovery measures in Australia**

	Conviction-based Forfeiture	Civil Forfeiture	Unexplained Wealth
Test	Beyond reasonable doubt; conviction for criminal offence	On balance of probabilities/ more likely than not	On balance of probabilities/ more likely than not
Onus of Proof	Crown	Crown	Respondent
Types of orders	Restraining, forfeiture	Restraining, forfeiture, pecuniary penalty; literary proceeds	Restraining, unexplained-wealth order; drug-trafficker declaration
Principal entity responsible	DPP	DPP in Victoria, WA, NT, SA, and ACT; CMC (Qld.), NSWCC (NSW); CACTF (Cth)	DPP in WA, SA, NT, CACTF (Cth), NSWCC
Jurisdictions	All	Cth, ACT, NSW, Qld, SA, Vic	WA, NT, Cth, SA, Queensland, NSW

** Note on 19 August 2014 Victoria enacted unexplained wealth legislation.

Source: Updated from information presented in Table 5.11 in Australia (Parliamentary Joint Committee on the Australian Crime Commission), *Inquiry into the legislative arrangements to outlaw serious and organised crime groups*, Canberra, Commonwealth of Australia, 2009.

1021 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

1022 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

Anti-money laundering

Money laundering is the process by which criminals, particularly those involved in organised crime, seek to convert illegally derived funds into funds that appear to be legitimate. Those involved use a range of methods and complex transactions to disguise the origin of funds and to evade prosecution. Money laundering has created concern for governments across the globe and led to the development of a sophisticated regulatory regime designed to detect activities and to obtain financial intelligence for use by law enforcement and counter-terrorism agencies (Australian Transaction Reports and Analysis Centre (AUSTRAC) 2013).

Over the last decade, legislation has been introduced to combat both money laundering and the financing of terrorism. Internationally, the FATF seeks to coordinate global efforts to minimise risks of money laundering and terrorism financing by promoting its Forty Recommendations, which ask countries to incorporate specific principles into their criminal justice systems, law enforcement procedures and financial regulatory systems (FATF 2012).

In Australia, the recommendations of the FATEF, alongside other developments in the financial system and improvements in the control of financial crime generally, led to the introduction of legislation that is now reflected in the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006 (Cth)* (AML/CTF Act). The AML/CTF Act creates reporting and other obligations for entities, based upon the nature of their activities and the services they provide. An entity becomes a 'reporting entity' under the Act when it provides a 'designated service' as defined in the AML/CTF Act.¹⁰²³ The regulatory framework is risk-based, with reporting entities being responsible for identifying high-risk activities and customers within their business activities. The AML/CTF Act also establishes penalties for non-compliance with the legislation.

Mutual legal assistance

In Australia, the investigation and prosecution of transnational crime with an international aspect are becoming more common. The result of this is that a greater number of Commonwealth prosecutions are reliant on assistance from foreign law enforcement authorities, or could be greatly supported by that assistance. The CDPP is involved in two main categories of international work, namely mutual legal assistance and extradition. Australia participates in these systems through the Australian Central Authority, which is part of the Commonwealth Attorney-General's Department. Under the *Mutual Assistance in Criminal Matters Act 1987 (Cth)*, Australia may request and provide assistance to any overseas authorities in criminal investigations and prosecutions, subject to the provisions of the Act. This process is assisted by over 22 bilateral mutual assistance treaties and a number of multilateral conventions (AGD 2013).

Extradition

Extradition procedures under the *Extradition Act 1988 (Cth)* enable law enforcement to apply for an order that requires suspects to be relocated internationally to facilitate their criminal prosecution. The introduction of extradition allows a swifter resolution of criminal offences, particularly transnational organised crimes. Australia has made a number of changes to improve and expand its international mutual assistance regime. The *Extradition and Mutual Assistance in Criminal Matters Legislation Amendment Act 2012 (Cth)* received royal assent on 20 March 2012 and came into force on 20 September 2012 (Goldsmith et al. 2014). The Amending Act followed a comprehensive review of Australia's international criminal cooperation regime, which was first developed more than 20 years ago.

¹⁰²³ Reporting entities (such as banks and other financial institutions, insurance companies, securities and investment companies, gambling services, bullion dealers and alternative remittance services) are required to forward transaction and financial activity reports to the regulator, AUSTRAC.

Since 20 September 2012, Australia can register non-conviction-based proceeds of crime orders from, and seek temporary non-conviction-based restraining orders on behalf of, any country following a mutual assistance request. Australia previously could only register foreign non-conviction-based proceeds of crime orders made in countries that are listed in regulations: the United States, the United Kingdom, Canada, Ireland and South Africa. Additionally, Australia can only seek temporary non-conviction-based restraining orders on behalf of those same countries (Goldsmith et al. 2014).

Special techniques of investigation

Australian law enforcement agencies employ a number of particular techniques in relation to serious and organised crime. These include undercover policing (assumed identities), the use of informants and controlled operations.

In 2001, the Australian Parliament reviewed these investigative techniques and extended the use of controlled operations (formerly used only in relation to narcotics importation) to apply to the investigation of any serious offence under Commonwealth law: see the *Measures to Combat Serious and Organised Crime Act 2001* (Cth). In particular, section 15H of the *Crimes Act 1914* (Cth) was amended to read:

A 'controlled operation' is an operation that:

- (a) involves the participation of law enforcement officers; and
- (b) is carried out for the purpose of obtaining evidence that may lead to the prosecution of a person for a serious Commonwealth offence; and
- (c) may involve a law enforcement officer or other person in acts, or omissions to act, that would, apart from subsection 15I(1) or (3), constitute a Commonwealth offence or an offence against a law of a state or territory.

The use of controlled operations is an important means of obtaining evidence against organised crime figures who might otherwise evade prosecution.

Commonwealth entities involved in responding to organised crime in Australia

There are a number of Commonwealth entities that engage in specialised activities relating to the control of organised crime in Australia. They include the Australian Government Attorney-General's Department (AGD), the Australian Crime Commission (ACC), the Australian Federal Police (AFP), the Australian Customs and Border Protection Service (ACBPS), the Australian Transaction Reports and Analysis Centre (AUSTRAC), CrimTrac, the Office of the Commonwealth Director of Public Prosecutions (CDPP) and the Australian Commission for Law Enforcement Integrity (ACLEI).

Attorney-General's Department

The role of the AGD in relation to transnational organised crime is to lead other Commonwealth agencies through the development and amendment of relevant policies and legislation. Specifically, in order to assist Australian agencies in responding to transnational organised crime, the AGD developed a whole-of-government *Commonwealth Organised Crime Strategic Framework* (the Framework, AGD 2010a) in late 2009. The purpose of the Framework is to coordinate the activities of relevant agencies and 'seeks to enhance the relationship between the Commonwealth and industry on organised crime matters' (AGD 2010a, n.p.). The Framework specifically highlights the challenges of addressing organised crime including those related to the demand for illicit commodities such as drugs (AGD

2010a). The Framework aims to assist in the sharing of law enforcement intelligence and in the prosecution of transnational criminals who seek to evade criminal prosecution or who attempt to conceal the proceeds of crime (AGD 2010a).

The AGD has also developed a *National Organised Crime Response Plan 2010–13* (AGD 2010b) which aims to strengthen the policy, legislative and operational architecture within Australia to combat organised crime. Of particular concern is the involvement of organised crime groups in the illicit drug trade and the role played by states and territories in developing and enforcing their respective criminal laws and policies to address such activities. The Plan states that ‘organised crime activity invariably exploits Australia’s communities, from vulnerable sectors such as the users of illicit drugs to individuals who purchase counterfeit goods’ (AGD 2010b, p.7). Both policy documents provide a strategic response to all aspects of organised crime, not only those relating to the illicit drugs market.

The Department also works closely with national security agencies to develop greater interoperability between agencies and to enhance inter-agency collaboration in managing national security risks. One aspect of this concerns the prevention of infiltration of secure aviation and maritime sites by organised crime who may seek to corrupt workers in these locations to facilitate the movement of illicit substances through air and sea ports, or to obtain employment in these workplaces. Instances of such illegality were identified in 2009 (Besser & McKenzie 2009; ACC 2009) and led to the establishment of a number of law enforcement task forces to respond to the threats. In Melbourne, Operation Trident, was set up in July 2012 with six partner agencies: Victoria Police, the AFP, ACBPS, AUSTRAC, the ATO and the ACC (ACC 2013). Subsequently, following an inquiry by the Parliamentary Joint Committee on Law Enforcement (2011), the *Customs and AusCheck Amendment (Organised Crime and Other Measures) Act 2013* (Cth.) was introduced to strengthen the maritime sector and supply chain against infiltration by organised crime. This included:

- placing new obligations on cargo terminal operators and cargo handlers, including mandatory reporting of unlawful activity and fit and proper person checks;
- creating new offences for obtaining and using restricted information to commit an offence or for unlawfully disclosing that restricted information;
- granting ACBPS the power to impose new licence conditions on cargo terminal operators at any time and making it an offence to breach certain licensing conditions; and
- enabling a Maritime Security Identification Card (MSIC) to be suspended where the cardholder has been charged with a serious offence (ACC 2013, p. 3).

In 2012-13, AusCheck completed 71,594 background checks for the Aviation Security Identification Card scheme, 38,333 background checks for the Maritime Security Identification Card scheme, and 189 background checks for the National Health Security checking scheme (AGD 2013, p. 45). These checks are essential to ensure that high-risk individuals who may be associated with organised crime are unable to obtain employment in security protected environments that could facilitate the importation of illicit substances.

Australian Crime Commission

The ACC is a Commonwealth entity within the Attorney-General’s Portfolio and provides advice to government, law enforcement and the public sector on how the impact of serious and organised crime can be minimised in Australia. The ACC is responsible for addressing nationally significant crime, by providing intelligence, investigation and criminal database services. The ACC’s executive director Ms Judith Lind described the Commission’s role in responding to organised crime and the illicit drug trade:

In relation to our capabilities, we have traditional law enforcement police response capabilities in terms of investigations, disruptions, seizures and arrests; but a very large role is played through the

production of intelligence products in informing other stakeholders, trying to identify where there are vulnerabilities which organised crime can exploit, communicating that to policy and other agencies, and really trying to focus on reducing harm and preventing organised crime into the future. That is really the business model of the ACC.¹⁰²⁴

The ACC manages the Australian Criminal Intelligence Database (ACID) and the Australian Law Enforcement Intelligence Network (ALEIN). These tools provide federal, state and territory law enforcement and other regulatory authorities with the capacity to securely store, retrieve, analyse and share criminal information and intelligence on a national basis. These intelligence holdings have led to the successful apprehension of organised crime figures and to the general deterrence of potential organised criminal activities. An example of a successful operation that has disrupted organised crime in Australia is Taskforce Eligo, established in 2012 as an ACC-led multi-agency special investigation into the use of alternative remittance and informal value transfer systems by serious and organised crime. Taskforce Eligo includes Victoria Police and has resulted in the seizure of \$580 million worth of drugs and assets since its inception.¹⁰²⁵

The ACC's Board, which approves the use of the Commission's special coercive powers, is also responsible for determining special operations and special investigations. One of the Board-approved special intelligence operations is the High Risk and Emerging Drugs Determination (HRED). Recently, the HRED was extended to include the examination of new psychoactive substances and new types of performance and image-enhancing drugs and is now known as HRED 2.¹⁰²⁶

Finally, the ACC publishes a range of confidential and public intelligence products that provide assessments of the current state of serious and organised crime risks in Australia including threat assessments, illicit drug data reports, strategic assessments of crime risks and crime profile facts sheets.

Australian Federal Police

The AFP was established in 1979 by the *Australian Federal Police Act 1979 (Cth)*. The AFP enforces Commonwealth criminal law and protects Commonwealth and national interests from crime in both Australia and overseas.

The AFP is Australia's international law enforcement and policing representative, and the chief source of advice to the Australian Government on policing issues. Law enforcement functions performed by the AFP include, but are not restricted to, enforcing laws relating to drug trafficking, fraud against government revenue and expenditure, other forms of organised crime such as money laundering and trafficking in persons and people smuggling, and politically sensitive matters including corruption (AFP 2013).

The AFP established the Case Categorisation and Prioritisation Model (CCPM) in 2010 in order to ensure that its limited resources are directed to the matters of highest priority and the decision to accept or reject matters for investigation is guided by this precept (AFP 2010).¹⁰²⁷ Using this model, the AFP focuses on eight key national functions that include serious and organised crime.

International operations

In relation to the AFP's international operations, three key elements have been identified:

- ◆ Collaboration — brokering collaboration with international law enforcement agencies to drive investigations and support bilateral or multi-lateral cooperation;

1024 Ms Judith Lind, Executive Director, Australian Crime Commission, Public Hearing, Canberra, 10 February 2014.

1025 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

1026 Ms Judith Lind, Executive Director, Australian Crime Commission, Submission, 10 April 2014.

1027 Australian Federal Police 2010. *Operational priorities*. <http://www.afp.gov.au/about-the-afp/operational-priorities.aspx>

- ◆ Intelligence gathering — collection and exchange of criminal intelligence in support of international law enforcement efforts; and
- ◆ Capacity building — enhancing the capacity and the capability of international law enforcement agencies to combat transnational crime (AFP 2013).

Assistant Commissioner Jabbour described the AFP's international network in the following terms:

The AFP has an elaborate international network of liaison officers situated in 26 countries, and currently we have 91 liaison officers overseas. The purpose of the international network is to facilitate the exchange of intelligence between law enforcement agencies — and that is all Australian law enforcement agencies in Australia — and foreign counterparts overseas with a view, as I said earlier, to trying to interdict and prevent the drugs from coming to Australia.¹⁰²⁸

Confiscation of assets

The AFP plays a critical role as one of the Commonwealth entities involved in responding to organised crime through its domestic and international activities. As Goldsmith et al. (2014) observe, 'one of the most important initiatives has been the establishment of the multi-agency Criminal Assets Confiscation Task Force¹⁰²⁹ in 2011 that investigates and litigates matters pertaining to the proceeds of crime' (p.133). The task force is led by the AFP and brings together agencies with a key role in the investigation and litigation of proceeds of crime matters, including the ACC and the Australian Taxation Office (ATO). Task force investigations teams are located in several cities around Australia and incorporate a mix of specialist skills from the AFP including federal agents (police officers), forensic accountants and financial investigators. The ATO provides financial analysis support through co-located officers, and further support in the form of officers in its Serious Non-Compliance Teams, who take action on matters referred to them by the task force if the ATO considers it is appropriate. The ACC also contributes co-located officers and provides support in target identification and strategic advice on money-flows that impact on Australia (Goldsmith et al. 2014).

One of the first investigations undertaken by the task force in April 2011 related to a joint investigation between the AFP, the Victoria Police, ACC and ACBPS into an organised crime syndicate that was allegedly trafficking drugs throughout Australia. As part of its investigation, officers from the task force seized approximately \$4.5 million worth of assets, including two residential properties, a light aircraft and three luxury vehicles (AFP 2011).

Australian Customs and Border Protection Service

The ACBPS describes its role as follows:

The ACBPS is responsible for managing the security and integrity of Australia's borders. It works closely with other governmental and international agencies including the AFP, the Department of Agriculture, Department of Immigration and Border Protection and the Department of Defence to detect and deter unlawful movement of goods and people across the border (ACBPS 2014, n.p.).

Of specific relevance to the present Inquiry, the ACBPS has a lead role in the prevention and detection of illicit drugs, such as methamphetamine, crossing national borders.¹⁰³⁰ From 1 July 2015, the Department of Immigration and Border Protection and the ACBPS will be consolidated into a single Department of Immigration and Border Protection.

¹⁰²⁸ Assistant Commissioner Ramzi Jabbour, National Manager, Serious and Organised Crime, Australian Federal Police, Public Hearing, Canberra, 10 February 2014.

¹⁰²⁹ See <http://www.afp.gov.au/policing/proceeds-of-crime.aspx>.

¹⁰³⁰ Mr Roman Quaedvlieg, Deputy Chief Executive Officer, Border Enforcement, Australian Customs and Border Protection Service, Submission, 11 April 2014.

The Australian Border Force, a single frontline operational border agency, will then be established within the department.

The ACBPS has a fleet of ocean-going patrol vessels and contracts aerial surveillance providers for civil maritime surveillance and response. Interception of illegal drugs is a high priority and sophisticated techniques are used to target high-risk aircraft, vessels, cargo, postal items and travellers. This includes intelligence analysis, computer-based analysis and profiling, detector dogs and various other technologies such as container x-rays used to distinguish materials such as explosives and drugs.

The contemporary border-control environment presents particular challenges for ACBPS due to increasing volumes of cargo and traveller movements that create complexity in supply chains and travel routes. The ACBPS is aware of Australian-based criminal groups, working with transnational organised crime associates, who are involved in a range of illegal activities across borders including the illegal importation of methamphetamine.¹⁰³¹

To address the changing nature of transnational organised crime that has an impact on Australia's borders, ACBPS has developed the following priorities, being to:

- work ahead of the border to identify and manage risk;
- maximise the number of cross border movements where intervention is not required;
- focus on intelligence;
- have non-intrusive technologies and unobtrusive intervention processes;
- be flexible and scalable in our intervention approach;
- use global partnerships to manage cross-border flows;
- assist industry to participate efficiently in international trade and travel; and
- have a supportive workforce engagement and development model (ACBPS 2014, n.p.).

The ACBPS, in its submission to the Committee, described the measures undertaken by the agency for the interception of illicit substances at the Australian border, including the use of improved technology and intelligence sharing. One initiative involved the implementation of the Strategic Border Command within ACBPS:

The Command will have advanced real-time intelligence, communications and surveillance systems to monitor and manage the border on an integrated, real-time 24 hour/seven days a week basis. It will direct the work of ACBPS regional border commands, which will be informed on state and territory lines. In order to support the initiative, the ACBPS is enhancing its policies and processes for the collection, management, exploitation, storage, use and sharing of intelligence and information.¹⁰³²

Australian Transaction Reports and Analysis Centre

AUSTRAC is a Commonwealth entity within the Attorney-General's portfolio and is Australia's financial intelligence regulator and specialist financial intelligence unit (FIU). The Centre undertakes functions in accordance with the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006* (Cth). AUSTRAC describes its role as follows:

In its role as AML/CTF regulator, AUSTRAC assists its regulated population to meet customer identification, reporting, record keeping and other requirements under the *Anti-Money Laundering and Counter-Terrorism Financing Act 2006* (AML/CTF Act) and FTR Act. It also receives information on the movement of cash and other forms of payments into and out of Australia. As Australia's FIU, AUSTRAC assists Australian law enforcement, national security, social justice and revenue agencies and certain

1031 Mr Roman Quaedvlieg, Deputy Chief Executive Officer, Border Enforcement, Australian Customs and Border Protection Service, Submission, 11 April 2014.

1032 Mr Roman Quaedvlieg, Deputy Chief Executive Officer, Border Enforcement, Australian Customs and Border Protection Service, Submission, 11 April 2014.

international counterparts in the investigation and prosecution of serious criminal activity, including terrorism financing, organised crime and tax evasion (AUSTRAC 2009, p.4).

Australia's anti-money laundering and counter-terrorism financing (AML/CTF) regime seeks to achieve six strategic objectives:

1. improve industry compliance;
2. enhance our financial intelligence;
3. build productive relationships;
4. bolster the AML/CTF regime;
5. strengthen corporate governance; and
6. improve ourselves (AUSTRAC 2009, p.4).

In its regulatory role, it oversees compliance with the reporting requirements by a wide range of financial services providers, including the gaming industry and others. In its intelligence role, it provides financial transaction reports information to Commonwealth, state and territory law enforcement and revenue agencies. AUSTRAC collects, retains, compiles, analyses and disseminates financial transaction reports and issues guidelines and circulars to those entities required to report specified transactions.

In order to effectively control transnational organised crime, AUSTRAC works in collaboration with partner agencies that include Australia Government law enforcement, national and border security, revenue, regulatory and human services agencies, as well as state and territory law enforcement and revenue agencies (AUSTRAC 2013). It also works collaboratively with Australian industries and businesses to strengthen the measures to detect money laundering activity and to protect both business and customers from criminal activity.

Some of the recent activities performed by AUSTRAC are shown in its annual *Typologies and Case Studies* reports (AUSTRAC 2013). Prosecutions involving international trafficking in methamphetamine have been facilitated through financial intelligence gathered by AUSTRAC. Often, the payments made in connection with international drug importations can be identified through financial intelligence and used to link those who make or receive payments with the illicit drug importations undertaken.

CrimTrac

Another entity that falls within the Attorney-General's portfolio, is CrimTrac, a Commonwealth entity that supports the functions of the police by using technology to produce real-time information required to solve crimes. The objective of CrimTrac is to enhance Australian policing and law enforcement through the delivery of high quality information services that meet the need of the law enforcement community.¹⁰³³ CrimTrac's mission is to maintain and deliver high-quality, timely and cost-effective information to national law enforcement services to ultimately:

- provide faster suspect identification;
- clear the innocent;
- shorten investigation times so more crimes can be investigated; and
- result in higher crime clearance rates.

In its submission, CrimTrac described the national databases that it maintains which are integral to policing across the different states and territories in Australia as follows:

¹⁰³³ Mr Doug Smith APM, Chief Executive Officer, CrimTrac, Submission, 16 April 2014.

- The National Automated Fingerprint Identification System (NAFIS) enables police agencies to solve crimes by quickly and reliably establishing a person's identity from fingerprint and palm impressions left at crime scenes.
- The National Criminal Investigation DNA Database (NCIDD) assists police partner agencies across Australia to:
 - (a) compare DNA profiles from crime scenes with profiles from convicted offenders to identify or eliminate them as potential suspects in other crimes;
 - (b) match DNA profiles from two or more unsolved crime scenes, thereby linking seemingly unrelated police investigations; and
 - (c) identify missing persons, unknown deceased persons and disaster victims.
- The National Police Reference Services (NPRS) is a suite of technology services designed to support Australia's operational police and non-police law enforcement agencies to share policing information related to persons, vehicles and firearms across state and territory borders. The NPRS currently holds 8.7 million persons records and 2.8 million photographs which allows police to access information, for example, about names and aliases, identity details, warning and warrants etc.
- The National Firearms Identification Database (NFID) provides a national firearms reference table of all known makes, models and variants of firearms in Australia and is used by police, the ACC, ACPBS and AGD as a reference source to consistently identify record and register firearms.¹⁰³⁴

These databases provide police with national operational data that support the investigation of crimes within Australia and internationally. CrimTrac's functions are reliant upon the operating environment of individual jurisdictions and the agency considers data security and privacy as critical to its function. In his submission, Mr Doug Smith, CrimTrac's Executive Officer stressed the key objective of maintaining privacy:

Number one is from a CrimTrac perspective and my perspective privacy is a very important thing. I have always made the point that if there are concerns about privacy, that goes to the trust and reputation of the organisation, so I am very keen to make sure that the protection of information is there. When we talk about privacy, I do not associate that with anonymity. In a lot of quarters, people make the leap from privacy to anonymity. I think that is too big a leap. Unfortunately in some of the conversations people want to remain completely anonymous in the information world, which is unrealistic.¹⁰³⁵

The Office of the Commonwealth Director of Public Prosecutions

The Office of the CDPP is an independent prosecution service established in 1984 to prosecute alleged offences against Commonwealth law. The CDPP describes its functions as being:

to provide an effective and efficient independent prosecution service that contributes to a fair, safe and just Australia where Commonwealth laws are respected, offenders are brought to justice and potential offenders are deterred. The CDPP is within the Commonwealth Attorney-General's portfolio, but operates independently of the Attorney-General and the political process (CDPP 2014a, n.p).

Some of the key areas within the jurisdiction of the CDPP include crimes related to serious drugs, money laundering, cybercrime, counter-terrorism, fraud, commercial and general prosecutions (CDPP 2014b, n.p.). Recent prosecutions have specifically involved the importation and distribution of methamphetamine, including crystal methamphetamine.

The Australian Commission for Law Enforcement Integrity

The ACLEI 'provides independent assurance to government about the integrity of prescribed law enforcement agencies and their staff members' (ACLEI 2013, n.p.). The office of

1034 Mr Doug Smith APM, Chief Executive Officer, CrimTrac, Submission, 16 April 2014.

1035 Mr Doug Smith APM, Chief Executive Officer, CrimTrac, Submission, 16 April 2014.

the Integrity Commissioner and ACLEI are established by the *Law Enforcement Integrity Commissioner Act 2006 (Cth)* (the LEIC Act).

The ACLEI investigates corruption issues involving staff members and former staff members of the:

- Australian Crime Commission and the former National Crime Authority
- Australian Customs and Border Protection Service
- Australian Federal Police
- Australian Transaction Reports and Analysis Centre
- CrimTrac Agency, and
- prescribed aspects of the Department of Agriculture (ACLEI 2013, p.iv).

ACLEI's primary role is to investigate law enforcement-related corruption issues, giving priority to serious and systemic corruption. The Commission's principal role in relation to organised crime lies in its ability to investigate alleged instances of corruption involving staff of the above entities who may have been targeted by organised crime for the purposes of obtaining strategic intelligence on police operations or other information that could be used to avoid prosecution.¹⁰³⁶

Victorian responses to organised crime

Victoria has two principal agencies with responsibility for responding to organised crime, Victoria Police and the Independent Broad-based Anti-corruption Commission (IBAC).

Victoria Police

Victoria Police is a large organisation employing 15,761 people including sworn police members, public servants, protective services officers, forensic scientists and other specialists. Effective service delivery is provided through 54 Police Service Areas (PSAs), split across 21 divisions within four regions — North-Western Metropolitan, Southern Metropolitan, Eastern and Western. These regions correspond with those of other Victorian government departments, enhancing cross-department service delivery, particularly in the area of emergency management (Victoria Police 2014, n.p). Of relevance to the control of organised crime is the Crime Command Department that employs specialist investigative skills to undertake major proactive and reactive inquiries into serious crimes and criminal activity, supported by technical, intelligence and forensic services. Victoria Police describes its focus on organised crime in 2012-13 as follows:

Over the past year, we have sought to tackle organised crime at all its levels. Organised crime is an untaxed, \$5b per annum enterprise. In response, we have established a number of collaborative task forces with other law enforcement agencies. For example, the Trident Task Force, which tackles crime on the waterfront, has participated in the seizure of hundreds of tonnes of illicit commodities and millions of dollars in cash and assets. We have also worked to create a hostile environment for outlaw motorcycle gangs with a key feature being the disruption of their activities, including advocating significant anti-criminal association legislation, the cancellation of firearm licenses and the examination of outlaw motor cycle gang involvement in a range of Victorian industries (Victoria Police 2013, p.58).

Victoria Police also 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 has addressed is the need for better security in

¹⁰³⁶ For an analysis of risks of this nature see Rowe, Akman, Smith & Tomison (2013).

Victorian ports to prevent the importation of illicit drugs into the state. In particular, Trident 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.¹⁰³⁷ 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.¹⁰³⁸

In particular, Taskforce Trident note:

[t]here are identified issues with the oversight and administrative management of the card system with no central agency responsible for the issuing or verification of the MISCs. Anecdotally there are challenges with counterfeit cards being used and recent advice suggests there will be a review into the card system process.¹⁰³⁹

Independent Broad-based Anti-corruption Commission (IBAC)

The primary purpose of the IBAC is to strengthen the integrity of the Victorian public sector, and to enhance community confidence in public sector accountability (IBAC 2013). IBAC's relevance to organised crime is similar to that of ACLEI, in that it seeks to prevent and to investigate instances in which organised crime figures may have sought to corrupt Victorian public servants to facilitate criminal activities. IBAC's principal objectives and functions are set out under the *Independent Broad-based Anti-corruption Commission Act 2011 (Vic)*. In summary, they are to:

- provide for the identification, investigation and exposure of serious corrupt conduct, and police personnel misconduct
- assist in the prevention of corrupt conduct, and police personnel misconduct
- facilitate the education of the public sector and the community about the detrimental effects of corrupt conduct and police personnel misconduct on public administration and the community, and the ways in which corrupt conduct and police personnel misconduct can be prevented
- assist in improving the capacity of the public sector to prevent corrupt conduct and police personnel misconduct (IBAC 2013, n.p.).

IBAC's jurisdiction for identifying and preventing serious corrupt conduct extends across the Victorian public sector including statutory authorities and state and local government. IBAC also has a broader role in relation to assessing police personnel conduct, and investigating and preventing misconduct by police personnel (IBAC 2013).

Victorian legislation dealing with organised crime

Each of Australia's states and territories has enacted legislation aimed at responding to organised criminal activities in various ways. Ayling & Broadhurst note that:

there are many offences on the statute books in Australia that involve the preparation for and facilitation of criminal activities that may amount to organised crime (conspiracy laws, aiding and

1037 A person has an operational need to hold an MSIC if his or her occupation or business interests require, or will require, him or her to have unmonitored access to a maritime security zone at least once a year. This includes:

- Port, port facility and port service workers;
- Stevedores;
- Transport operators such as train and truck drivers;
- Seafarers on Australian regulated ships and;
- People who work on and/or supply offshore oil and gas facilities.

See *Maritime Transport Security Act 2003*.

1038 See <http://msic.net.au/msic-program>.

1039 Lucinda Nolan, Deputy Commissioner, Victoria Police. Correspondence to the Law Reform, Drugs and Crime Prevention Committee, 19 August 2014.

abetting, accessory before and after the fact, possession of and dealing with stolen property, and so on) and that directly target organised crime (corruption offences and money laundering, for example) and public violence (assault, homicide and so on) (2013, p.4).

These laws include organised crime control orders, anti-fortification laws, proceeds of crime and asset confiscation including unexplained wealth, as well as state and territory-based anti-money laundering laws. 'New laws passed in several Australian jurisdictions to deal with OMCGs are modelled on terrorism legislation but further entrench membership of undesirable organizations, those that are perceived as threats to public order, as a ground for coercive state action' (Ayling 2011, p.262).

Victoria's asset confiscation legislation enables the proceeds of organised crime to be restrained and confiscated in specified circumstances as described below.

Organised crime control orders

The Victorian Government introduced the Criminal Organisation Control Bill 2012 (Vic) on 14 November 2012 which provided for the making of declarations and control orders against organised crime groups. Section 1 of the *Criminal Organisation Control Act 2012* (Vic) sets out the main purposes of the Act as being:

- (a) to provide for the making of declarations and control orders for the purpose of preventing and disrupting the activities of organisations involved in serious criminal activity, and of their members, former members, prospective members and associates; and
- (b) to provide for the recognition and application of declarations and control orders made under corresponding laws.

The legislation seeks to identify, disrupt and restrict criminal activities perpetrated by individuals who are known to be part of or associated with organised crime groups, syndicates or networks. Part 2 of the Act specifies the requirements necessary for declarations to be made.

Division 1 — Applications for declarations

s.14. Chief Commissioner may apply for declaration

The Chief Commissioner may apply to the Court for a declaration that—

- (a) an organisation is a declared organisation; or
- (b) an individual is a declared individual.

s.15. Form and content of application

(1) An application under section 14 must—

- (a) be in writing; and
- (b) identify the particular organisation or individual in respect of which or whom the declaration is sought; and
- (c) state the grounds on which the declaration is sought; and
- (d) set out the details of any previous application for a declaration in respect of the organisation or individual and the outcome of that application.

(2) In the case of an application in respect of an organisation, the organisation may be identified in the application by—

- (a) if the organisation is a company or registered foreign company within the meaning of the Corporations Act, its ACN, ABN or ARBN;

- (b) if the organisation is an incorporated association, its name and the registration number assigned to it under the *Associations Incorporation Reform Act 2012*;
 - (c) if the organisation is another kind of incorporated body or association, its name and—
 - (i) the registration number (if any) assigned to it under the law under which it is incorporated; or
 - (ii) any other particulars that are sufficient to identify it;
 - (d) if the organisation is an unincorporated body or association—
 - (i) the name by which it is commonly known; or
 - (ii) any other particulars that are sufficient to identify it.
- (3) An application must be accompanied by at least one affidavit which addresses the grounds on which the declaration is sought.¹⁰⁴⁰
- (4) An application must be served on the respondent as soon as practicable after the application is made.

Under section 43, the Court may, upon the application of the Chief Commissioner, make a control order in relation to a declared organisation, or in relation to a declared individual.

Division 2—Determination of applications

s. 43 Court may make control order

- (2) The Court may make a control order that applies to an organisation if the Court is satisfied that—
- (a) the organisation is a declared organisation; and
 - (b) the making of the control order is likely to contribute to the purpose of preventing or disrupting serious criminal activity by—
 - (i) the organisation; or
 - (ii) any members, former members or prospective members of the organisation.

The Court may make a control order that applies to an individual if the Court is satisfied that—

- (a) the individual is—
 - (i) a declared individual; or
 - (ii) a declared organisation member; and
 - (b) the making of the control order is likely to contribute to the purpose of preventing or disrupting—
 - (i) serious criminal activity by the declared individual or declared organisation member; or
 - (ii) serious criminal activity by any other person that is being or may be facilitated by the declared individual or declared organisation member.
- (3) For the purposes of subsection (1) or (2), the Court may be satisfied that the making of a control order is likely to contribute to the purpose of preventing or disrupting serious criminal activity without having to determine which particular applicable offence or offences would be prevented or disrupted.

¹⁰⁴⁰ See section 19 for the grounds for making a declaration.

- (4) The Court may decide that it is satisfied as required by subsection (1) or (2) only if it is satisfied by acceptable, cogent evidence that is of sufficient weight to justify the making of a control order.

The Act sets out a non-exhaustive list of the conditions that may be imposed as part of a control order made in relation to an organisation, which include the requirements that the organisation be prohibited from 'continuing to operate, carry on a business or take new members',¹⁰⁴¹ that it exclude certain members¹⁰⁴² and also that it prohibits 'from using specified property it owns, possesses, uses or occupies for specified activities i.e. whether that property is located in Victoria or elsewhere'¹⁰⁴³ (New South Wales Parliamentary Research Service 2013, p.42). The conditions set out in the Act that may be used for control orders against individuals are stated in section 47 of the Act.

47. Content of control orders—individuals

- (1) In making a control order that applies to an individual, the Court may impose the conditions the Court considers appropriate.
- (2) Without limiting subsection (1), a control order that applies to an individual who is a declared organisation member may include conditions that do any one or more of the following—
- (a) prohibit the individual from associating with another declared organisation member or an associate of another declared organisation member;
 - (b) restrict, as specified in the condition, the individual from associating with another declared organisation member or an associate of another declared organisation member;
 - (c) prohibit the individual from continuing to be a member of a declared organisation;
 - (d) prohibit the individual from participating in the activities of a declared organisation;
 - (e) restrict the nature of the individual's membership of a declared organisation or participation in the activities of a declared organisation;¹⁰⁴⁴
 - (f) prohibit the individual from using or possessing property which a declared organisation owns, possesses, occupies or uses;

Section 68 of the Act specifies the penalties associated with failing to comply with a control order for individuals and organisations.

68. Individual to whom or organisation to which a control order applies must comply with order

- (1) An individual or organisation that knows or is reckless as to the fact that a control order is in effect that applies to the individual or organisation must not contravene that control order.

Penalty: In the case of an individual, 600 penalty units or imprisonment for 5 years or both;

In case of a body corporate, 3000 penalty units.

- (2) An offence against subsection (1) is an indictable offence.

¹⁰⁴¹ See section 45 (2) (a)

¹⁰⁴² Section 45 (2) (c)

¹⁰⁴³ Section 45 (2) (g)

¹⁰⁴⁴ Example: A condition may prohibit a member from wearing or displaying the patches or insignia of the declared organisation.

- (3) For the purposes of subsection (1), service of a copy of a control order that applies to the individual or organisation is proof, in the absence of evidence to the contrary, that the individual or organisation knows that a control order that applies to that individual or organisation is in effect.
- (4) An individual who is prohibited under a condition of a control order from being a member of a declared organisation does not contravene that condition for the purposes of subsection (1) if—
 - (a) the individual presents or points to evidence that suggests a reasonable possibility that he or she took all reasonable steps to cease to be a member of the organisation as soon as practicable after he or she knew that the order was in effect; and
 - (b) the contrary is not proved (beyond reasonable doubt) by the prosecution.
- (5) In proceedings for an offence against subsection (1) for a contravention by an individual (the accused) of a condition of a control order that prohibits the individual from associating with other individuals, it is not necessary for the prosecution to prove that the accused associated with another person for any particular purpose or that the association would have led to the commission of any offence.
- (6) In this section, control order includes any ancillary order.

Part 5 of the Act sets out provisions that aim to protect 'criminal intelligence from disclosure and establishes a scheme through which the Chief Commissioner can apply to the Supreme Court for an order protecting certain information from disclosure to the respondent during proceedings relating to declarations or control orders' (NSW Parliamentary Research Service 2013, pp. 42-43). Under the same section, provisions relating to declarations from other jurisdictions are stated.

Subdivision 2—Registration of corresponding declaration

88. Registration of corresponding declaration by Prothonotary

- (1) On an application under section 86,¹⁰⁴⁵ the Prothonotary must register the corresponding declaration if the Prothonotary is satisfied—
 - (a) that the declaration is in effect; and
 - (b) if the law of the jurisdiction in which the declaration was made requires notice of the declaration to be published—that the requirement has been complied with; and
 - (c) if the law of the jurisdiction in which the declaration was made requires that the declaration be served on any organisation, person or group of persons—that the requirement has been complied with or is taken to have been complied with.
- (2) The Prothonotary must not register a corresponding declaration unless the Prothonotary is satisfied of the matters set out in subsection (1).

Also in Victoria, the *Vagrancy (Repeal) and Summary Offences Act 2005* (Vic) was re-enacted into the provisions of the *Summary Offences Act 1966* (Vic) which enabled the use of offences of consorting with organised crime figures under section 49F of the Act.

49F. Consorting

¹⁰⁴⁵ Chief Commissioner may apply for registration of corresponding declaration –

(1) The Chief Commissioner may apply to the Prothonotary for registration of a corresponding declaration

(2) An application for registration of a corresponding declaration does not need to be served on the respondent.

- (1) A person must not, without reasonable excuse, habitually consort with a person who has been found guilty of, or who is reasonably suspected of having committed, an organised crime offence.

Penalty: 2 years imprisonment.

- (2) The defendant bears the burden of proving reasonable excuse for habitual consorting to which a charge of an offence against sub-section (1) relates.
- (3) In this section— “organised crime offence” means an indictable offence against the law of Victoria, irrespective of when the offence was or is suspected to have been committed, that is punishable by level 5 imprisonment (10 years maximum) or more and that—
- (i) involves 2 or more offenders; and
 - (ii) involves substantial planning and organisation; and
 - (iii) forms part of systemic and continuing criminal activity; and
 - (iv) has a purpose of obtaining profit, gain, power or influence.

This legislation was introduced as a proactive measure to enable law enforcement agencies to disrupt organised crime by targeting individuals engaged in the planning of such criminal activities.

Prior to the introduction of the Act in 2013, a number of other provisions existed in Victoria to combat organised crime.¹⁰⁴⁶ Although the Committee understands that the current Victorian *Criminal Organisation Control Act 2012* (Vic.) has not been widely used,¹⁰⁴⁷ it believes that the legislative package available to control organised crime groups in Victoria is adequate, and that the particular problem of crystal methamphetamine does not require additional measures to control organised crime groups and their members who may be involved in this particular drug market.

Other states and territories

Similar legislation on organised crime control orders has been introduced in most other states and territories. The first, introduced in South Australia, was the *Serious and Organised Crime (Control) Act 2008* (SA). ‘The law is in effect designed to disturb and, ideally, to dismantle Outlaw Motorcycle Gangs (OMCGs) activities, and prevent them from conducting illegal business in South Australia’ (Groves & Marmo 2009, p.422). The Northern Territory followed by introducing its *Serious Control Act 2009* (NT), and subsequently New South Wales with its *Crimes (Organisation Control) Act 2012* (NSW). In 2012, Western Australia also passed the *Criminal Organisations Control Act 2012* (WA).

In Queensland, the relevant legislation is the *Criminal Organisation Act 2009* (Qld) which was introduced to disrupt and restrict the activities of organisations involved in criminal activities. In an assessment of this legislation, Schloenhardt (2011) stated that ‘it ignores the most fundamental notion of organised crime: that is the fact that criminal organisations are economically motivated and driven by profits rather than by individual associations and group’ (p.113). More recently, Queensland enacted the *Vicious Lawless Association Disestablishment Act 2013* (Qld) whose objectives are specified in section 2 of the Act:

¹⁰⁴⁶ They include the *Major Crime (Investigative Powers) Act 2004* (Vic.), the *Crimes (Assumed Identities) Act 2004* (Vic.), the *Crimes (Controlled Operations) Act 2004* (Vic.), the *Ombudsman Legislation (Police Ombudsman) Act 2004* (Vic.), the *Crimes (Amendment Act) 2004* (Vic.), the *Major Crime (Special Investigations Monitor) Act 2004* (Vic.), the *Major Crime Legislation (Office of Police Integrity) Act 2004* (Vic.) and the *Corrections and Major Crime (Investigative Powers) Act 2004* (Vic.) (Corns 2005). The *Major Crime (Investigative Powers) Act 2004* (Vic.) established a coercive questioning regime for organised criminals and these powers enable police to gather intelligence to target organised criminal activity and to identify suspects for investigation (Bartels 2010).

¹⁰⁴⁷ Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

- (1) The objects of the Act are to:
 - (a) disestablish associations that encourage, foster or support persons who commit serious offences; and
 - (b) increase public safety and security by the disestablishment of the associations; and
 - (c) deny to persons who commit serious offences the assistance and support gained from association with other persons who participate in the affairs of the associations.
- (2) The objects are to be achieved by:
 - (a) imposing significant terms of imprisonment for vicious lawless associates who commit declared offences; and
 - (b) removing the possibility of parole for vicious lawless associates serving terms of imprisonment except in limited circumstances; and
 - (c) encouraging vicious lawless associates to cooperate with law enforcement agencies in the investigation and prosecution of serious criminal activity.

Mr Stefan Kuczborski, a member of the United Motorcycle Council of Queensland, is seeking to challenge some of the provisions of the Act in the High Court on the grounds that ‘they infringe the right to free speech and breach Australia’s obligations under various treaties, including the convention against cruel, inhumane and degrading punishment’ (Withey 2014, n.p.).

Anti-fortification laws

In 2013, the Victorian Government introduced new laws to allow police to forcibly enter the premises of OMCGs and to remove fortifications. The laws allow police to apply to a Magistrates’ Court to have fortifications, including CCTV and other surveillance equipment, removed from gang property where serious criminal activity is suspected. The groups will have to remove the fortifications at their own expense and if they fail to do so, police can forcibly enter and demolish or remove them (Carlyon 2013). Deputy Commissioner Graham Ashton was reported to have said at the time the legislation was introduced that ‘large walls and clubhouse gates often intimidate people in the surrounding community. They present a considerable threat to community safety, not only in relation to firearms but also drug trafficking’ (Carlyon 2013, n.p.).

Section 1 of the *Fortification Removal Act 2013* (Vic) enables the Chief Commissioner of Police to apply to a Magistrates’ Court for an order requiring the ‘removal or modification of fortifications on premises that are connected to certain criminal offences’. Section 11 of the Act provides:

11. Magistrates’ Court may make fortification removal order

- (1) The Magistrates’ Court, on an application under section 6, may order the removal or modification of a fortification in place at the premises in respect of which the application is made.
- (2) The Magistrates’ Court may make an order under subsection (1) if the Court is satisfied that—
 - (a) there is a fortification in place at the premises in respect of which the application is made; and
 - (b) there are reasonable grounds to believe the premises are being used, or have been used or are likely to be used—
 - (i) for or in connection with the commission of a specified offence; or

- (ii) to conceal evidence of a specified offence; or
 - (iii) to keep the proceeds of a specified offence.
- (3) For the purposes of subsection (2), the Magistrates' Court may be satisfied of the matters specified in paragraph (b) of that subsection without having to determine whether any particular specified offence has been committed.

Part 3 of the Act specifies the powers of police to enter premises while the removal order is in effect along with directions from the Magistrates' Court after the removal order has ceased.

25. Inspecting fortified premises while the fortification removal order is in effect

While a fortification removal order is in effect, a member of Victoria Police is authorised to —

- (a) enter and inspect fortified premises in accordance with Division 3¹⁰⁴⁸ to determine whether —
 - (i) a fortification has been removed or modified as required under the order; or
 - (ii) a fortification that was removed as required under the order has been replaced or restored; or
 - (iii) a fortification that was modified as required under the order has had the modification removed or undone; or
 - (iv) another fortification has been constructed or installed on the premises; and
- (b) while at the premises, do anything that is reasonably necessary to make a determination referred to in paragraph (a).

Part 4 of the Act specifies the procedures for the enforcement of fortification removal orders including those related to enforcement notices¹⁰⁴⁹ and associated powers.¹⁰⁵⁰ These sections mainly relate to the requirements for placing a notice either on the entrance of the relevant premises or near such places, and the ability of the Police to enter premises without a warrant on a date specified in the notice and to carry out actions for the removal of fortification based on reasonable grounds.

Part 5 of the Act contains the following provisions regarding the obstruction of Police during inspection and removal of fortifications.

43. Obstructing inspection of fortified premises

A person must not, without reasonable excuse, hinder or obstruct a member of Victoria Police who is exercising a power under section 35.

Penalty: 240 penalty units or imprisonment for 2 years or both.

44. Obstructing enforcement of fortification removal order

- (1) A person must not, without reasonable excuse, hinder or obstruct a member of Victoria Police who is exercising a power under section 37.

Penalty: 240 penalty units or imprisonment for 2 years or both.

- (2) A person must not, without reasonable excuse, hinder or obstruct a person who is assisting a member of Victoria Police to remove or modify a fortification under section 37(1)(c).

¹⁰⁴⁸ See extension of compliance period.

¹⁰⁴⁹ See section 36 (1) to (3).

¹⁰⁵⁰ See section 37 (a) to (d).

Penalty: 240 penalty units or imprisonment for 2 years or both.

45. Failure to comply with direction to leave fortified premises

A person must not, without reasonable excuse, refuse or fail to comply with a direction given to the person under section 38.

Penalty: 20 penalty units.

46. Obstructing removal of person from premises

A person must not, without reasonable excuse, hinder or obstruct a member of Victoria Police who is removing another person from fortified premises under section 39.

Penalty: 60 penalty units or imprisonment for 6 months or both.

Other sections provide for interference with affixed documents, construction and installation on certain premises including in premises for which fortification removal order has been previously made (ss. 47-49).

Other states and territories

Most other states and territories have similar provisions for the removal of fortifications. In the Northern Territory, the *Serious Crime Control Act 2009* (NT) contains fortification removal provisions. In Tasmania, the *Police Offences Act 1935* (Tas) allows for the issue of fortification warning notices, while in South Australia, the *Statutes Amendment (Anti-Fortification) Act 2003* (SA) inserted in the *Summary Offences Act 1953* (SA) and *Development Act 1993* (SA) anti-fortification provisions. In New South Wales, provisions for removal of fortification are provided for in the *Law Enforcement Powers and Responsibilities Act 2002* (NSW), and in Queensland under the *Criminal Organisation Act 2009* (Qld) and in Western Australia within the *Corruption and Crime Commission Act 2003* (WA) similar powers are made available.

Proceeds of crime and asset confiscation legislation

All Australian states and territories have legislation that can be used to recover the proceeds of crime. The original Australian state and territory legislation for recovering proceeds of crime adopted conviction-based recovery and most have since reformed their laws to include the ability to confiscate assets using civil recovery mechanisms that do not require a criminal conviction before recovery proceedings can commence (Goldsmith et al. 2014).

In Victoria the *Confiscation Act 1997* (Vic.) repealed the earlier *Crimes (Confiscation of Profits) Act 1986* (Vic.) and introduced civil recovery provisions that enable the Director of Public Prosecutions (DPP) to apply for orders for civil recovery and for conviction-based recovery (Goldsmith et al. 2014). Professor Goldsmith described the effectiveness of such proceeds of crime laws:

The potential is largely under-exercised as being neglected because it is about taking away profit incentive for the larger operations. I think one of the challenges you face is that you are looking at the mum-and-dad operations right through to transnational and major organised motorcycle gang groups. If the big profits are being made in the large groups, then with proceeds of crime, unexplained wealth, incapacitating the police or the agency responsible, I think, is an area where there is so much potential that has not been examined yet. There is a Commonwealth Taskforce that I think is trying to respond in this area.¹⁰⁵¹

¹⁰⁵¹ Professor Andrew Goldsmith, Strategic Professor of Criminology, Flinders University (via teleconference), Public Hearing, Canberra, 11 February 2014.

Broadly, the legislation in Victoria enables the forfeiture of the proceeds of certain offences regardless of their form.

Section 3A states the main objects of this Act are—

- (a) to deprive persons of the proceeds of certain offences and of tainted property; and
- (b) to deter persons from engaging in criminal activity; and
- (c) to disrupt criminal activity by preventing the use of tainted property in further criminal activity.

Part 2 of the Act deals with the use of restraining orders as follows:

14. Restraining orders

- (1) A restraining order is an order that no property or interest in property, that is property or an interest to which the order applies, is to be disposed of, or otherwise dealt with by any person except in the manner and circumstances (if any) specified in the order.
- (2) If a provision of this Act confers a power to apply for a restraining order in respect of property in which a person has an interest, the application may be made in respect of one or more of the following—
 - (a) specified property of the person;
 - (b) all the property of the person, including property acquired after the making of the order;
 - (c) specified property of the person and all other property of the person, including property acquired after the making of the order;
 - (d) all the property of the person, including property acquired after the making of the order, other than specified property;
 - (e) specified property of another person.
- (3) If the court making a restraining order considers that the circumstances so require, the order may direct a trustee specified in the order to take control of some or all of the property specified in the order.
- (4) A restraining order may, at the time it is made or at a later time, provide for meeting—
 - (a) the reasonable living expenses (including the reasonable living expenses of any dependants); and
 - (b) reasonable business expenses—
 - of any person to whose property the order applies if the court that makes or made the order is satisfied that these expenses cannot be met from unrestrained property or income of the person.
- (5) A court, in making a restraining order, must not provide for the payment of legal expenses in respect of any legal proceeding, whether criminal or civil, and whether in respect of a charge to which the restraining order relates or otherwise.
- (6) Subject to subsections (4) and (5), a restraining order may be made subject to any conditions that the court thinks fit.

Section 17 of the Act specifies procedures concerning applications for restraining orders:

- (1) If, having regard to the matters referred to in subsection (1A), the court is satisfied that the circumstances of the case justify the giving of notice to a person affected,

the court may direct an applicant under section 16(1)¹⁰⁵² or 16(2) to give notice of the application to any person whom the court has reason to believe has an interest in the property that is the subject of the application.

Section 19 of the Act sets out the requirement to give notice of restraining orders:

- (1) If—
 - (a) a restraining order is made in respect of property of a person; and
 - (b) notice had not been given to that person of the application for the order—

the applicant must give written notice of the making of the order to that person.
- (2) If a person to whom notice must be given under subsection (1) cannot be found after all reasonable steps have been taken to locate the person, the applicant must cause to be published in a newspaper circulating generally in Victoria a notice containing details of the restraining order or give notice to that person in any other manner that the court directs.

Part 2A concerns the use of so-called ‘freezing orders’ while Part 3 specifies the provisions for court orders relating to forfeiture of property and tainted substitution declarations. Part 4 of the Act explains the civil forfeiture regime, including when orders can be made and how property is to be dealt with. Section 36I provides:

- (1) A civil forfeiture restraining order may be made to preserve property or an interest in property in order that the property or interest will be available to satisfy any civil forfeiture order that may be made under Division 2.
- (2) If the Supreme Court or the County Court makes a civil forfeiture restraining order in respect of property or an interest in property, the civil forfeiture restraining order must state that the property or interest is restrained to preserve property or an interest in property so that the property or interest will be available to satisfy a civil forfeiture order.

There are also a range of other provisions in the Act including the effect of forfeiture (Part 5), exclusion orders (Part 6), return of property (Part 7), pecuniary penalty orders (Part 8) and provisions relating to search warrants (Part 11).

Part 15 also concerns the registration of orders made in other jurisdictions.

124 Definition

In this Part—

proceeds of crime means—

- (a) proceeds of a Schedule 1 offence or an offence against a law of the Commonwealth that may be dealt with as an indictable offence (even if it may, in some circumstances, be dealt with as a summary offence) committed in Victoria; or
- (b) any property that is derived or realised, directly or indirectly, by any person from acts or omissions that—

1052 (1) If a person has been, or within the next 48 hours will be, charged with or has been convicted of a Schedule 1 offence—

(a) the DPP may apply, without notice, to any court; or

(b) an appropriate officer may apply, without notice, to the Magistrates’ Court or the Children’s Court—

for a restraining order in respect of property in which the accused has an interest or which is tainted property in relation to that offence.

(2) The DPP or a prescribed person, or a person belonging to a prescribed class of persons, may apply, without notice, to the Supreme Court or the County Court for a restraining order in respect of property under certain conditions specified in the provisions (b) to (d).

- (i) occurred outside Victoria; and
- (ii) would, if they had occurred in Victoria, have constituted an offence referred to in paragraph (a).

Under this section, provisions exist on the registration of interstate orders, their effects, duration and cancellation. Section 131 (1) states:

- (1) If property has been seized under a search warrant issued in reliance on the commission of an interstate offence and a court of the other State or the Territory makes an order—
 - (a) directing that the property be returned to the person from whose possession it was seized; or
 - (b) directing that that person be allowed access to the property—
 the order must, as far as possible, be given effect to in Victoria.

Other states and territories

Other states and territories have similar legislation including New South Wales which currently has two Acts allowing for the recovery of criminal assets, the *Criminal Assets Recovery Act 1990* (NSW) and the *Confiscation of Proceeds of Crime Act 1989* (NSW)) (Goldsmith et al. 2014). In the Australia Capital Territory, the *Confiscation of Criminal Assets Act 2003* (ACT) applies and includes provisions for both conviction-based and civil asset recovery. Queensland has the *Confiscation of Proceeds of Crime Act 2002* (Qld), South Australia has the *Criminal Assets Confiscation Act 2005* (SA), Western Australia has the *Criminal Property Confiscation Act 2000* (WA) and the Northern Territory also has the *Criminal Property Forfeiture Act 2002* (NT). Tasmania remains the only Australian jurisdiction that still requires an offender to be convicted of a crime prior to the confiscation of any property.

State and territory unexplained wealth laws

Similar to that of the Commonwealth legislation on unexplained wealth, some states and territories have enacted their own unexplained wealth provisions. Western Australia was the first Australian jurisdiction to introduce such legislation in 2000 as part of the *Criminal Property Confiscation Act 2000* (WA), followed in 2003 by the Northern Territory through its *Criminal Property Forfeiture Act 2002* (NT) (Goldsmith et al. 2014). Similar legislation has also been introduced in Queensland which has the *Criminal Proceeds Confiscation Act 2009* (Qld) and South Australia which introduced the *Serious and Organised Crime (Unexplained Wealth) Act 2009* (SA). New South Wales has also enacted unexplained wealth provisions under the *Criminal Assets Recovery Act 1990* (NSW).

Victoria did not have specific unexplained wealth legislation during most of the period of this Inquiry. Representatives from law enforcement agencies in Victoria during the Inquiry emphasised the need for such legislation. For example, the Victoria Police submission pointed out that:

The ability of Victoria Police to disrupt the involvement of Organised Crime Groups (OCGs) in the ATS market through prosecution is restricted at present because the structure of OCGs enables the decision-makers to distance themselves from the offences. OCGs employ a wide variety of ways to launder proceeds from ATS trafficking. Current methods of investigating criminal proceeds are difficult and complex for police. The introduction of unexplained wealth legislation would assist Victoria Police to disrupt the activities of OCGs.¹⁰⁵³

¹⁰⁵³ Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

However, on 19 August 2014, as previously noted, unexplained wealth legislation was enacted in the Victorian Parliament. Despite this, the use of unexplained wealth laws has, however, led to considerable discussion and some criticism, both with respect to Commonwealth as well as state and territory legislation. Goldsmith et al. (2014), for example, observed:

While the introduction of unexplained wealth provisions in 2010 was not without criticism, with a number of organizations expressing their concerns that the provisions were a removal of the presumption of innocence and other common-law rights, there are also grounds for concern that expectations of these provisions' effectiveness against organized crime are unrealistic and that their implementation is far more difficult than might be expected. Part of the context for assessing the contribution from provisions of this kind comes from the experience in Western Australia and the Northern Territory. Despite these provisions appearing to have very broad application, the practical reality is that their application is narrower than originally envisaged by the legislature. This is not to undermine the usefulness of the unexplained-wealth provisions, as without them there are undoubtedly cases that might otherwise be out of the reach of proceeds of crime litigation. However, it is important that these provisions are viewed as just one option in the arsenal of proceeds of crime tools (Goldsmith et al. 2014, p.130).

Although it is expected that the introduction of unexplained wealth laws in Victoria would enhance the ability of law enforcement to respond to the financial motivations underpinning organised crime, as indicated above in the discussion of the federal provisions, efforts need to be made to ensure harmonisation of any laws that are enacted with those in other jurisdictions. As Goldsmith et al. (2014, p.138), observe:

Further effort is needed to find ways in which the nine distinct criminal law jurisdictions, eight different police forces, a number of specialist law-enforcement agencies, nine different prosecution authorities, plus associated state, territory and national taxation authorities, not to mention the range of other government and private agencies holding information relevant to financial investigations, can cooperate more effectively in identifying suitable targets and bringing proceedings.

Anti-money laundering offences

In addition to the federal AML/CTF regime, each state and territory has specific criminal offences that proscribe money laundering activities. The majority of money laundering offences differ from jurisdiction to jurisdiction, although the current provisions in New South Wales, Victoria and Tasmania are largely consistent except for slight variations in maximum penalties. Generally, any person who processes, receives, conceals, or imports the proceeds or instruments of crime is guilty of an offence of money laundering. In most jurisdictions, maximum penalties are graded in accordance with the defendant's state of mind and the seriousness of the offence.

Victoria has had two pieces of legislation that proscribe money laundering, the *Confiscation Act 1997 (Vic)* and the *Crimes Act 1958 (Vic)* amended by the *Crimes (Money Laundering) Act 2003 (Vic)*. Sections 122 and 123 of the *Confiscation Act 1997 (Vic)* were repealed by the 2003 Act, leaving the primary state legislation for money laundering in Victoria as the *Crimes Act 1958 (Vic)*.

One of the main purposes of the money laundering provisions contained in the *Crimes Act 1958 (Vic)* is to secure existing loopholes which may be exploited by criminal organisations travelling between jurisdictional boundaries. In doing so, the Act gives further clarification about the term 'proceeds of crime', as well as creating additional provisions for dealing with 'instruments of crime'. The amendments also brought the state money laundering laws closer to those in operation at the Commonwealth level. Again, the predominant difference between this Act and the Criminal Code is that fines are not available as an alternative or additional penalty.

The relevant provisions of the *Crimes Act 1958* (Vic) commenced on 1 January 2004. The primary purposes of the amendments under the *Crimes (Money Laundering) Act 2003* (Vic) were to repeal Part 14 of the *Confiscation Act 1997* (Vic) and to amend the *Crimes Act 1958* (Vic) by inserting new offences in relation to: dealing with the proceeds of crimes; dealing with property suspected of being proceeds of crime; and dealing with property which subsequently becomes an instrument of crime. The 2003 amendments to the *Crimes Act 1958* (Vic) provide a detailed list of money laundering terms including 'dealing with', 'instrument of crime', 'proceeds of crime' and 'property' (s. 193):

193 Definitions

(1) In this Division—

deal with includes receive, possess, conceal or dispose of;

instrument of crime means property that is used in the commission of, or used to facilitate the commission of—

- (a) an offence referred to in Schedule 1 to the *Confiscation Act 1997*; or
- (b) an offence against a law of the Commonwealth that may be dealt with as an indictable offence (even if it may, in some circumstances, be dealt with as a summary offence); or
- (c) an offence against a law of another State, a Territory or a country outside Australia that would have constituted an offence referred to in paragraph (a) if it had been committed in Victoria;

proceeds of crime means property that is derived or realised, directly or indirectly, by any person from the commission of—

- (a) an offence referred to in Schedule 1 to the *Confiscation Act 1997*; or
- (b) an offence against a law of the Commonwealth that may be dealt with as an indictable offence (even if it may, in some circumstances, be dealt with as a summary offence); or
- (c) an offence against a law of another State, a Territory or a country outside Australia that would have constituted an offence referred to in paragraph (a) if it had been committed in Victoria;

property includes money and all other property real or personal including things in action and other intangible property.

(2) For the purposes of the definitions of *instrument of crime* and *proceeds of crime*, it is necessary to prove facts that constitute one or more offences referred to in paragraph (a), (b) or (c) of those definitions but the particulars of an offence need not be proven.

Section 194 of the *Crimes Act 1958* (Vic) has four offences for dealing with the proceeds of crime.

194 Dealing with proceeds of crime

(1) A person must not deal with proceeds of crime—

- (a) knowing that it is proceeds of crime; and
- (b) intending to conceal that it is proceeds of crime.

Penalty: Level 3 imprisonment (20 years maximum).

(2) A person must not deal with proceeds of crime knowing that it is proceeds of crime.

Penalty: Level 4 imprisonment (15 years maximum).

- (3) A person must not deal with proceeds of crime being reckless as to whether or not it is proceeds of crime.

Penalty: Level 5 imprisonment (10 years maximum).

- (4) A person must not deal with proceeds of crime being negligent as to whether or not it is proceeds of crime.

Penalty: Level 6 imprisonment (5 years maximum).

- (5) It is a defence to a prosecution for an offence under this section if the accused satisfies the court that the accused dealt with the property in order to assist the enforcement of a law of the Commonwealth, a State or a Territory.

The four offences are distinguished by determining the element of fault to be proven by the prosecution. Unlike the *Confiscation Act 1997* (Vic), these four offences are graded in accordance with whether the mental element involved specific intent, knowledge, recklessness or negligence. The longest maximum sentence under the *Crimes Act 1958* (Vic) for people who deal with property knowing that it is the proceeds of crime and who intend to conceal this, is 20 years. Section 195 sets out a strict liability offence which provides that those who deal with proceeds of crime reasonably suspected to be proceeds of crime, are liable to a maximum of two years' imprisonment. Similarly, under section 195A, anyone who deals with property which subsequently becomes an instrument of crime, is also liable to imprisonment for a period of between five and 15 years. There is no mention of a monetary fine as an alternative option of punishment for any of the offences.

The provisions contained in the *Crimes Act 1958* (Vic) are comparatively similar to the offences under Division 400 of the Commonwealth Criminal Code. The Act is comprehensive in its description of money laundering offences and offers a clear separation of fault elements. Apart from the exclusion of fines as an alternative or additional penalty, the Act's maximum custodial sentence is also similar to that in the Criminal Code.

Other states and territories

Other states and territories have also enacted criminal provisions for money laundering. In 2002, the Council of Australian Governments made an agreement between the Commonwealth and the state and territory jurisdictions in order to form a more unified approach against the issue of money laundering (Strong 2005). In doing so, the agreement encouraged harmonisation of provisions, as well as inclusion of various Commonwealth provisions into state legislation (Strong 2005).

In New South Wales, the *Criminal Assets Recovery Act 1990* (NSW) and *Confiscation of Proceeds of Crime Act 1989* (NSW) includes provisions related to money laundering offences. The Australian Capital Territory has introduced the *Confiscation of Criminal Assets Act 2003* (ACT), Queensland has the *Criminal Proceeds Confiscation Act 2002* (Qld) and the Northern Territory has enacted the *Criminal Property Forfeiture Act 2002* (NT). In South Australia, the *Criminal Assets Confiscation Act 2005* (SA) applies and Western Australia has similar legislation which is the *Criminal Property Confiscation Act 2000* (WA). In the Northern Territory, the *Criminal Property Forfeiture Act 2002* (NT) and the *Crimes (Confiscation) Act 1988* (NT) includes provisions for money laundering offences.

Administrative approaches to controlling organised crime

In addition to these criminal justice legislative responses to organised crime, a number of alternative strategies are available. Ayling (2014), for example, described the use of

administrative regulatory approaches to the control of organised crime in the Netherlands as follows:

The Dutch approach is an example of a situational crime prevention approach, in that it is 'not primarily aimed at the perpetrators of organised crime, but rather at the various circumstances that facilitate organised crime' (Van de Bunt 2004, p. 695). 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 '[t]he 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' (Olsthoorn & van Hees 2011, p. 2). In accordance with established situational techniques (POP Center 2010), the emphasis is on increasing the efforts, increasing the risks and reducing the rewards of organised crime (Nelen 2010). Two basic ideological assumptions underlie this approach (Huisman & Nelen 2007). The first is that public administration should not facilitate organised crime. The second is that responsibility for combating and preventing organised crime lies not just with criminal justice agencies but also with administrative authorities (Ayling 2014, p.91).

An example of the way in which administrative regulatory approaches can have an impact on organised crime comes from Project 1012 undertaken in Amsterdam, and described by Ayling:

Project 1012 was established by Amsterdam's municipal council following a September 2007 parliamentary report produced by the Van Traa team entitled *Limits to Law Enforcement; New Ambitions for the Wallen* that outlined the need to address the criminal infrastructure of the Red Light district. Project 1012 aims to ensure a better balance between the different types of businesses that operate in the 1012 postal area, resulting in "an appealing cocktail of style and excitement, so partly "red-light district", but at the same time an inviting neighbourhood for everyone who wants to explore the shops, galleries, museums, restaurants, trendy eateries and old-style "brown cafés"... This is to be achieved through a program of "repurposing" of properties, involving licence withdrawal and the refusal of new licences to force the closure of coffee shops, prostitution windows and casinos, the purchase of real estate to prevent its further use by criminal groups and to prevent acquisition by them, and measures to reverse degradation of infrastructure (2014, p. 94).

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. In particular the issue of liquor licences, firearm permits, security agents' and crowd controllers' licences all require administrative decisions to be made about the fitness, or otherwise, of individuals to participate in the relevant sectors. Ayling (2014) argues that enhanced scrutiny of such applications could be one way of limiting the criminal opportunities available to organised crime. Already this has been used in both Queensland and New South Wales to exclude organised crime groups from controlling tattoo parlours:

[F]ollowing a spate of drive-by shootings involving tattoo parlours, laws relating to the licensing of both the parlours and tattooists have recently been enacted in NSW and Queensland, aimed at breaking the connection between OMCGs and tattoo parlours. Similarly, in recent NSW anti-associations laws aimed at OMCGs, a person subject to a control order is automatically excluded from applying for or holding a licence or permit to undertake certain prescribed activities (such as selling liquor or possessing firearms) or occupations (including tow truck operator, pawn broker, casino operator, motor dealer or repairer and so on) while the order is in force (Ayling 2014, p. 88).

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. In particular the issue of liquor licences, firearm permits, security agents' and crowd

controllers' licences all require administrative decisions to be made about the fitness, or otherwise, of individuals to participate in the relevant sectors. Ayling (2014) argues that enhanced scrutiny of such applications could be one way of limiting the criminal opportunities available to organised crime.

The Committee believes that such an approach is worthy of further consideration for implementation in Australia, and in Victoria specifically. In conducting further research into this approach, the Committee notes the need to address the many theoretical and practical problems that Ayling (2014) has identified in her research on the administrative approach adopted in the Netherlands, including issues relating to privacy, procedural fairness and potential crime displacement effects. Nonetheless, the administrative approach may work effectively if designed carefully and adapted to the local situation in Victoria.

Conclusion

The responses to organised crime explored in this chapter have been developed in consideration of the fact that such activities often transcend national boundaries. Australia remains aware of the actual and potential threats posed by organised crime networks including their involvement in the illicit drug trade and this has led to various measures being developed by policy-makers and practitioners to inform intelligence, law enforcement and political decision-making processes. The Commonwealth law enforcement agencies have, over the years, developed increased capacity to target and disrupt organised crime activities within Australia and overseas and such efforts have been facilitated through domestic legislation at the federal as well as state and territory level.

Agencies throughout Australia seek to act cooperatively in setting national priorities against organised crime and in coordinating their activities to support those priorities. There is also a complex network of agencies that assist in the integration of intelligence and support for law enforcement throughout the country. The introduction of the Commonwealth *Organised Crime Strategic Framework* and the *Organised Crime Response Plan* have been instrumental in facilitating the collaboration between federal and state and territory law enforcement agencies in countering transnational organised crime.

As this chapter indicates, law enforcement and legislative responses to organised crime extend beyond law enforcement to a wide range of other public sector agencies. The Commonwealth legislation on proceeds of crime, money laundering and others has been instrumental in playing a critical role in the targeting of assets gained through organised crime activities.

Although the main bodies with responsibility for dealing with organised crime are at the Commonwealth level, for example, the AFP and the ACC, most of the state and territory police services have divisions with specific responsibilities for dealing with organised criminal activities that affect their own local interests. Such efforts are informed by a suite of legislation introduced by each jurisdiction including Victoria in areas such as organised crime control orders, anti-fortification laws, proceeds of crime including unexplained wealth provisions, and anti-money laundering.

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.

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.

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.

20. International and Domestic Precursor Controls

Introduction

Preceding chapters in this Report have examined the many legislative responses to the use of methamphetamine in Australia, and in Victoria, particularly those relating to unlawful importation, manufacture, supply, possession and use of these drugs. In addition to these legislative responses, there is a set of complementary approaches to control access to the precursor chemicals and laboratory equipment used for the manufacture of methamphetamine. Such precursors and equipment are, however, also used for legitimate purposes by the pharmaceutical industry and chemical manufacturers and suppliers. In the Submission of the Criminal Justice Division of the Attorney-General's Department to the Productivity Commission's Study into Chemicals and Plastics Regulation in 2007, it was argued that 'controlling the interface between the legitimate market for these chemicals and illicit drug manufacturing is an internationally recognised strategy for reducing the supply of ATS [amphetamine type stimulants]' (Attorney-General's Department 2007, p.1). Such efforts require a collaborative approach between law enforcement and regulatory agencies, the pharmaceutical industry and businesses involved in the manufacture and supply of chemicals.

This chapter examines the regulations and policies relevant to the control of precursor chemicals and equipment that could be used in the production of methamphetamine within Australia. It begins by exploring the international efforts relating to precursor controls established pursuant to the *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (UNODC 1988), and then considers national precursor control measures that operate within Australia. These include the Poisons Standard, the National Drug Strategy 2010-2015 and the National Precursor Control Framework. Initiatives such as Project STOP and the use of End User Declarations are examined to show how governments and industries have responded collaboratively to the problem. However, as Nicholas has observed, 'despite the implementation of a range of successful precursor control activities, illicit manufacturers are circumventing these controls by substituting controlled precursors with those which are outside international controls' (2008, p.105). The Committee believes that certain reforms could be made that would assist in minimising the use of chemicals and equipment for the illicit manufacture of drugs such as methamphetamine.

International precursor controls

The *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (UNODC 1988) is the principal international instrument relevant to the control of precursors used to manufacture illicit drugs. It provides comprehensive measures against drug trafficking, including provisions against the diversion of precursor chemicals as well as requirements for international cooperation with respect to the extradition of drug traffickers, controlled deliveries and transfer of proceedings (UNODC 1988). Australia became a signatory to the convention on 14 February 1989. The purpose of the convention is stated in Article 2:

The purpose of this Convention is to promote the co-operation among the Parties so that they may address more effectively the various aspects of illicit drugs and psychotropic substances having an international dimension. In carrying out their obligation under the Convention, the Parties shall take necessary measures, including legislative and administrative measures, in conformity with the fundamental provisions of their respective domestic legislative systems (UNODC 1988, p.2).

Article 12 of the convention relates to the control of precursor chemicals used to manufacture illicit drugs including methamphetamine, and contains the following provisions:

- (a) General obligation for parties to take measures to prevent diversion of the substances in Table I and Table II¹⁰⁵⁴ of the 1988 Convention and to cooperate with each other to that end (para. 1);
- (b) Mechanism for amending the scope of control (paras. 2-7);
- (c) Requirement to take appropriate measures to monitor manufacture and distribution, to which end parties may control persons and enterprises, control establishments and premises under licence, require permits for such operations and prevent accumulation of substances in Tables I and II (para. 8);
- (d) Obligation to monitor international trade in order to identify suspicious transactions, to provide for seizures, to notify the authorities of the parties concerned in case of suspicious transactions, to require proper labelling and documentation and to ensure maintenance of such documents for at least two years (para. 9);
- (e) Mechanism for advance notice of exports of substances in Table I, upon request (para. 10);
- (f) Confidentiality of information (para. 11);
- (g) Reporting by parties to the International Narcotics Control Board (para. 12);
- (h) Report of the Board to the Commission on Narcotic Drugs (para. 13);
- (i) Non-applicability of the provisions of article 12 to certain preparations (para. 14) (UN 2013, p.56).

Each year, the International Narcotics Control Board of the United Nations publishes a list of precursors and chemicals frequently used in the illicit manufacture of narcotic drugs and psychotropic substances (UN 2013). The latest list released in 2013 states 'the illicit manufacture of methamphetamine in Oceania relies on smuggled ephedrine and pseudo ephedrine in bulk form and in the form of pharmaceutical preparations' (UN 2013, p.13). This is in keeping with the evidence received by the Committee concerning the situation as it affects Victoria (see discussion in Chapters 15, 16 and 17 on the manufacture, distribution and supply of methamphetamine).

According to the UNODC, 'the international community has, over the years, strengthened a control system aimed at enabling legal trade of such chemicals while preventing diversion into illicit manufacture' (UNODC 2014b, p.xii). It is generally accepted that precursor controls are the most effective tool for responding to international illicit drug trade. Mr Jeremy Douglas of the UNODC, when asked about the substantial quantity of precursors being intercepted at the Australian border, told the Committee:

1054 At 25 September 2013, Table I specified: Acetic anhydride, N-Acetylanthranilic acid, Ephedrine, Ergometrine, Ergotamine, Isosafrole, Lysergic acid, 3,4-Methylenedioxyphenyl-2-propanone, Norephedrine, Phenylacetic acid, 1-Phenyl-2-propanone, Piperonal, Potassium permanganate, Pseudoephedrine, Safrole.

Table II specified: Acetone, Anthranilic acid, Ethyl ether, Hydrochloric acid, Methyl ethyl ketone, Piperidine, Sulphuric acid, Toluene.

On the point of precursors I do think that if you were to think about prioritisation, if you want to assist countries overseas prior or early, that is a good priority — precursor control. A lot of those countries have very little knowledge of precursors. They do not have strong regulatory systems, and if you do not have the precursors, it is very difficult to make the drug. You can make it with other methods, but you have to be a good chemist to make it without pseudoephedrine or ephedrine. That is an area where countries do need help, and probably it is a good idea to prioritise that kind of assistance.¹⁰⁵⁵

Some of the key challenges regarding international precursor controls facing the International Narcotics Control Board include:

- (a) The rapid adaptation by chemical trafficking organisations to changes in regulatory systems and successful law enforcement;
- (b) The increasing sophistication in the illicit manufacture of drugs and their precursors; and
- (c) The diversity in the use of alternate chemicals for illicit drug manufacture (UN 2013, p.28).

These problems are illustrated by the ability of criminals to avoid current precursor controls by using alternative chemicals that are not currently regulated. The 2014 *World Drug Report*, for example, stated that ‘traditional precursors are being replaced with alternate precursors and chemicals that are not under international control’ (UNODC 2014b, p.53). Earlier in this Report, a representative from the Australian Crime Commission (ACC) presented evidence regarding emerging concerns over methamphetamine being detected at the Australian border that has been manufactured using Phenyl-Propane (P2P), a chemical used by the Mexican drug cartels.¹⁰⁵⁶ The United Nations report on precursors and chemicals also identified this problem:

P-2-P can be used in the illicit manufacture of amphetamine or methamphetamine and can be synthesized from phenylacetic acid and its esters, as well as other ‘pre-precursors’. International trade in P-2-P is limited both in volume and the number of countries involved, while trade in phenylacetic acid is far more significant. P-2-P-based methods are used by criminal groups for illicit manufacture of methamphetamine in Mexico and amphetamine in European countries (UN 2013, p.14).

Even though methamphetamine production in Australia usually makes use of ephedrine and pseudoephedrine, the importation of pre-precursors has received greater attention in recent years. Ritter et al. (2012) also identified the problem of pre-precursors being used to evade current precursor controls:

Masked precursors are chemical precursors that have been converted into a substance, which is usually an unregulated substance, and therefore difficult to be detected (Customs KI). Pre-precursors are chemicals that are not under international control but are usually closely related to precursors. These chemicals can be transformed into precursor chemicals using chemical processes. Pre-precursors are produced specifically for international trafficking purposes in order to circumvent international controls (Ritter et al. 2012, pp.58-59).

The development of international pre-precursor control measures has been a key focus of the UN International Narcotics Control Board and has led to a number of strategies being developed to address specific issues. These include:

- the use of more sophisticated ways to obtain precursor chemicals;
- the use of transit countries with weak control systems;
- the emergence of organized criminal groups specialized in the supply of precursor chemicals;

¹⁰⁵⁵ 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.

¹⁰⁵⁶ Mr Shane Neilson, Head of Determination, Australian Crime Commission, Public Hearing, Canberra, 10 February 2014.

- the creation of front companies to conceal illegal imports;
- the domestic diversion and subsequent smuggling of precursor chemicals to final destinations in order to bypass the international control system;
- the misuse of pharmaceutical preparations (notably preparations containing ephedrine and pseudoephedrine) and;
- the emergence of non-scheduled precursor chemicals, including various pre-precursors that can be easily converted into the required precursors (UNODC 2014b, p.xiv).

Australia has developed a suite of regulations relating to precursor chemicals that aim to prevent such chemicals being diverted from legitimate use into the illicit marketplace.

National precursor controls

Commonwealth regulations

Precursor control measures are implemented both at international and domestic levels. Domestic precursor control measures include regulations that are implemented at Commonwealth as well as state and territory level. In Australia, chemicals that are imported and exported are regulated pursuant to legislation used to prohibit the transportation of specific substances. Other initiatives have been developed through strategies, frameworks and precursor monitoring tools nationally for the purpose of ensuring that chemicals that are used for legitimate purposes are not able to be diverted for the production of illicit drugs. The background paper on the National Amphetamine Strategy described the nature of these precursor regulations implemented in Australia, and elsewhere, as:

- Criminalising the supply of precursor chemicals for the use of ATS production;
- Limiting the amount of licit drugs allowed to be purchased in pharmacies and over-the-counter;
- Restricting the international and intra-national movement of large quantities of precursor chemicals; and
- Attempting to monitor the movement and supply of drugs that can be utilised in the production of ATS (Department of Health and Ageing 2007, p.118).

Importation controls

The Office of Chemical Safety (OCS) located within the Department of Health is responsible for granting permits and licences that authorise the importation and exportation of certain narcotic drugs, psychotropic substances, precursor chemicals, antibiotics and androgenic/anabolic substances controlled under the *Customs (Prohibited Imports) Regulations 1956 (Cth)* and *Customs (Prohibited Exports) Regulations 1958 (Cth)* (Department of Health 2013).¹⁰⁵⁷ Not all substances that are controlled are subject to both importation and exportation restrictions and the authorisations required also differ between classes of substances. Schedule 4 of the *Customs (Prohibited Imports) Regulations 1956 (Cth)* contains the list of drugs which are defined as a chemical, compound, or substance or thing.¹⁰⁵⁸ The list of drugs includes ATS such as methamphetamine as well as ephedrine, pseudoephedrine and Phenylacetic acid used in the Phenyl-Propane (P2P) manufacturing method.

Exportation controls

The *Customs (Prohibited Exports) Regulations 1958 (Cth)* also contains a list of drugs including substances such as pseudoephedrine in schedule 8 that are prohibited for exportation if

¹⁰⁵⁷ Department of Health 2014, 'Drug Control Section', The Department of Health Website. <http://www.health.gov.au/internet/main/publishing.nsf/Content/treaties-and-compliance>.

¹⁰⁵⁸ See *Customs (Prohibited Imports) Regulation, Section 5 (20) (a)*.

specified conditions, restrictions or requirements are not complied with. The definitions of drugs and precursor substances are stated under Division 2 of the regulation.

Division 2 — Drugs and precursor substances

9A Definitions for Division 2

(1) In this Division:

1988 Convention has the same meaning as *Convention* has in the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990*.

active principle includes an active isomer or a mixture of isomers of a drug.

authorised person means an officer of the Department authorised in writing by the Secretary for the regulation in which the expression appears.

Department means the Department administered by the Minister administering the *Therapeutic Goods Act 1989*.

derivative means a substance chemically derived from a drug or from which a drug may be regenerated, including a salt.

drug means a narcotic drug or a psychotropic substance, including a chemical or compound and a plant or a part of a plant, but not including a preparation that is a narcotic preparation within the meaning of Schedule 3 to the Single Convention.

narcotic drug means a drug that is a drug for the purposes of the Single Convention.

precursor substance means a substance mentioned in Schedule 9.

psychotropic substance means a substance that is a psychotropic substance for the purposes of the Psychotropic Substances Convention, including a preparation within the meaning of that Convention.

Psychotropic Substances Convention means the Convention on Psychotropic Substances that was adopted and opened for signature at Vienna on 21 February 1971.

The Poisons Standard

Domestic precursor controls in Australia also include the provisions of the Poisons Standard which is used to classify various pharmaceutical medications, controlled drugs and prohibited substances (Department of Health 2014b). The *Standard for the Uniform Scheduling of Medicines and Poisons* (the Standard or the SUSMP) is made under paragraph 52D(2)(b) of the *Therapeutic Goods Act 1989* (Cth), and specifies a classification of medicines and poisons in Schedules for inclusion in the relevant legislation of the states and territories. It also includes model provisions for containers and labels, a list of products recommended to be exempt from these provisions, and recommendations about other controls on drugs and poisons (Department of Health 2014b).

Schedule 3 of the SUSMP contains a list of pharmacist-only medicines which are defined as substances, the safe use of which requires professional advice but which are available to the public from a pharmacist without a prescription. Schedule 8 specifies controlled drugs that are defined as substances which should be available for use but require restrictions in terms of manufacture, supply, distribution and possession and use to reduce abuse, misuse and physical and psychological harm. Amphetamine and methamphetamine are listed under that schedule.

The Commonwealth regulations provide instruments for the monitoring and control of precursor chemicals used to manufacture methamphetamine.

Commonwealth policies

National Drug Strategy

The *National Drug Strategy 2010–2015* provides for a coordinated, integrated approach to alcohol and other drug-related issues in Australia. The overarching approach of the strategy is harm minimisation based on the three pillars of demand reduction, supply reduction and harm reduction. The objectives with respect to supply reduction note that:

Reducing the supply of illegal drugs requires activity at Australia's borders to prevent and disrupt importations of illegal drugs and their precursors and within Australia to prevent the cultivation, manufacture and distribution of illegal drugs. Legislative frameworks exist and require constant enforcement to ensure a reduction in the supply of illegal drugs (Ministerial Council on Drug Strategy 2011, p.14).

The Intergovernmental Committee on Drugs (IGCD) manages the ongoing work of the National Drug Strategy (NDS) and is a Commonwealth, state and territory government forum of senior officers who represent health and law enforcement agencies in each Australian jurisdiction and New Zealand, as well as representatives of the Australian Government Department of Education, Employment and Workplace Relations (Ministerial Council on Drug Strategy 2011). The IGCD provides policy advice to relevant ministers on drug-related matters, and is responsible for implementing policies and programs under the National Drug Strategy framework (Ministerial Council on Drug Strategy 2011). Within the IGCD structure, there are a number of standing committees and time-limited working groups engaged in undertaking work to meet the actions set out in the NDS 2010–2015.

National Pharmaceutical Drug Misuse Framework 2012–2015

The IGCD plays an important role in informing illicit drug supply reduction efforts including precursor control measures at Commonwealth and state and territory level. Of particular relevance is the work of the Standing Committees on Illicit Drugs and Pharmaceutical Drugs Misuse (Ministerial Council on Drug Strategy 2011). The Standing Committee oversees the development and implementation of the National Pharmaceutical Drug Misuse Framework 2012–2015. This Framework established nine different priority areas with related action items. The priority area applicable to the diversion of pseudoephedrine-based medications specifies the following actions:

1. Evaluate the extent to which different jurisdictional regulatory models impact on the misuse of these drugs and identify standardisation benchmarks for good practice.
2. Explore options to enhance the information sharing capacities of law enforcement and health agencies to reduce opportunities for theft, diversion, trafficking and fraud in pharmaceutical drugs.
3. Monitor and respond to emerging trends in local and international Internet pharmacies.
4. Encourage the Pharmaceutical Benefits Advisory Committee and the Therapeutic Goods Administration to increase the emphasis placed on potential harms associated with pharmaceutical drug misuse in their decision making processes (Ministerial Council on Drug Strategy, National Drug Strategy (NDS) 2011, pp.10-11).

National Precursor Control Framework

In addition to these policies, the National Precursor Control Framework seeks to deliver a national approach to the control of precursor chemicals through a collaborative decision-making model (NDS 2011). This Framework was established in accordance with the Ministerial Council on Drug Strategy in November 2010 and aims to reduce the risk of diversion of precursor chemicals by implementing a thorough risk assessment process,

including risk mitigation approaches developed by the Precursor Advisory Group (PAG) (Department of Health 2014a).

The PAG is made up of Commonwealth, state and territory government stakeholders and an industry stakeholder group, the Precursor Industry Reference Group (PIRG) (Department of Health 2014a). Chemicals suspected of being used for the manufacture of illicit drugs are identified by law enforcement agencies including the Australian Crime Commission and the Australian Federal Police as well as by those working within the chemicals industry. For example, 'the Forensic Drug Intelligence (FDI) team of the AFP has two projects which are funded by the Confiscated Assets Account — the Enhanced National Intelligence Picture on Illicit Drugs (ENIPID) and the National Drug Precursor Risk Assessment Capability (NDPRAC)' (ACC 2014, p. 200). Reports from ENIPID and NDPRAC ensure that effective responses to emerging trends in illicit drugs, production methodologies and precursor chemicals are maintained. The chemical industry also plays a vital role in the implementation of the Framework. According to the ACC:

The PAG directs the NDPRAC to carry out risk assessments on prioritised chemicals and, in consultation with the PIRG, uses these assessments to make recommendations to the IGCD for regulatory or other action relating to these chemicals (ACC 2014a, p.201).

Anti-diversion strategies

In addition to these regulatory and policy responses aimed at precursor control, specific policy responses have also been developed and implemented at Commonwealth and state and territory level. 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* that was developed in 1994 that, inter alia, requires chemical manufacturers and suppliers to record transactions involving high risk chemicals and equipment through the use of 'End User Declarations' (EUD).

Project STOP

Background

Project STOP was developed by the 'Queensland Branch of the Pharmacy Guild and the Queensland Police Service as a real-time, web-based database for the recording of customer information relevant to the purchase or attempted purchase of pseudoephedrine-based products' (Ransley et al. 2011, p.vi). The intention behind the implementation of Project STOP was to respond to the higher number of clandestine laboratories that were detected in Queensland when the initiative was introduced in 2005. 'Rolled-out nationally in August 2007, Project STOP assists pharmacists in determining the legitimacy, or otherwise, of requests for pseudoephedrine-based products, thereby increasing access for therapeutic use and preventing diversion where possible'.¹⁰⁵⁹ According to Ransley et al. (2011):

The database enables pharmacies to record three types of transaction — sales, non-sales and sales made under duress. It also detects where a transaction has begun but an entry has not been completed, and also has the capacity to track purchases by individuals, based on their proof of identification — although not all states require this to be produced (p.14).

Implementation

The national implementation of Project STOP was funded through the federal Attorney-General's Department based on partnerships among federal, state and territory police and health authorities as well as community pharmacists (Siggins Miller 2009). In Queensland,

¹⁰⁵⁹ Mr Allan Crosthwaite, Director and Mr Stan Goma, Manager — Professional Services, The Pharmacy Guild of Australia — Victoria, Submission, 10 December 2013.

Ransley et al. (2011) found that ‘the initial take-up of Project STOP by Queensland pharmacies was very high, assisted by the fact that the [Pharmacy] Guild provided it to them free of charge and regardless of whether they were Guild members’ (p.15). Data on pharmacy registrations, number of pharmacy instruction kits sent, and national participation rates given in Table 20.1, show that Queensland had the highest number of registrations in February 2010 and Victoria was ranked third. In terms of percentage uptake of Project STOP as at February 2010, the Australian Capital Territory and the Northern Territory had 100 percent compliance rates, with Queensland and Tasmania almost 92 percent. Victoria had the third lowest percentage in February 2010 at 77 percent.

Table 20.1: Pharmacy registrations, instructions kits sent and uptake by jurisdiction in February 2010

State or Territory	Registered	Kits sent	% Uptake
Australian Capital Territory	61	61	100.00
Northern Territory	28	28	100.00
Queensland	1,017	1,046	91.97
Tasmania	126	137	91.97
Western Australia	470	523	89.87
South Australia	314	408	76.96
New South Wales	1,100	1,723	63.84
Victoria	917	1,190	77.06
Total	4,033	5,116	78.82

Source: Ransley et al. 2011, p.16.

‘As at 30 June 2013, 79.4 percent of approved community pharmacies were registered with Project STOP, compared with 79.2 percent at 30 June 2012’ (ACC 2013d, p. 177). The take-up of Project STOP is primarily due to whether or not it is mandatory in different states and territories. Online recording of pseudoephedrine sales is currently mandatory in Queensland, Western Australia and South Australia but not in Victoria. Although the majority of pharmacies in Victoria have registered for Project Stop, the absence of mandatory participation makes compliance much lower than jurisdictions in which it is mandatory.¹⁰⁶⁰

Comparing Queensland with Victoria

Research has been conducted to assess the differences observed between Queensland and Victoria in the operation of Project STOP. Ransley et al. (2011) found that in Queensland:

The scheme imposes a complex criminal and regulatory web around the sale of pseudoephedrine products. Significant responsibilities have been imposed on pharmacists, not only to verify the therapeutic needs of their customers, but also check and record their identity. This information must be both kept in a register and also routinely passed on to two separate agencies — the police service and health regulators. Agents of both are authorised with coercive powers to check on pharmacists’ compliance with regulatory responsibilities. Sanctions for non-compliance can be imposed both under criminal law and under the registration and disciplinary system applying to pharmacists (Ransley et al. 2011, p. 20).

¹⁰⁶⁰ Mr Allan Crosthwaite, Director and Mr Stan Goma, Manager — Professional Services, The Pharmacy Guild of Australia — Victoria, Submission, 10 December 2013.

Arguably, the success of Project STOP in Queensland has been due to the strictness with which the program has been administered, whereas in Victoria a more cooperative approach has been adopted, as Ransley et al. (2011) outlined:

Coercive measures are directed against direct participants and the principal strategies directed against pharmacists are those seeking voluntary compliance or cooperation. Police may seek to form partnerships with pharmacists, but they are given little in the way of tools to facilitate the co-option of pharmacists as third parties in the policing process (p.23).

Mr Jason Ferris described for the Committee the nature of his current research with other colleagues based on a comparison between Project STOP in Queensland and Victoria. He explained the data he has gathered from the Guild Link from both the jurisdictions:

In Queensland we have a population of 4.6 million, and roughly half a million transactions are being processed through Project STOP in a given year. In Victoria there are about 5.7 million people, and only about 250 000 transactions — so half that number — being processed in a given year. Again, this is a function of the voluntary system occurring in Victoria compared to Queensland.¹⁰⁶¹

Ransley et al. (2011) also argued that Project STOP has been used to a lesser extent in Victoria than in Queensland owing to the lack of incentives in Victoria for pharmacists to record transactions:

This is because [Victoria does] not require pharmacists to record information about every pseudoephedrine transaction. In Victoria, a pharmacist only needs to record information about sales regarded as 'reasonably suspicious'. This is a subjective test requiring the pharmacist to make an informed judgement about the individual purchaser and about their conduct. This judgement is made in the absence of relevant information such as the purchaser's previous attempts to obtain pseudoephedrine. In addition, the pharmacist lacks any legal reason to require the purchaser to provide identification (pp. 43-44).

Ransley et al. (2011) concluded that 'Project STOP works best in an environment where recording and reporting pseudoephedrine sales is mandated and where the police agency provides strong and practical support for partnership policing approaches' (p.44).

Funding and privacy concerns

The future sustainability of the program in terms of funding and privacy concerns relating to the storage of personal information are issues that need to be addressed. Mr Jason Ferris made reference to the issue of funding when asked by the Committee to assess Project STOP from the perspective of pharmacies if it were made mandatory:

As I understand it, up until the last year Project STOP in Queensland was freely provided to pharmacists through the Queensland branch of GuildLink Australia, and supported by the Queensland pharmacy guild for that distribution of Project STOP. There was a lot of support via the guild and a lot of support by the pharmacies to have the program in place and basically respect this process of a tool that can be used to help assist reducing transactions to those who may be trying to divert pseudoephedrine.

In the last year, with the pressure on the guild to keep Project STOP active but the cost that GuildLink then has in running it, they have begun to ask pharmacies who are non-pharmacy union members to pay for it to cover the costs of keeping it running for those who are non-members. I believe this has gone to all states and territories, it is just not in Queensland, for those who are choosing not to use Project STOP, although it is mandatory that an electronic system is used.¹⁰⁶²

1061 Mr Jason Ferris, Senior Research Fellow, Institute for Social Science Research, University of Queensland, Public Hearing (via video conference), Canberra, 12 February 2014.

1062 Mr Jason Ferris, Senior Research Fellow, Institute for Social Science Research, University of Queensland, Public Hearing (via video conference), Canberra, 12 February 2014.

Mr Ferris also described to the Committee the procedures associated with the collection and storage of information within Project STOP. In particular, he made reference to access to historical information of individuals who have purchased pseudoephedrine-based products from pharmacies:

I do not know for sure, but I am pretty sure that the only people who have access to get someone's history without it being a current transaction are police and law enforcement and Queensland Health or other health services which are allowed legitimately to have access to the information being stored on the server by GuildLink. I would like to say that pharmacists cannot go and look at anyone they think they want to have a look at to see what they are doing and be proactive in trying to find people who are pseudo runners.¹⁰⁶³

Currently, personal information in jurisdictions where Project STOP is mandatory is handled in the strictest of confidence. Should real-time monitoring be implemented nationally, the Guild believes that such systems should:

- be developed in a manner which ensures security and patient privacy is maintained according to contemporary and accepted guidelines and practices;
- meet legislative requirements;
- be integrated with dispensing and prescribing software to maximize convenience of use by pharmacists and prescribers to ensure complete and accurate patient records are maintained. The seamless integration of these systems into dispensing and prescribing software, to avoid the need for multiple sets of data entry, is crucial for the viability of such systems; and
- be adapted and applied to other medicines which may be subject to abuse and/or misuse to address the growing problem of doctor and pharmacy shopping.¹⁰⁶⁴

Effectiveness

Project STOP appears to have had a positive impact in terms of restricting the number of clandestine laboratories present in Queensland. 'Within the 12 months following the implementation of Project STOP in late 2005, Queensland law enforcement agencies observed a 23 percent reduction in the number of clandestine laboratories in operation, and made over 30 drug-related arrests' (Groves & Marmo 2009, p.423). 'Officers in Queensland, given the detail and form of identification data obtained from the Project STOP database, and its comprehensiveness, can relatively easily identify patterns of "pseudo-shopping" and identify the individual or individuals perpetrating this activity' (Ransley 2011 et al., p.30).

In Victoria, police data on arrests for the diversion of pseudoephedrine-based medications have fluctuated between 2008 and 2013 (see Ch 16, Table 16.4), while amphetamine seizures have generally increased (see Ch 16, Table 16.5). Between 2003–04 and 2012–13, the number of clandestine laboratories detected has increased nationally, including in those states and territories in which Project STOP has operated (see Ch 16, Table 16.2). Of course, not all illicit ATS production makes use of medicines containing precursor chemical diverted from pharmacies.

In those jurisdictions in which Project STOP has not been fully implemented, opportunities exist for diversion of pseudoephedrine-based products to continue. The imbalance in the availability of data across jurisdictions presents problems for law enforcement in addressing the problem of 'pseudo-runners' who travel across borders to make purchases of pseudoephedrine-based medications for the manufacture of methamphetamine. Ritter, Bright & Gong (2012), however, believe that the problem of 'pseudo-runners' appears to

¹⁰⁶³ Mr Jason Ferris, Senior Research Fellow, Institute for Social Science Research, University of Queensland, Public Hearing (via video conference), Canberra, 12 February 2014.

¹⁰⁶⁴ Mr Allan Crosthwaite, Director and Mr Stan Goma, Manager — Professional Services, The Pharmacy Guild of Australia — Victoria, Submission, 10 December 2013.

be reducing. They also found that 'there has been a trend back to P2P-type methods in response to restrictions on the availability of pseudoephedrine and drug law enforcement will be required to focus on the precursors and manufacture techniques utilised for P2P manufacture' (Ritter, Bright & Gong 2012, p.80).

In conversation with the Committee, Dr Andrew Groves referred to the work he has undertaken with Associate Professor Marinella Marmo, particularly that which has examined the displacement effects of the introduction of the program:

I think there is a fine line between reducing the availability or accessibility of these chemicals for those who want to manufacture methamphetamine, and reducing the effectiveness of legitimate medicines to the community. So I think it is a very difficult issue to address in terms of where the restriction or regulation occurs. I know that in one of the questions you talk about, in terms of the chain of supply if you compare the different manufacture of methamphetamine using different precursor chemicals, obviously there is a significant problem of displacement, so obviously if you place far stricter regulations on a particular chemical, it may force a lot of these I guess organised crime groups, as you call them, to use different chemicals.¹⁰⁶⁵

The need for a national approach

Owing to the fact that Project STOP has been implemented at different rates in the various states and territories, this has created an environment in which crime displacement can occur across borders. Mr Jason Ferris told the Inquiry that:

One of the big things that is certainly present from the work from Alison Ritter that we are aware of — and we talked about it earlier on today — is pseudo runners will go to good lengths and distance to get their medication for producing methamphetamine. If it costs 20 bucks to buy a packet of Sudafed, 40 bucks to buy that packet and make a gram of speed and a gram of speed is worth \$500, there is good incentive to do that — or a gram of methamphetamine. One of the big things is if you do not have it nationally consistent, you get pushing of the problem across borders, so you get the Queensland runners going into New South Wales, all the way down to Victoria. You also cannot put all this information together cohesively to at least determine whether or not a system such as Project STOP or anything else does do its job. This is one of the drawbacks to all of this.¹⁰⁶⁶

A submission to the Committee by the Pharmacy Guild of Australia also highlighted the key benefits of the broader implementation of real-time monitoring systems such as that which exists in Queensland:

- Targeted Regulation — In the case of *Pharmacist Only Medicines (S3)*, real-time monitoring can serve to retain the appropriate level of access to medicines for the community at large, whilst restricting inappropriate and/or criminal use. This constitutes a much more sophisticated tool than simple scheduling changes.
- Professional Decision Support — Real-time monitoring by prescribers and pharmacists would provide a powerful, data-driven decision-support tool by electronically linking these health professionals and helping them determine if the prescription or sale/dispensing of a medicine is appropriate. Real-time monitoring not only reduces the risk of criminal diversion but also facilitates the safe and appropriate use of medicines.
- Data Collection to Inform Policy Direction — The data-collection element of such monitoring systems can provide governments and health bodies with the evidence to properly inform future decision-making in the area of medicines regulation and scheduling.

¹⁰⁶⁵ Dr Andrew Groves, Research Officer, Flinders Law School, Flinders University, Public Hearing (via video conference), Canberra, 11 February 2014.

¹⁰⁶⁶ Mr Jason Ferris, Senior Research Fellow, Institute for Social Science Research, University of Queensland, Public Hearing (via video conference), Canberra, 12 February 2014.

- Support to law enforcement — Where appropriate, information and data can also be provided to police and/or law enforcement agencies.¹⁰⁶⁷

Mr Doug Smith, from the CrimTrac agency, also highlighted the importance of implementing a nationally-consistent approach to Project STOP:

[Project STOP] was instituted in Queensland in 2005, and it was about pseudo traffickers, or people running around shopping for pseudoephedrine. At present it is hosted by the Pharmacy Guild of Australia and has a take-up of about 60 per cent. In my opinion it is critically important that that type of information is readily available nationally.

A series of papers have been presented to commissioners at different points in time. This conversation has been going on for a while. I think it would be a real shame from my perspective as the chief executive officer of CrimTrac if we did not come to a satisfactory conversation with the pharmacy guild over this particular initiative. I was involved with the use of Project Stop information in the Northern Territory when I was an assistant commissioner there. I have seen its benefits in a number of other states in my role at CrimTrac. What we do not have at the moment is a way forward with respect to Project Stop. I am unaware of what you may or may not have been told about the future of it, but the brief I have had is that Project Stop as a pharmacy guild initiative probably needs a little bit of life support. I think it would be a real shame if we did not take some steps to ensure that that information capability was not lost to law enforcement.¹⁰⁶⁸

Alternative approaches

It is also important, however, to consider alternate policy options with respect to reducing the methamphetamine problem.

The work of Manning, Ransley, Smith, Mazerolle and Cook (2013) in Queensland, for example, suggested the use of a framework for synthesising expert opinion and evaluating alternative policy options. A hierarchical model was developed in order to identify the best policy alternative from amongst Project STOP, outright bans, prescription-only supply, increased reactive policing and a do-nothing approach. It was concluded that ‘there is strong support from experienced practitioners and policy makers for more regulatory approaches aimed at prevention of illicit methamphetamine problems, and surprisingly little support, across a range of dimensions, for increased policing as the strategy of choice’ (Manning et al. 2013, p.392). Ransley et al. (2011) also canvassed alternative approaches:

A viable alternative option to mandatory recording and reporting, adopted by the New Zealand Government in October 2009, restricts pseudoephedrine products to being available on a prescription only basis ... and an even more drastic solution would be an outright ban on the products. Pharmacists have an interest in preserving their share of profit in pseudoephedrine sales, which would be significantly restricted under either of these options. Failure to reduce the methamphetamine problem through measures such as Project STOP may well lead to the adoption of a more drastic option (p.25).

Summing up the benefits of Project STOP

Generally, the introduction of Project STOP has received support from many sectors including the Pharmacy Guild and federal and state and territory law enforcement entities. However, states such as Victoria that have adopted a voluntary approach are understood to have gained less benefits from Project STOP than places in which it is mandatory. A submission from Victoria Police to the Committee was supportive of Project STOP becoming mandatory in Victoria:

1067 Mr Allan Crosthwaite, Director and Mr Stan Goma, Manager — Professional Services, The Pharmacy Guild of Australia — Victoria, Submission, 10 December 2013.

1068 Mr Doug Smith APM, CEO, CrimTrac, Public Hearing, Canberra, 11 February 2014.

Victoria Police is actively involved in Project STOP which is a voluntary project operated by the Pharmacy Guild of Australia. It encourages pharmacists to record sales of pseudoephedrine based medications and is a useful tool in the identification of pseudo runners. The project is not compulsory in Victoria. While pseudoephedrine-based medication does not account for the bulk of methamphetamine manufacture in Victoria, it is a significant factor in a large proportion of the smaller laboratories. Compulsory participation would give a clearer indication of the distribution of these products for ATS manufacture.¹⁰⁶⁹

The Committee believes that the benefits of making Project STOP mandatory in Victoria clearly outweigh any disadvantages and is supportive of this approach. Further consultation may, however, be needed to assess the financial implications of such an approach. In Queensland, for example, Ransley et al. (2011) found that 'the initial take-up of Project STOP by Queensland pharmacies was very high, assisted by the fact that the [Pharmacy] Guild provided it to them free of charge and regardless of whether they were Guild members' (p.15). Funding for the initial roll-out of Project STOP was initially obtained from the Australian Government Attorney-General's Department, although support has also been provided from the pharmacy profession. In view of its national relevance and importance, the Committee believes that federal resourcing of Project STOP would be appropriate.

Code of Practice for the Supply Diversion into Illicit Drug Manufacture

The chemical industry in Australia has also been involved in other collaborative ventures with law enforcement agencies to limit the diversion of precursor chemicals and laboratory equipment that could be used in the illicit manufacture of methamphetamine. The *Code of Practice for the Supply Diversion into Illicit Drug Manufacture* was developed in 1994 by the Plastics and Chemicals Industrial Association (PACIA) and the Science Industry Australia (SIA) (Intergovernmental Committee on Drugs 2008). The Code which was updated in October 2008 has the following objectives:

- To protect against the diversion of chemicals and scientific equipment into the illicit production of drugs.
- To cooperate with government and law enforcement agencies in the controlled delivery of chemicals and scientific equipment destined for use in the illicit production of drugs, where this is expected to lead to the apprehension and conviction of criminals involved in such trade or production.
- To educate and train staff and where practical end users of the precursor drug chemicals as to the issues involved and the procedures to be adopted (Intergovernmental Committee on Drugs 2008, p.3).

The Code requires chemical manufacturers and suppliers to record drug precursor transactions including the completion of End User Declarations (EUD). 'Companies are reminded that there are varying legislative requirements in jurisdictions that enforce the reporting of sales of drug precursors and they also cover the responsibilities of storing and disseminating EUDs' (Intergovernmental Committee on Drugs 2008, p.4). The nature of the EUD process in Victoria and its benefits were described to the Committee by Assistant Commissioner Jabbour:

Currently point-of-purchase sales controls require the submission of a completed EUD, or end-user declaration, document for precursor sales, but that is only in five jurisdictions. In Victoria EUDs are to be presented to law enforcement officers upon request. Only two jurisdictions require automatic submission of EUDs to law enforcement. That may be an area if we start to regulate the sale and distribution of other chemicals that are currently commercially available in this country and which go towards making the end product. Typically pseudoephedrine in a large volume will be imported because, to be frank, the number of tablets you need to purchase from the chemist or divert is far

¹⁰⁶⁹ Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

too great. To be able to import that is a significant step forward in the production process, but then you need the other chemicals that go toward production. If we were to concentrate our efforts in this country and have these end user documents, I think that might be a useful mechanism to at least alert law enforcement to suspicious sales of these goods.¹⁰⁷⁰

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.¹⁰⁷¹

The Committee believes that mandatory EUD reporting to Victoria Police would be beneficial and that a system of secure electronic recording and transmission should be examined in order to minimise administrative costs. The Committee suggests that an electronic EUD notification system could be maintained by Police Chemical Diversion Desks that would make national communication of notification data more efficient.

Conclusion

The *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (UNODC 1988) provides a comprehensive mechanism through which member states are able to prevent the diversion of precursor chemicals used to manufacture methamphetamine. There are, however, ongoing challenges faced by the international community in controlling both precursor chemicals and, more recently, pre-precursors and non-scheduled precursor chemicals that are being used to evade international controls. As a signatory to this Convention, Australia plays an active role in restricting the sale and supply of precursor chemicals. Commonwealth strategies such as the National Drug Strategy 2010–2015 and frameworks such as the National Pharmaceutical Drug Misuse Framework 2012–2015 and the National Precursor Control Framework all help to ensure that adequate measures are met through coordinated action. Domestic precursor control measures such as the Standard for the Uniform Scheduling of Medicines and Poisons and the *Code of Practice for the Supply Diversion into Illicit Drug Manufacture* are also important policy measures in responding to the illicit manufacture of methamphetamine in Australia. With ongoing refinement and more extensive implementation in Victoria, the production of methamphetamine and other illicit drugs could be further curtailed.

The mandatory implementation of Project STOP in Victoria, and the mandatory notification of EUDs to Victoria Police would both enhance Victoria's response to precursor controls. The Committee believes that adequate resources should be provided to enable both these recommendations to be implemented without delay, ideally throughout Australia. In view of the national relevance and importance of such initiatives, the Committee believes that federal resourcing would be appropriate. Such collaborative approaches allow federal and state law enforcement entities to work in partnership with the pharmaceutical and chemical industries in order to prevent the manufacture of methamphetamine.

1070 Assistant Commissioner Ramzi Jabbour, National Manager, Serious and Organised Crime, Australian Federal Police, Public Hearing, Canberra, 10 February 2014.

1071 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

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 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.

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.

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.

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.

21. Addressing Methamphetamine through Law Enforcement: Local level Policing, Alternative Justice and Diversion

Introduction

There has been a huge 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 (Wundersitz 2007). 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. Importantly, the increase in domestic policing of local level use and dealing is also apparent.

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.¹⁰⁷² 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.

Policing methamphetamine use

Police officers play a crucial role in addressing methamphetamine. Accordingly, a variety of front-line responses have been developed to address methamphetamine-related crime. These include:

The establishment of strike forces to tackle gang crime; boosting police numbers to increase detection and the visible presence of police on the streets ; improving recruitment strategies and training opportunities,¹⁰⁷³ strengthening information technology, including database capacity activities; and implementing initiatives to strengthen relationships with community groups and young people. As intelligence led policing has become more widespread, law enforcement agencies have also sought to become partners and users of drug early warning systems (Makkai & Beattie 2012, p.171).

¹⁰⁷² Certainly many, if not most member countries of the European Union are moving away from sentences involving custodial terms for minor drug offences. See European Monitoring Centre for Drugs and Drug Addiction 2013.

¹⁰⁷³ See also Chapter 25 for a discussion of police training in the context of methamphetamine use and related crime.

Increasingly, police strategies are being premised on the basis that drug-related crime, particularly when it is a consequence of drug dependence, is a health issue that should be addressed by police in conjunction with health professionals. This is certainly true of Victoria Police's approach to addressing low level drug crimes that are committed to sustain a personal drug habit.¹⁰⁷⁴

Victoria Police strategies

Victoria Police have adopted policy and strategic plans that address drug-related crime and disorder. The *Victoria Police Illicit Drug Strategy* for example, adopts and incorporates the strategic approach of the Victorian Government's *Alcohol and Drug Strategy 2013-2017* (Department of Health (Vic) 2012) with its emphasis on the three key pillars of supply, demand and harm reduction interventions. In particular this approach concentrates on:

- ◆ Disruption: reducing the supply of drugs at all levels;
- ◆ Targeting repeat offenders: focusing on the links between drugs and volume crime; and
- ◆ Reducing re-offending by using treatment and diversion programs where they are most likely to be effective.¹⁰⁷⁵

The use of diversion and specifically the Victoria Police Illicit Drug Diversion Initiative is a particularly important aspect of this strategy, discussed later in this chapter.

Victoria Police is currently also preparing a specific strategy focusing on amphetamine type stimulant (ATS) issues. This includes supply and law enforcement, prevention and harm reduction issues and support approaches.¹⁰⁷⁶

The key objective of the plan will be to ensure police activity continues to be directed at multiple aspects of the ATS problem. The plan will support Victoria Police's role at the national level and as a key partner in the implementation of the Victorian government's approach.

The strategy will have a problem-oriented approach, addressing specific ATS issues such as repeat offenders, geographic hotspots, drug driving, child protection, community education, treatment programs and clandestine laboratory clean up.¹⁰⁷⁷

The proposed Strategy builds on the current role the police play in addressing illicit drug use generally. This role is multifaceted and may range from assisting other law enforcement authorities such as the AFP and Customs and Borders officers in the search and interdiction of the drugs, to taking a person suffering from methamphetamine-related illness to a health facility. The role of police in supply side interventions and criminal investigation of methamphetamine trafficking and supply is discussed in Chapter 19. This section concentrates primarily on the issue of front-line policing of methamphetamine use.¹⁰⁷⁸

Policing in partnership

Notwithstanding their important function in addressing methamphetamine use in the community, the police are unable to undertake this task alone. Increasingly, at a local level, police are working in partnership with health, mental health and social workers to address

1074 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

1075 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

1076 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

1077 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

1078 For an account of the types of policing operations conducted by a regional division of Victoria Police to address methamphetamine trafficking and related crimes, see Superintendent Paul O'Halloran, Superintendent and Divisional Commander Eastern Region Division 4, Victorian Police, Submission, 24 February 2014.

methamphetamine (and other drug) related problems.¹⁰⁷⁹ As Assistant Commissioner Graham Ashton stated:

Victoria Police is firmly of the view that there needs to be a coordinated whole of government response to ATS issues. Solutions to most of the problems are outside the scope of police intervention alone. Collaboration between law enforcement, health, justice and education agencies is needed to ensure that all Victorian government programs addressing ATS issues are aligned.¹⁰⁸⁰

Ambulance Victoria is a key partner assisting the police in this role.

A key partnership — The relationship between police officers and ambulance officers in addressing methamphetamine abuse

As indicated above, intervening with someone who may be exhibiting problematic methamphetamine-related behaviours increasingly requires a partnership approach. Both police and ambulance officers are front-line practitioners in dealing with methamphetamine abuse. Often ambulance officers will be the first person in the health system that has contact with a user in crisis. Surprisingly, however, given the reputation of methamphetamine users for agitation and aggression, police officers are not always called to incidents where users are exhibiting signs of a 'meltdown'. Also, ambulance officers may be reluctant to call upon police assistance, possibly because a user might associate them with a law enforcement role.¹⁰⁸¹ As one senior Ambulance Victoria officer has remarked:

There are many myths associated with the provision of emergency health care. The area of major concern to ATS users when paramedics are involved relates to the dual engagement of police [and ambulance officers]. All emergency workers, whether they are from law enforcement or from health, are focused on the best possible outcome for the patient. Therefore it is rare that police are contacted by paramedics for ATS issues in Australia. Paramedics engage the police when there is a risk to public safety, or to assist when the patients are at risk to themselves, so if there is any suggestion of violent behaviour then the police will be notified (Eade 2012, p.143).¹⁰⁸²

Some stakeholders in the community have claimed that police (and mental health workers) 'are allegedly reluctant to attend incidents involving individuals coming off

1079 In terms of supply side controls, increasingly traditional law enforcement bodies are also leveraging external institutions for assistance. 'Hybrid governance' or 'third party policing' identifies how traditionally 'state activities such as policing have been shared and evolved to private interests and external institutions' (Cherney, O'Reilly & Grabosky 2005, p.19) in precluding the supply of synthetic drugs. Federal law enforcement agencies such as the AFP and ACC may work in tandem not only with state police, for example, but also health departments, local governments, legitimate chemical manufacturing industries, glassware suppliers and pharmacists. Such partnerships may operate through 'conscriptio'; for example requiring private enterprise to provide end use declarations of precursor chemicals to voluntary arrangements such as the prescription drug monitoring system 'Project Stop'. See Chapter 20 for further discussion.

1080 Correspondence from Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police to the Law Reform, Drugs and Crime Prevention Committee, 7 November 2013.

1081 As one Geelong based ambulance officer told the Committee:

'We do not ask too many questions [of those they attend] because we do not want people to think we are there to investigate. Our role is to treat and resuscitate someone. If we ask too many questions people will not contact us when someone is unconscious. The aspects of crime behind [the use] is something that we do not get involved in'. Mr Terry Marshall, MICA Paramedic and Group Manager, Ambulance Victoria, Barwon District, Public Hearing, Geelong, 28 October 2013.

1082 For a personal account of operational policing methamphetamine use and trafficking on the 'front-line', see '*The impact of amphetamine type stimulants on operational policing: a personal choice for which everyone pays*' (Allen 2012). This account by a senior sergeant of the Queensland Police Service based in the Brisbane CBD relates the physical and emotional dangers associated with addressing methamphetamine use and related crime and the personal toll it can take on officers in the 'firing line'. A similar account outlining the problems faced by paramedics in addressing methamphetamine use is given by a representative of Ambulance Victoria. See '*The impact of amphetamine type stimulants on ambulance services*' (Eade 2012).

methamphetamine.¹⁰⁸³ Other evidence, however, has suggested that the police have a far greater role in encountering and addressing methamphetamine use, particularly in cases where a user may be ‘high’ or alternatively going through the withdrawal period or is otherwise displaying irrational behaviours.¹⁰⁸⁴ Ambulance officers have acknowledged to the Committee that in such cases the police backup is a valuable and necessary adjunct to guaranteeing both patient and paramedic safety and successfully restraining the affected person and/or bringing him to medical attention.¹⁰⁸⁵

Front-line responses — traditional approaches may not be effective

Whatever the extent of police involvement in methamphetamine triggered crises or incidents, it is clear that on occasion they are required to intervene. McKetin, McLaren and Kelly’s study of methamphetamine users in Sydney found that in their daily work police will have contact with a range of people who use methamphetamine, including intoxicated users and those going through withdrawal or exhibiting methamphetamine psychosis, including behaviours ranging from passive and confused, to hostile, irrational or aggressive moods. Often such contact was unplanned and unanticipated adding to the risks involved in intervening (2005, p.122). In many situations the encounter with the methamphetamine affected person may have been incidental to their police duties. For example, an officer on traffic duty may have been called upon to deal with the sudden impulsive and threatening behaviour of a person exhibiting signs of methamphetamine psychosis (McKetin, McLaren & Kelly 2005, p.128).

The Committee received evidence that police in Victoria are also being confronted with incidents requiring restraint because of possible psychotic or at least irrational methamphetamine-related behaviour. Increasingly, for example, police are bringing ‘Section 10’ patients into emergency rooms because of their volatile and in some cases psychotic behaviour caused through possible methamphetamine consumption.¹⁰⁸⁶ Superintendent Jock Menzel told the Committee that in the Gippsland region mental health patient transfers by police related to crystal methamphetamine-induced psychosis have tripled over the past three years, putting police at serious risk.¹⁰⁸⁷ Similarly, Superintendent Daryl Clifton from the Bendigo region told the Committee that partly due to an increase in methamphetamine-

1083 Mr John Blewonski, Chief Executive Officer, VincentCare Victoria, Submission, 21 October 2013.

Kerry Strachan, Group Manager with Ambulance Victoria also told the Committee that there was less back-up from Victoria Police in drug-related attendances than there used to be and in fact there is a policy directive from Victoria Police to the effect that police should only attend in cases where paramedics are in danger or being threatened. This according to Mr Strachan is primarily due to a lack of staffing and Victoria Police being ‘resource hungry’.

See Mr Kerry Strachan, Group Manager, Ambulance Victoria, Public Hearing, Bendigo, 25 October 2013. See also Mr Richard Marchingo, Ambulance Paramedic, Ambulance Victoria, Public Hearing, Bendigo, 25 October 2013.

Michael Whelan paramedic with Ambulance Victoria also told the Committee that very seldom will police attend unless there is an actual case of violence ‘So we can request it [police attendance] but at the moment paramedics are attending quite often without police support’. Mr Michael Whelan, MICA Team Manager, Ambulance Victoria, Public Hearing, Shepparton, 25 February 2014.

1084 On the general relationship between police and ambulance officers and their respective and intertwining roles, see 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. For an account of the informal protocols used between ambulance crew and police as to when the latter should become involved in addressing a methamphetamine-related incident, see Mr Terry Marshall, MICA Paramedic and Group Manager, Ambulance Victoria, Barwon District, Public Hearing, Geelong, 28 October 2013.

1085 See Mr Mike Fuery, Paramedic, Ambulance Victoria, Public Hearing, Wodonga, 24 February 2014.

1086 See for example, Dr David Eddey, Director of Emergency Medicine, Barwon Health, Public Hearing, Geelong, 28 October 2013.

A ‘Section 10 patient’ refers to someone exhibiting signs of mental illness apprehended by a police officer under Section 10 of the *Mental Health Act 1986*. A police officer in such circumstances must believe that the person in question is in danger of harming himself or herself or another.

1087 Superintendent Malcolm (Jock) Menzel, Divisional Commander, Eastern Region Division 5 — Morwell, Victoria Police, Public Hearing, Traralgon, 28 January 2014. See also Superintendent Paul O’Halloran, Superintendent and Divisional Commander Eastern Region Division 4, Victorian Police, Submission, 24 February 2014 for a discussion of the impact of a huge increase in mental health transfers occurring in the Eastern region of Victoria.

related incidents the ‘police time spent on mental health at the moment’ in rural areas is ‘astronomical’.¹⁰⁸⁸ As such, it has been recognised that training in mental health issues is imperative for members of the Victoria Police.¹⁰⁸⁹

Certainly the occasional exhibitions of psychotic violence and the extraordinary strength and resistance to pain or injury shown by people with methamphetamine psychosis-related symptoms¹⁰⁹⁰ can make customary police methods of de-escalation and intervention, including the use of manual force, ‘talking down’ or capsicum sprays, ineffective.¹⁰⁹¹ A number of senior police witnesses to this Inquiry have affirmed that traditional police methods such as those used to address alcohol-related behaviour ‘are not always easily or readily effective’.¹⁰⁹² Moreover, from a purely resource intensive perspective, ‘It takes a lot more police officers to resolve an incident where ice is present than would be with alcohol or cannabis’.¹⁰⁹³

In short, the approach of Victoria Police to addressing methamphetamine use and indeed other illicit drugs and alcohol has moved away in recent years from a traditional go it alone law enforcement/investigative role to a partnership approach that places health issues at the centre of interventions, at least when it comes to users and low level user/dealers. As Superintendent Paul O’Halloran told the Committee:

Law enforcement solely is not the answer to this, like a number of issues in my view it is a community problem, it is a social problem, it is a government problem, it is a policing problem across the state. In order to address that, we need a multifaceted approach. Certainly education is a big part of that...

Certainly from the information I have received from my members across the division, better resourcing and health is also required, a holistic approach to both offenders and victims in relation to this, so we break that cycle, a multi-agency commitment both in Victoria and across the border and nationally needs to be done. It is a matter of the whole country aligning properly in treating and addressing amphetamine type substances.¹⁰⁹⁴

This approach to front-line policing is perhaps best summed up by Mr Don Currie, the Manger of Gateway Community Health in Wodonga. He told the Committee that:

Victoria Police are trying to combat it [methamphetamine] from a health perspective. The message I get from the police certainly is they do not see every single person that is a drug user as being of no benefit to society. Like us, they want to help them just as much as we do.¹⁰⁹⁵

1088 Superintendent Daryl Clifton, Victoria Police, Public Hearing, Bendigo, 25 October 2013. Similar comments as to the police’s involvement in mental health issues, particularly in rural areas were made by Superintendent Jock Menzel from the Gippsland region.

See Superintendent Malcolm (Jock) Menzel, Divisional Commander, Eastern Region Division 5 — Morwell, Victoria Police, Public Hearing, Traralgon, 28 January 2014.

1089 The training and education needs of Victoria Police are discussed in Chapter 25 Suffice to state that current Victoria Police operational qualifications (OSTT) require all members to complete online training specific to dealing with people with a mental illness or suffering from psychosis.

‘Learning outcomes encourage our members to use empathy and understanding during incidents involving mentally ill persons who are possibly drug affected and or suffering psychosis. These incidents will possibly involve members of the public, outside agencies as well as the subject and police. Safety first must be the number one priority and maintained at all times.’ Superintendent Paul O’Halloran, Superintendent and Divisional Commander Eastern Region Division 4, Victorian Police, Submission, 24 February 2014.

1090 See discussion in Chapter 6.

1091 See evidence of Superintendent Paul Pottage, Division Commander, Division 1 (Geelong) Western Region, Victoria Police, Public Hearing, Geelong, 28 October 2013. See also discussion in McKetin, McLaren and Kelly for some techniques that police could use to defuse such situations. In some cases the authors advise the simplest and most advisable approach may be to postpone contact with the user until the psychosis subsides (2005, p.134).

1092 See Superintendent Daryl Clifton, Victoria Police, Public Hearing, Bendigo, 25 October 2013.

1093 Superintendent Don Downes, Western Region, Division 2, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

1094 Superintendent Paul O’Halloran, Superintendent and Divisional Commander Eastern Region Division 4, Victoria Police, Public Hearing, Wodonga, 24 February 2014.

1095 Mr Donald Currie, Team Manager Alcohol & Other Drugs, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014.

This 'new' approach to policing drugs has also been endorsed by other senior members of the Victoria Police. For example, in a speech given to the Yarra Drug and Health Forum in July 2013, Assistant Commissioner Andrew Crisp stated that drug abuse should be seen as a health issue rather than a law and order issue. Mr Crisp was also reported as having said that more funding should be given to health, welfare and alcohol and other drug (AOD) services than simply increasing police or building more gaols:

We should tackle it [drug abuse] as a health issue. Police are an agency of last resort; we're left to pick up the pieces. At times there is too much emphasis on police. We're [only] one part of the solution.¹⁰⁹⁶

Investigative policing

The investigation of the supply of methamphetamine is primarily discussed in Chapters 14–17. It should be noted, however, that according to evidence given to the Inquiry, detection of offending has improved in recent years due to an increased use of intelligence gathering techniques that focus on ATS. Pro-active investigation units for example, target drug types that have the greatest impact in terms of risk. Such risk includes 'serious, organised and volume crime together with the harm to the public, offenders, offenders' families, police and emergency and government agencies dealing with these issues'.¹⁰⁹⁷

Cross-border policing

One of the operational difficulties for Victoria police is the significant amount of cross-border trafficking of methamphetamine that occurs, particularly in border towns such as Mildura or Wodonga. Generally Victoria Police would seem to have good relationships with their colleagues in New South Wales and South Australia¹⁰⁹⁸ and readily share intelligence with regard to methamphetamine supply or conduct joint operations to interdict the drug.¹⁰⁹⁹

Alternative criminal justice approaches

It has long been recognised that traditional law enforcement approaches to address low level drug offending has been counterproductive. For example, as discussed later in this chapter, traditional approaches that rely on fining or imprisoning relatively low level offenders not only do little to address the possible cause of the offending such as the drug use but can also result in recidivism by a person once released from gaol to sustain possible drug dependence. Traditional approaches are also more costly than alternative justice reinvestment models.¹¹⁰⁰ Ultimately, alternative criminal justice approaches are about addressing the causes of crime rather than just dealing with its consequences (Alberti et al. 2004).

1096 Quoted in Alana Schetzer 2013, 'More police 'no solution' to drug woes', *The Age*, 11 July. Online at www.theage.com.au/more-police-no-solution-to-drug-woes-20130710

1097 Superintendent Paul O'Halloran, Superintendent and Divisional Commander Eastern Region Division 4, Victorian Police, Submission, 24 February 2014.

1098 For example, all police officers who work in the Victorian Murray river towns are sworn in as constables in New South Wales. To a certain extent this is also true in South Australia. See Superintendent Paul Naylor, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013.

1099 See for example evidence of Superintendent Paul Naylor, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013; Superintendent Paul O'Halloran, Superintendent and Divisional Commander Eastern Region Division 4, Victoria Police, Public Hearing, Wodonga, 24 February 2014; Superintendent Michael Sayer, Eastern Region, Victoria Police, Public Hearing, Shepparton, 25 February 2014.

Such cooperation does not mean that there are not legal and technical difficulties that can impede effective cross-border policing with regard to drug trafficking; for example, the need to issue extra-territorial warrants and have suspects extradited from interstate. A lack of uniform computerised data may also mean that one police force is not necessarily aware of intelligence pertaining to criminal activities on the other side of the border, making local personal interaction between neighbouring police forces drug intelligence units even more important. On this point see Superintendent Paul O'Halloran, Superintendent and Divisional Commander Eastern Region Division 4, Victorian Police, Submission, 24 February 2014.

1100 See discussion on justice reinvestment later in this chapter.

Therefore a variety of strategies and programs have been developed and implemented to address this issue. One of the most important strategies to keep offenders out of the criminal justice system is that based on diversion. In addition, specialist courts with powers to make dispositions addressing a person's drug use are being used increasingly as alternatives to traditional sentencing practices.

Diversion programs

In the context of drug offending, diversion is one of many processes designed to reduce the number of drug offenders entering the formal criminal justice system. The concept of diversion is twofold. It recognises that diverting people to a range of treatment, education, support and other services might give them an alternative to ongoing and future offending relating to their drug use or dependence. In addition, such interventions may divert them away from further or entrenched involvement with the criminal justice system.

There are four main categories of drug diversion initiatives:

- ◆ Police based programs that offer drug education and assessment for individuals detected for minor possession offences;
- ◆ Court level, predominantly bail based programs designed to provide assessment and short term treatment for less serious offenders whose criminal behaviour is related to their illicit drug use;
- ◆ Intensive pre and post-sentencing drug court programs that offer long-term, intensive treatment for entrenched offenders whose drug dependency is a key contributor to their offending; and
- ◆ Specialist 'drug prisons' such as in NSW the Compulsory Drug Treatment Correctional Centre specialising in abstinence based treatment and rehabilitation for offenders with long term illicit drug dependency and (associated criminal activity) (Wundersitz 2007).

Drug diversion can sit anywhere along the criminal justice continuum. In other words, diversion can apply to processes at the front end of the system before formal charges are laid, for example cautioning or warnings for the use and possession of cannabis. The Victoria Police drug cautioning programs are an example of a diversionary program aimed at targeting interventions appropriate and proportionate to the seriousness of the criminal offence and the circumstances of the individual offender.

Drug diversion can also apply to processes at the final stages of the criminal justice system — the sentencing stage. For example, in New South Wales a custodial correctional facility unique of its kind in this country allows prisoners to receive intensive treatment and care for their entrenched drug dependence and, perhaps more importantly, gain the coping skills necessary to prepare them for life on the 'outside'.¹¹⁰¹ In the middle of the spectrum is a range of programs designed to rehabilitate or support the drug-dependent offender in the community, either as part of a bail support program or a post-sentence order in the community. The aim of all of these diversionary processes is to re-direct offenders away from the conventional justice processes.

Diversion as part of therapeutic justice

Diversion programs are a central component of the model for therapeutic justice. Therapeutic justice is the study of how legal systems affect the emotions, behaviors and mental health of people.¹¹⁰² The concept examines how the law and legal process and those who enact it

1101 See discussion later in this chapter.

1102 See Black's Law Dictionary 9th edition 2009.

may be helpful or harmful to people's wellbeing and mental health. It looks to alternatives that may improve the therapeutic consequences for those involved in the legal system and society generally, including the use of specialist courts for particular problems. Although therapeutic justice had its genesis in mental health law and the establishment of mental health courts and review tribunals, the concept quickly was applied in both the United States and in Australia to other forms of law including juvenile, disability, domestic violence and importantly in this context drug law and drug-related offending. Drug diversion programs and drug courts in turn are seen as part of a therapeutic jurisprudence approach that 'use[s] the authority of the court to address the underlying problems of individual litigants' (Berman & Feinblatt 2001, p.125).

The use of therapeutic justice principles saw the pioneering of problem-solving courts in Victoria from 2005. Two early models emerged: the intensive co-location of services in the Neighbourhood Justice Centre, a community court established in Collingwood with a single magistrate to service the City of Yarra where drug use and associated crime were major issues, and the Court Integrated Services Program (CISP) at Melbourne, Sunshine and Latrobe Valley. Other initiatives include the Drug Court of Victoria, Koori Court (Children and Adult Divisions), the ARC List and the Mental Health Court Liaison Service (MHCLS). These and other specialist initiatives are discussed later in this chapter.¹¹⁰³

Finally, the concept of justice reinvestment is relevant to the issue of drug-related offending and is closely related to both restorative and therapeutic models of justice.

Justice reinvestment reflects the idea that prevention is better than cure and that expenditure on prisons is not cost-effective and can only ever be a short-term solution to criminal offending. The concept and how it relates to drug-related offending is discussed later in this chapter.

Diversion and alternative justice programs in Victoria

Diversion programs as they relate to drug offending can assist drug offenders to cease or reduce their drug taking behaviour or at least manage it more appropriately. Drug diversion programs can:

[f]ocus on the pre-arrest stage, pre-trial stage, at pre-sentencing, and finally on release from prison. Depending on where the intervention occurs in the process, the initiative can be police or court based. The level of intensity also varies with police diversion schemes tending to be less intensive (ie an education program), through more intensive court based programs such as drug courts (Makkai & Beattie 2012, p.171).

Mr Wayne Muir, CEO from the Victorian Aboriginal Legal Service explained to the Committee why diversionary, therapeutic and alternative approaches to justice including the Drug court and the Koori court¹¹⁰⁴ were so important in the context of drug-related offending:

We come from the angle that even though we operate in the legal sphere, we actually believe that people who are victims of dealers need to be treated from a health perspective, not a criminal perspective. Even for those who end up being incarcerated we believe there need to be greater therapeutic approaches. 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

¹¹⁰³ For a discussion of how a new restorative/therapeutic justice model could be developed for the Goulburn Valley region of Victoria, see Ms Karen Gurney, Managing Lawyer, Goulburn Valley Community Legal Centre, and Mr Peter Noble, Coordinator, Loddon Campaspe Community Legal Centre, Submission, 31 October 2013.

¹¹⁰⁴ See discussion below.

be confronting them. If they simply get locked up with little or limited therapeutic or restorative justice approaches or justice reinvestment approaches, they come out and their behaviours have not necessarily adjusted or amended. ... If you want to think about therapeutic approaches and making our communities safer, I would much rather invest some money in making sure that a person is not regressing back into the same sorts of behaviours or networks or that we have done some work around the family to strengthen some family resilience.¹¹⁰⁵

A wide range of diversion initiatives and specialist court programs are currently available in Victoria that may support an offender to assist his or her drug-related problems.

The Illicit Drug Diversion Initiative

The Australian government in conjunction with the states has funded a number of drug diversion programs under the Illicit Drug Diversion initiative (IDDI).

IDDI involves offering a caution to a person detained for use or possession of an illicit drug other than cannabis on the condition that they undertake a clinical drug assessment and enter any prescribed drug treatment. The offender must meet eligibility criteria and agree to the caution. The person will be provided with a drug assessment appointment time immediately. Where possible, the appointment will be scheduled for no more than five working days from the time of arrest. Subsequent treatment will commence as close as possible to the time of arrest.

To be eligible for a caution under the drug diversion program, the person must be

- over 10 years of age
- be arrested for the use and/or possession of a small (non-trafficable) amount of illicit drugs other than cannabis
- admit to the offence and
- not have received any more than one previous cautioning notice (including cannabis caution).¹¹⁰⁶

Pre-arrest diversion is based on the rationale that diversion can:

- reduce illicit drug use and drug-related crime
- reduce costs of drug-related crime and law enforcement
- reduce the number of people appearing before the courts for use or possession of small quantities of illicit drugs, freeing up police and court resources
- assist individuals to take personal responsibility and regain control over their lives, thus leading to safer environments for all Australians and reducing the considerable personal and social costs of drug use on our communities.¹¹⁰⁷

The IDDI program was evaluated by the Australian Institute of Criminology in 2008.¹¹⁰⁸ The research from this study found that 75 percent of people did not reoffend following their diversion, and that of the 25 percent that did, two-thirds were offending at lower rates than prior to being diverted. Dr Roger Volk from South East Alcohol and Drug Service (SEADS) told the Committee that they would like to see the cautioning program subject to better research and review. In his view the cautioning program could be potentially of great benefit by not only diverting offenders who were at a relatively early stage in their criminal offending away from the criminal justice system but also in being 'a tremendous teachable moment' for people whose 'ice use was not yet seriously problematic'. That is, the

1105 Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Public Hearing, Melbourne, 17 February 2014.

1106 See http://www.police.vic.gov.au/content.asp?Document_ID=5059.

1107 Australian Government Department of Health and Ageing (2004). *Illicit Drug Diversion Initiative — COAG Framework*.

1108 *Police drug diversion: a study of criminal offending outcomes* (Payne, Kwiatowski & Wundersitz 2008).

police cautioner could use the interaction to advise on, or refer to, possible support services related to their drug use.¹¹⁰⁹

A submission from Victoria Police commending the IDDI program stated that:

In the five years since the evaluation, the program remains effective, with approximately 80 percent of offenders not having further contact with police.

Utilisation of the program by police has increased by 17 percent since 2010 to a yearly average of 49 percent of those who are eligible, being diverted. A record 1,634 Drug Diversions were issued in 2012-13. However, there is clearly scope to further increase use of the IDDI by police.

Amphetamine type stimulant [ATS] users have been able to access the IDDI, and have been doing so in increasing numbers, consistent with the increase in the number of offences where an ATS has been the primary drug of concern. The following figures show the increase in the number of diversions over the past three years:

- 2010-2011: 468 diversions
- 2011-2012: 673 diversions
- 2012-2013: 882 diversions.¹¹¹⁰

Most of the people who were diverted fell into the 18–35 age group, and the majority were male.

Enforcement Review Program

Often drug-related offenders and particularly people who are drug dependent may find it difficult to pay fines for relatively minor infringements. The non-payment or defaulting of such fines has traditionally had the potential to escalate the offender's involvement with the law. To partly address this issue the Enforcement Review Program was established. In some relatively minor criminal or civil cases where a person has outstanding fines registered in the Infringements Court and has a serious addiction to drugs and alcohol and/or a mental illness, neurological or intellectual disability, and/or is homeless, and that condition has impaired their judgment at the time of the offence, that person may apply for a revocation of fines under the special circumstances category. Such revocation will not apply in case of fines incurred as a result of drunk or drug-driving offences.¹¹¹¹

CREDIT/Bail Support Program

In December 2004, in consultation with the Department of Justice and Corrections Victoria, the Magistrates' Court of Victoria combined the Court Referral & Evaluation for Drug Intervention & Treatment Program (CREDIT) and the Bail Support Program (BSP).¹¹¹²

The CREDIT/ Bail Support Program aims to achieve the following outcomes:

- ◆ successful completion of bail by the accused who would otherwise be remanded in custody;
- ◆ reduction in the number of accused remanded due to lack of accommodation and/or treatment or support in the community;
- ◆ successful placement of the accused in drug treatment and/or rehabilitation programs; and

1109 Dr Roger Volk, Forensic and Other Drugs Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

1110 Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

1111 See Section 65 *Infringements Act 2006* (Vic).

1112 <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/court-support-services/credit-bail-support-program>

- ◆ long-term reduction in involvement of the accused in the criminal justice system.¹¹¹³

Clients may be provided with a range of services while on bail, including:

- ◆ assessment and development of a plan for treatment and support;
- ◆ case management for up to four months, including support and monitoring; and
- ◆ referrals and linkages to community support and treatment services.¹¹¹⁴

Any defendant who is eligible for a period of bail may be referred to the CREDIT/Bail Support Program for assessment. The Program is also available to the accused regardless of whether a plea has been entered or whether they intend to plead guilty or not.

The program provides a wide range of services to people placed on bail. These can include assessment, case management, monitoring and support with regard to their substance abuse problem including referrals to drug and alcohol treatment providers. This includes referral to and in some cases payment of pharmacotherapy services. Moreover, the program allows for people on bail to be placed in short-term accommodation if they may otherwise be homeless.¹¹¹⁵

Referral to the CREDIT/ Bail Support Program can be made by a magistrate, police officer, legal representative, court nominee, family or the client themselves. Clients are required to commit to treatment and attend regular support meetings with their case manager.

Court Integrated Services Program

The Department of Justice and the Magistrates' Court of Victoria established the Court Integrated Services Program (CISP) in 2006. The program provides accused persons including those with substance abuse related problems with access to services and case management support to reduce rates of re-offending. It operates from the time a person is charged with a criminal offence up until their plea in the Magistrates' Court. The program currently only operates at the Latrobe Valley, Melbourne and Sunshine Magistrates' Courts.

Aims and services

The CISP aims to:

- ◆ provide short term assistance before sentencing for accused with health and social needs;
- ◆ work on the causes of offending through individualised case management;
- ◆ provide priority access to treatment and community support services; and
- ◆ reduce the likelihood of re-offending.¹¹¹⁶

The CISP provides:

- ◆ a multi-disciplinary team-based approach to the assessment and referral to treatment of clients;
- ◆ three levels of support based on the assessed needs of the client;

1113 <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/court-support-services/credit-bail-support-program>

1114 <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/court-support-services/credit-bail-support-program>

1115 The Department of Justice employs an external housing provider to supply housing and housing support. This may also include teaching skills in budgeting, independent living skills and assistance in acquiring long-term accommodation. See Magistrates' Court of Victoria *Specialist Courts and Court Support Services* 2014, pp.12-13.

1116 <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/court-support-services/court-integrated-services-program-cisp>

- ◆ case management for up to four months for medium and high risk clients;
- ◆ referrals and linkages to support services including drug and alcohol treatment, acquired brain injury services, accommodation services, disability support and mental health care; and
- ◆ services for Koori clients such as the Koori Liaison Officer program.¹¹¹⁷

Eligibility for and referral to CISP

There are a number of eligibility criteria for being placed on CISP. These include:

- ◆ Any party to a court proceeding can access the CISP by way of referral, including applicants, respondents and accused from all jurisdictions of the Magistrates' Court.
- ◆ The accused is on summons, bail or remand pending a bail hearing.
- ◆ The client's history of offending or current offending indicates a likelihood of further offending.
- ◆ The client has physical or mental disabilities or illnesses, drug and alcohol dependence or misuse issues, or inadequate social, family and economic supports that may contribute to the frequency or severity of their offending.
- ◆ The program is available to the accused regardless of whether a plea has been entered or whether they intend to plead guilty or not.
- ◆ The accused must provide consent to be involved in the program.¹¹¹⁸

Referrals to the CISP can be made by the police, legal representatives, magistrates, court staff, support services, family, friends, or the person themselves. Most referrals are from the accused's legal representatives.

The CISP Process

The following outline is the standard procedure for a client who wishes to take advantage of the CISP program in the context of his or her substance abuse problem.

- ◆ The client is referred to CISP.
- ◆ An initial screening takes place.
- ◆ If accepted, the client is allocated a caseworker.
- ◆ The caseworker completes a detailed assessment covering legal, health, drug problems and social history.
- ◆ The client returns to court where an order may be made to participate in CISP.
- ◆ An order may be accompanied by conditions including those as to bail.
- ◆ The magistrate may order progress reviews.
- ◆ The caseworker prepares a case management plan.
- ◆ A case plan may include referral to (drug treatment) programs.
- ◆ Ongoing supervision and monitoring of plan.
- ◆ At the end of bail period, client returns to court and enters plea.

1117 <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/court-support-services/court-integrated-services-program-cisp>

1118 <http://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/court-support-services/court-integrated-services-program-cisp>

- ◆ The magistrate sentences client taking where relevant CISP participation into account.

There are three levels at which the CISP process operates. The Community Referral level involves minimal support and links to services. The Intermediate level may require a case management plan and monitoring. The Intensive level involves the highest level of case management, support and in the case of drug-related offenders, treatment.

Evaluation of CISP

In 2010, after three years of operation, the CISP was independently evaluated by Dr Stuart Ross of the University of Melbourne (Program Evaluation) in conjunction with Price Waterhouse Coopers (Economic Evaluation).¹¹¹⁹ Bearing in mind that CISP operates only at three courts (two metropolitan and one regional) overall the evaluation found that:

[m]agistrates and other stakeholders showed a high level of support for the program and its outcomes; and, compared with offenders at other court venues, offenders who completed CISP showed a significantly lower rate of reoffending in the months after they exited the program.¹¹²⁰

The program evaluation found that magistrates use the CISP in four ways. It:

- ◆ provides them with independent and valuable assessments as to a defendant's issues and problems that may have contributed to their criminal offending;
- ◆ enables them to identify and select an appropriate 'therapeutic' response and the service agency that may most effectively deliver this response;
- ◆ allows them to supervise and monitor the case management by receiving regular feedback and case reports on defendants; and
- ◆ helps them to prepare defendants for a Community Corrections Order or other disposition.¹¹²¹

The evaluation also made some interesting findings with regard to demographic data for the period 2007–2010 including:

- ◆ 81 percent of CISP clients were male.
- ◆ 70 percent of clients (2,349 cases) reported some form of illicit drug use. Of these 1,326 clients reported intravenous injecting of illicit drugs.
- ◆ 65.4 percent of Latrobe Valley clients and 40 percent of metropolitan clients reported problematic alcohol use.
- ◆ 33 percent of clients reported a form of mental health problem.
- ◆ Clients who identified as Aboriginal or Torres Strait Islander comprised 8.1 percent of all CISP clients.¹¹²²

The economic evaluation of CISP also showed some positive outcomes with some significant economic benefits associated with the program. The evaluation examined the cost-effectiveness of the program. Measuring outcomes against program inputs (annual funding) the evaluation found the following benefits:

- ◆ A reduction in re-offending — which will reduce the direct costs of crime (eg. property damage) and costs associated with sentencing of offenders (eg. prison).

1119 See also the Victorian Auditor-General's Report, *Problem Solving Approaches to Justice*, VAGO 2011 at p.32.

1120 http://www.magistratescourt.vic.gov.au/sites/default/files/Default/CISP_Evaluation_Report.pdf

1121 http://www.magistratescourt.vic.gov.au/sites/default/files/Default/CISP_Evaluation_Report.pdf

1122 http://www.magistratescourt.vic.gov.au/sites/default/files/Default/CISP_Evaluation_Report.pdf

- ◆ A reduction in the number of offenders sentenced to a custodial order following participation in CISP. This reduction will cut the direct costs associated with imprisonment.
- ◆ For those on a Community Based Order or another type of order, a reduction in the number of offenders who breach order conditions. This reduces the cost associated with locating and re-sentencing offenders.¹¹²³

In monetary terms the economic evaluation found:

- ◆ A \$1.98 million dollar saving per annum in avoided costs of imprisonment as a result of CISP
- ◆ Estimated total benefits of \$16, 826,420 savings from reduced re-offending over a projected 30-year period
- ◆ Estimated total benefits of \$7,470,662 from reduced re-offending over a projected 5 year period
- ◆ Estimated total benefits of \$4,948,726 from reduced re-offending over a projected 5 year period
- ◆ \$5.90 worth of savings for the community for every one dollar spent on CISP.¹¹²⁴

Community views on CISP

A number of witnesses who gave evidence to the Committee highly commended the CISP program and its diversion of drug dependent clients away from imprisonment and the criminal justice system. According to one witness, for example, the benefit of CISP and other diversionary programs is not only that they divert drug-related offenders away from prison but such diversion is based on very clear, intensive, well prepared, integrated and coordinated treatment and support plans. There is also inbuilt follow-up around their treatment progression.¹¹²⁵

Magistrate Clive Alsop, as coordinating magistrate for the Latrobe Valley Court, is one of the few Victorian magistrates who can make referrals to CISP. He told the Committee that with the expected abolition in suspended sentences, magistrates need more rather than fewer diversionary dispositions available to them. He views CISP as an excellent cost-effective program that should be extended. In particular he praised the work of CISP support staff in preparing background and assessment reports that 'are absolutely thorough and absolutely spot on'.¹¹²⁶ Mr Alsop stressed the fact that referring a client to CISP is not an easy option. Whilst successful completion of a CISP may result in a non-custodial disposition, the client must take their commitments to the conditions of the referral such as a course of drug rehabilitation or treatment seriously. At the end of the CISP period if the defendant pleads guilty, the magistrate then has the option to extend the defendant's involvement in his or her treatment regime by attaching it to the conditions of a community corrections order. This results, or at least ideally should result, in a seamless continuation of the diversionary/therapeutic process.¹¹²⁷

The only criticism many of these witnesses had was that because of its limited geographical catchment, many magistrates, particularly in rural and regional areas of the state, were not

1123 http://www.magistratescourt.vic.gov.au/sites/default/files/Default/CISP_Evaluation_Report.pdf

1124 http://www.magistratescourt.vic.gov.au/sites/default/files/Default/CISP_Evaluation_Report.pdf

1125 See Mr Richard Michell, Manager, Youth Outreach, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

1126 Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates Court, Public Hearing, Traralgon, 28 January 2014.

1127 Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates Court, Public Hearing, Traralgon, 28 January 2014.

able to refer clients to CISP. Such witnesses uniformly recommended that the CISP program be extended to most regional Magistrates' Courts across Victoria.¹¹²⁸

Other agency witnesses recognising that the valuable strategies of the program were needed in their communities have established their own similar but informal diversionary programs. For example, Primary Care Connect based in Shepparton stressed the need for their local Magistrates' Court to have the range of options enabling referral of drug affected clients into treatment programs. As Ms Lynne Macdougall told the Committee:

We have developed [a form of CISP] ourselves. We saw that there was a real need at our courts, so we developed a roster of workers so that we always have someone down at the court to do those cell assessments, to respond to the magistrate if they require a screening or assessment to see if drugs are a contributing factor to their offending. Then the magistrate will stand that matter down. They will do an assessment, then the recommendations will go back up to the magistrate. It works really well. We would have loved to have the funded model, but we do what we do. It has been incredibly successful.¹¹²⁹

Similarly Mr Peter Mellas is currently a sitting magistrate who had previously worked in a court where CISP operates but has been since transferred to Warrnambool. He told the Committee that if CISP cannot be rolled out to all areas of the state, it was imperative that less formal programs be developed on a local level to replicate its functions:

[o]ne of the things that is missing in this region is CISP. Having come now to a region here where there is no service of that kind available... Here in this region we do not even have credit bail,¹¹³⁰ so there is no one person I can send someone to or have them speak to who can then be the liaison point between all the available services, whether it be mental health, drug and alcohol, a GP, a housing service, a domestic violence service.

I am going to meet next week with WRAD, the local drug treatment service providers, trying to get other people to get at least an ad hoc system in place where we can refer people on, maybe develop that into a supervised bail type situation, because what I have found in relation to long-term alcohol, drug and other use, it has been of great experience to be working in courts of that kind where you can have people come in having committed offences, identify the cause of it and then supervise them over a period of time and then hopefully lead them out of the situation and the circumstances that has led them into that use.¹¹³¹

The Committee received a submission from Jelena Popovic, Deputy Chief Magistrate of the Magistrates' Court of Victoria, commending the benefits of CISP in addressing the needs of the court's clients, particularly those with substance abuse or mental health issues:

Most participants in the CISP program have drug and/or alcohol issues and many have a concurrent mental illness, acquired brain injury or an intellectual disability. Many also experience homelessness and poverty. Approximately 8% of CISP participants identify as Aboriginal or Torres Strait Islander. An independent evaluation of the CISP program conducted in December 2009 found that the program is successful in reducing further offending, thereby contributing to a safer community and generating savings to the taxpayer.

1128 See for example:

Mr Christofer Beal, Coordinator, Tanderra AOD Services, Bairnsdale, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014; Mr Richard Michell, Manager, Youth Outreach, Youth Projects, Public Hearing, Melbourne, 3 February 2014; Ms Lynne Macdougall, Manager, Alcohol, Tobacco and Other Drugs, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014.

1129 Ms Lynne Macdougall, Manager, Alcohol, Tobacco and Other Drugs, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014.

1130 The Credit Bail Support Program. See discussion above.

1131 Mr Peter Mellas, Warrnambool Magistrates' Court, Public Hearing, Warrnambool, 3 March 2014.

By utilising an individualised case planning approach, each CISP participant receives a package of support that is tailored to their individual situation. The CISP model itself provides a flexible and responsive approach to emerging social issues, such as shifting patterns of substance use, changing forms of offending and different types of offenders. As such, the CISP has been able to respond to recent increases in the number of accused who are perpetrators of family violence. CISP has also increasingly been working with accused who have issues with methamphetamine, utilising active case management and judicial monitoring.¹¹³²

Ms Popovic noted that whilst current funding only enables provision of services at the current locations (Melbourne, Sunshine and Latrobe Valley), the Magistrates' Court of Victoria would be responsive to further resources to allow expansion of CISP to all headquarters courts and some outlying rural and regional courts, 'thereby supporting an increased number of accused and providing equitable access across the state'.¹¹³³

The Criminal Justice Diversion Program

The Criminal Justice Diversion Program¹¹³⁴ provides mainly first time offenders with the opportunity to avoid a criminal record by undertaking conditions that benefit the offender, victim and the community as a whole. In January 1997, the Magistrates' Court of Victoria, in cooperation with Victoria Police, piloted the scheme at Broadmeadows Magistrates' Court. Senior police, courts and the legal profession reviewed the pilot and a revised scheme commenced at Broadmeadows and Heidelberg Courts in November 2000. It is now available to all Magistrates' Courts throughout Victoria.¹¹³⁵

Benefits of the program

The Diversion Program is aimed at improving the efficient use of court resources by facilitating the development of an alternative and/or complementary procedure to normal case processes:

The Magistrates' Courts intend the program to provide benefits to the victim (if any), the accused and the community as a whole. Victims are actively engaged and are invited to participate in the process, including on matters regarding restitution and how the offence has affected them; victims frequently receive letters of apology from the accused. Accused benefit from the program by avoiding an accessible criminal record, by receiving appropriate assistance through rehabilitation, counselling and/or treatment, whilst the community benefits by way of donations or unpaid community work to various charities or local community projects.¹¹³⁶

Eligibility

Before a Diversion can be recommended:

- ◆ The offence must be triable summarily
- ◆ The offence must not be subject to a minimum or fixed sentence or penalty (except demerit points)
- ◆ The accused must acknowledge responsibility for the offence
- ◆ The prosecution must consent for the matter to proceed by way of Diversion.

The existence of prior convictions does not disqualify an accused from the program but the court will take this into account in deciding whether the Diversion Program is appropriate.

1132 Ms Jelena Popovic, Deputy Chief Magistrate, Magistrate' Court of Victoria, Submission, 30 July 2014.

1133 Ms Jelena Popovic, Deputy Chief Magistrate, Magistrates' Court of Victoria, Submission, 30 July 2014.

1134 See section 59 of the *Criminal Procedure Act 2009*.

1135 <http://www.magistratescourt.vic.gov.au/publication/criminal-justice-diversion-program-brochure>

1136 <http://www.magistratescourt.vic.gov.au/publication/criminal-justice-diversion-program-brochure>

Where a charge involves a victim, the court seeks the victim's view of the matter:

This may include: whether the victim agrees with the course of action, the amount of compensation sought for damage to property, how the crime has affected the victim. Victims are not obliged to respond to the Court's contact. However, the victim is entitled to express his/her view by way of letter or in person on the day of hearing. The Court will notify victims of the hearing's outcome, if requested to do so.¹¹³⁷

In discussing the possibility of Diversion with the Informant, offenders are advised to be prepared to discuss their personal situation/circumstances including employment status, any prior criminal history, an explanation offered for the offence and the impact that a criminal record will have on the offender's life and future.¹¹³⁸ In the context of methamphetamine-related offences, a discussion of any drug-related dependence issues and the possibility of a drug treatment referral would be ordinarily raised.

Outcomes

If the court orders a diversion program and the conditions are successfully completed, the charges are discharged with no finding of guilt and the outcome is recorded as an Official Warning. The record is not available to the public, including potential employers. If the accused does not successfully complete the conditions, the matter is referred back to the Mention Court of the Magistrates' Court as if the matter was being listed for the first time and all information regarding Diversion is removed from the file.¹¹³⁹

Evaluation of the Criminal Justice Diversion Program

A process evaluation of the CJDP was undertaken by Turning Point Alcohol and Drug Centre in 2004. The Evaluation Report found that referrals to CJDP increased gradually with the rollout of the program to more Magistrates' Courts:

Over 13,500 defendants were referred to the program between November 2000 and September 2003, and over 11,000 have participated in the program. Data suggests that about 6% of the incoming criminal case load is being referred to the CJDP (Alberti et al. 2004, p.6).

Of the referrals made in the period of the evaluation (2000-2003) 13% were subject to diversion orders directing the offender to attend counselling, including drug counselling or treatment. Other types of diversion orders included attending defensive driving courses, undertaking community work or making an apology or paying compensation to the victim (Alberti et al. 2004, p.7).

The outcome of the evaluation was largely positive. An analysis of all diversion cases from November 2000 to September 2003 showed that 94 percent of diversions were successfully completed including the avoidance of a criminal conviction. Time spent in the program was highly variable, ranging from less than 30 days to over a year. More than two-thirds of diversions took between 91–240 days to complete.

Importantly, the re-offending rate within the group of offenders studied was low. However there were limitations to the evaluation:

From a sample of 100 participants it appears that 0 to 7% would be convicted of a subsequent offence in the 12 months following their commencement on the program. However, to assess the effectiveness of the program in reducing re-offending relative to other options for this participant group (and/or relative to the re-offending that might have occurred in the absence of the program), analysis of

1137 <http://www.magistratescourt.vic.gov.au/publication/criminal-justice-diversion-program-brochure>

1138 <http://www.magistratescourt.vic.gov.au/publication/criminal-justice-diversion-program-brochure>

1139 <https://www.magistratescourt.vic.gov.au/publication/criminal-justice-diversion-program-brochure>

comparison groups would be required, which was outside the scope of this evaluation (Alberti et al. 2004, p.6).

Nonetheless, despite these methodological limitations, interviews with a range of stakeholders and analysis of participant satisfaction questionnaires:

suggest[ed] the program is highly successful in assisting participants' rehabilitation, with key benefits including the avoidance of a criminal record and the benefits to the participant from undertaking community work. The high completion and low recidivism rates, together with strong satisfaction among participants, those who refer to the program and those involved in its delivery, suggest that diversion plans have been successful. The program has also fostered better linkages to various community supports (Alberti et al. 2004, p.7).

The Evaluation Report found that overall the 'central strength' of the program was that all parties in the process have something to gain or benefit:

The participant can avoid a criminal conviction by complying with the Diversion Order, hence a high compliance rate has been achieved across the program. Participants also recognise, acknowledge (by pleading guilty) and take responsibility for their actions. Victims receive recognition and possibly compensation. For Magistrates, it provides flexibility and the application of therapeutic jurisprudence, whilst police are included very centrally in the process. In achieving these outcomes the program benefits from its flexibility, where the Diversion Order can be tailored to suit the offence, the participant and the victim (Alberti et al. 2004, p.7).

The Drug Court of Victoria

Drug courts are a particular form of diversion that build on the therapeutic justice approach. The literature on drug courts is voluminous and it is not intended to address this in detail.¹¹⁴⁰ Drug courts usually sit at the 'hard end' of the criminal justice system designed to offer support and treatment for repeat offenders with an entrenched history of drug dependence and related criminal activity. In most cases they will be targeted at offenders likely to be facing a term of imprisonment. There are now over 2000 drug courts spread over all 50 states of the United States,¹¹⁴¹ and they also exist in New Zealand, Canada, Ireland, Scotland and England. Specialised drug courts are relatively rare in European countries, although some jurisdictions may divert offenders to treatment from the standard criminal courts. Drug courts have been established in most Australian states with the first ones in this country being in Parramatta, NSW and Perth, Western Australia in 1999.

The Drug Court of Victoria (DCV) commenced in May 2002 and is located in Dandenong. It is a division of the Magistrates' Court of Victoria that provides for the sentencing and supervision of the treatment of offenders with a drug and/or alcohol dependency. Such offenders must have committed an offence under the influence of drugs or alcohol or to support a drug or alcohol habit:

The Victorian Drug Court initiative is a response to the failure of traditional criminal justice measures to adequately address drug use and related offending. The Victorian model has attempted to incorporate the best features of existing drug courts in order to establish a unique program addressing the specific needs of Victoria.¹¹⁴²

1140 For a detailed discussion of Drug Courts, see Wundersitz 2007, pp.20 ff.

1141 The first Drug Court was established in Florida in 1989. For an account of the genesis and evolution of Drug Courts in the United States and their applicability to other jurisdictions, see Franco 2010. See also *Defining Drug Courts: The Key Components* (Bureau of Justice Assistance 2004). This resource gives a good account of the conceptual underpinnings of drug courts and the practical mechanisms as to how they operate.

1142 Mr Tony Parsons, Presiding Magistrate and Mr Peter Lauritsen, Chief Magistrate, Drug Court of Victoria, Submission, 22 October 2013.

The Drug Court seeks to further improve the safety of the community by focusing on the rehabilitation of offenders with a drug or alcohol dependency and providing assistance in reintegrating them into the community. The Committee made a site visit to the Court in December 2013. After a briefing session with Magistrate Tony Parsons and his staff, the Committee also sat in on a number of scheduled cases to see the operations of the court and how the therapeutic model worked in practice.

Structure of the Drug Court

The Drug Court Magistrate has the responsibility for the supervision of participants placed on the Drug Court program. A multi-disciplinary team consisting of a case manager, clinical adviser, a dedicated representative from Victoria Police and Legal Aid defence lawyer assist the Drug Court Magistrate.¹¹⁴³

The DCV contracts with several external agencies, including Healthscope Pathologies for drug screening services, the Monash Clinical Psychology Centre for psychological assessments and treatment, Monash Health's SEADS and the Salvation Army's Positive Lifestyle Centre (PLC) for drug and alcohol counselling services.

In addition, the DCV has close working relationships with a broad range of other relevant service providers including general medical practitioners, especially those who prescribe pharmacotherapy, psychiatrists, dentists and other health professionals. The DCV also works closely with detoxification institutions including De Paul House, Windana and Wellington House, residential therapeutic institutions including Odyssey House, Windana, Remar, Bridgehaven and The Basin, naturopaths, masseurs and practitioners of a range of alternative medical therapies.¹¹⁴⁴

To address socioeconomic issues with participants, the DCV works closely with the Sheriff's Office, Centrelink, a range of financial counsellors, literacy and other adult education programs, vocational trainers, men's behaviour programs, family violence and relationship counsellors. 'These and other resources and partnerships enable the DCV to construct rich, individually tailored treatment plans to address each participant's therapeutic requirements.'¹¹⁴⁵

Drug Treatment Orders

The chief purpose of the court is to impose and administer a sentencing order called a Drug Treatment Order (DTO) pursuant to sections 18X to 18ZT of the *Sentencing Act* 1991. The DTO is a gaol sentence which the defendant, called the participant, is able to serve in the community on the provision that the participant complies with a judicially monitored, highly structured, tailored and supervised drug dependence recovery program.

The DTO consists of two parts: the treatment and supervision component and the custodial component. The supervision and treatment part of the DTO lasts for two years (unless cancelled earlier by the DCV) and that part comprises the core and program conditions of the order.

The custodial component of the DTO is the sentence of imprisonment, up to two years in length, which the court imposes for the offences the subject of the DTO and which is held in suspension whilst the participant complies with the order.

1143 Magistrates' Court of Victoria *Guide to Specialist Courts and Court Support Services* 2014, pp.12-13. For further discussion of the DCV's structure and the role of personnel see Mr Tony Parsons, Presiding Magistrate and Mr Peter Lauritsen, Chief Magistrate, Drug Court of Victoria, Submission, 22 October 2013.

1144 Mr Tony Parsons, Presiding Magistrate and Mr Peter Lauritsen, Chief Magistrate, Drug Court of Victoria, Submission, 22 October 2013.

1145 Mr Tony Parsons, Presiding Magistrate and Mr Peter Lauritsen, Chief Magistrate, Drug Court of Victoria, Submission, 22 October 2013.

Accordingly, regardless of the length of the sentence of imprisonment, the DTO lasts for two years unless the court cancels the order sooner.

The success of the DTO is underpinned by rigorous supervision of participants and maintaining standards of accountability. Substance use is monitored by frequent alcohol and drug testing, general progress is monitored by the DCV Team's case managers and treatment progress by clinical advisors. Ongoing judicial supervision of the participants, in most cases on a weekly basis, is essential with the magistrate imposing predictable and proportionate rewards and sanctions for positive and negative behaviours respectively. By employing the principles of behaviour modification, ('carrots and sticks'), the DCV magistrate plays a crucial role in guiding participants through the order.¹¹⁴⁶

The DTO can be made by a Drug Court Magistrate if the defendant satisfies the following criteria:

- ◆ Lives in a postcode area specified in the Government Gazette;
- ◆ Pleads guilty to offences that are within the jurisdiction of the Magistrates' court;
- ◆ Is facing an immediate term of imprisonment not exceeding two years and which is not a sentence that the court would suspend wholly or in part;¹¹⁴⁷
- ◆ Is dependent on drugs and/or alcohol and that dependency contributed to the commission of the offences;
- ◆ Is facing charges that are not sexual offences nor involve the infliction of actual bodily harm unless it was of a minor nature; and
- ◆ Is not subject to a parole order or a sentencing order of the County or Supreme Court.

The order is structured into three phases. The participant must stay in each of the first two phases for a minimum of three months before progressing to the next phase, and the final phase for a minimum of six months before cancellation as a reward is considered. Participants who successfully complete all three phases can graduate from the order. Graduation involves the cancellation of the DTO and its associated sentence of imprisonment. Although the order lasts for a maximum of two years, a graduation and associated DTO cancellation can occur any time after the first 12 months.

Participants commence their orders on Phase 1, the stabilisation phase, which is the most intensive phase of the DTO. The Phase 1 treatment goals are to reduce drug use, cease criminal activity, stabilise accommodation and income arrangements, and to stabilise physical and mental health.

On Phase 2, the consolidation phase, additional treatment goals include achieving periods of abstinence, consolidating positive social relationships and developing life skills including commencement of education, training or employment.

The arduous requirements of Phase 1 are reduced somewhat with participants now having to test only twice per week. They attend case manager and clinical advisor meetings and counselling sessions fortnightly instead of weekly. Court reviews are also moved to a fortnightly schedule.

1146 Mr Tony Parsons, Presiding Magistrate and Mr Peter Lauritsen, Chief Magistrate, Drug Court of Victoria, Submission, 22 October 2013.

1147 Drug Court Magistrate, Tony Parsons told the Committee that this sentence limitation of two years maximum was one of the weaknesses of the Victorian Drug Court compared to other jurisdictions. For example, in New South Wales there is no sentencing cap, so drug court magistrates in that state can put people on drug treatment orders even if they have been sentenced to a five years plus maximum.

Mr Tony Parsons, Magistrate, Drug Court of Victoria, Public Hearing, Melbourne, 9 December 2013.

After at least three months of success on Phase 2, participants are eligible for promotion to Phase 3, the re-integration phase of the DTO. The treatment goals on this final phase of the DTO include abstinence from drugs and remaining crime free, as well as maintenance of stable accommodation, positive relationships and general health and wellbeing. Participants on this phase are also expected to engage with study or vocational training or gain employment and be fiscally responsible.

On Phase 3 the constraints of the order are further eased with participants submitting to drug testing only once a week and attending case manager, clinical advisor, counselling and court review obligations only once per month:

This enables the participant to be the primary driver of achieving identified Phase 3 goals and rewards the progress gained. In addition, it provides the opportunity for additional commitments such as goals of employment, study and other re-integration programs.

Sanctions and rewards

The DTO and its administration is based on a series of behavioural modification tools employing sanctions and rewards as outlined in Table 21.1.

The magistrate uses these rewards or incentives to acknowledge a participant's positive progress in addressing his or her drug addiction and to encourage continuing compliance with the program. Non-compliant behaviour is addressed by the use of escalating sanctions as a tool to motivate participants to comply with the conditions of the DTO.

Table 21.1: Rewards and sanctions that can be applied by the Drug Court Magistrate

Rewards	Sanctions
Verbal praise/encouragement	Verbal warning
Advancement to the next Program phase	Demotion to an earlier phase
Decreased supervision	Increased supervision
Decreased court appearances	Increased court appearances
Reduced drug testing	Increased drug testing
Gifts, vouchers, event tickets	Imposition of a curfew
Reduced unpaid community work	Unpaid community work
Reduced periods of incarceration	Periods of incarceration
Successful Program completion	Termination of participation in the Program

Source: Mr Tony Parsons, Presiding Magistrate and Mr Peter Lauritsen, Chief Magistrate, Drug Court of Victoria, Submission, 22 October 2013.

As the ultimate 'stick', the magistrate has the power to activate the custodial component of the DTO in order to impose a short term of imprisonment in response to non-compliance.

The purpose of imposing a short term of imprisonment is to maximise an offender's compliance with the DTO, reinforce accountability and, ultimately, to retain offenders on the program. The minimum period of imprisonment that a magistrate can impose in response to non-compliance is seven days.

In practice, once the participant has settled in to the order, the court is likely to impose a day of community work or a day of imprisonment for significant negative behaviour such as not attending a treatment or supervision appointment or returning a negative drug test. On the other hand the court

will reward significantly positive behaviours, such as consecutive clear drug tests, by reducing the balance of imprisonment sanctions.

When imprisonment sanctions reach 15 days, the court will send the participant in to custody to serve those 15 days. As with all sanctions and rewards, the consistent message to the participant is that they are required to be accountable for their behaviours, both positive and negative.¹¹⁴⁸

A soft option?

One of the criticisms made of DTOs and the operation of the court generally, particularly in its early years, was that it could be seen as a 'soft option' for offenders. This is something the Drug Court magistrate and his staff vehemently refute:

When people come onto a drug treatment order they lose all kind of rights. We require them to give us permission to contact all of their therapists, all of their family, and they're required, of course, to meet the rigorous demands of the order. So they give up a lot of rights, they're required to do a lot of hard work on this order and so I don't, I can't compel them, they've got to consent to the order...

- there is often in the community or can be a perception that the drug treatment order is a 'soft option'... there have been instances where people say 'this is simply too tough, I can't do this', and there are even more instances of people that come through this order and regardless of how they exit, regardless of whether it's graduation, successful completion, or by cancellation because they haven't been able to finish it at the time, they have said 'this was so much tougher than jail'. Some people just say, 'you know what? Just send me to jail. I just want to do my time, because it's what I'm used to'. So, the perception I think that can be held about the drug treatment order as a soft option is something that is perhaps misguided, or misinformed at least. Because it is certainly far more onerous on a person to be able to confront what they are trying to cover up than to simply go in and do the sentences they ordinarily would.¹¹⁴⁹

Evaluations of the Drug Court¹¹⁵⁰

A current evaluation of the DCV and its operations has been commissioned and is expected to be completed in late 2014. An earlier evaluation in 2005, three years after the pilot was initiated, was undertaken by Turning Point Alcohol and Drug Centre and Health Outcomes International. The evaluation assessed both the social and economic benefits of the program.

The evaluation found that there were clear benefits in the Drug Court program including:

- a cost benefit ratio of for every \$1 the program uses: the community dividend is \$5;
- a graduation rate of 15% with a projected completion rate of 30% per annum in subsequent years once the program had become more established;
- an increase in income of participants from 15% at intake, to 39% upon completion (not including unemployment benefits);
- a reduction in unemployment rates of participants by 32%;
- a 70% reduction in the number of prison days required by Drug Court participants who would have been placed in custody if not for the DTO;
- a reduction in re-offending rates per free day, per participant on the program, at 23% less than the

1148 Mr Tony Parsons, Presiding Magistrate and Mr Peter Lauritsen, Chief Magistrate, Drug Court of Victoria, Submission, 22 October 2013.

1149 Mr Tony Parsons, Magistrate, Drug Court of Victoria, Public Hearing, Melbourne, 9 December 2013 and Ms Elisa Buggy, DCV Program Manager, Drug Court of Victoria (currently on secondment to the Children's Court), Public Hearing, Melbourne, 9 December 2013.

1150 Evaluation of drug diversion programs of course is a complex area. Results may vary considerably depending on whether the program is a police diversion program aimed at diverting the offender away from the 'front end' of the criminal justice system or a court based program dealing with long-term and repeat offenders with entrenched drug-related criminal histories. For a detailed discussion of the problems associated with evaluating drug diversion programs, see Wundersitz 2007.

comparison control group;

- in addition, the reduction in re-offending rates was further significant for those participants who had graduated from the program, at 68% when compared with the control group.¹¹⁵¹

In short, the evaluation found that “the Drug Court...is both less costly and more effective than the alternative of imprisonment’ and had a greater effect on reducing offending rates compared to prison (Smart Justice 2013, p.2).¹¹⁵²

Magistrate Parsons spoke to the Committee about successful outcomes and what should count as ‘success’ for the purposes of the program. He stressed that success was often incremental and could not be looked at as simply a case of completely ceasing all drug use. Success may also be learning how to read and write, a long period of abstinence or entering paid employment:

Those that graduate are heroic: no crime, no drug use and employed. Instead of being a huge burden on the community, on the health system and the justice system, they’re giving back, they’re paying taxes. They’re fantastic. That’s about 15%. But, the other 50%, if we can get them to the end of the two year order, research is very clear: if they’re not abstinent, they’re using less; and if they’re still committing criminal offences, they’re committing them less often and they’re less serious. So, they are also a measure of success. So about two-thirds success rate based on that criteria — the aims of the order being to reduce the burden of crime.¹¹⁵³

Magistrate Parsons also put the cost-effectiveness of the program into perspective by telling the Committee:

[o]ne number that needs to be kept in mind is that this programme keeps roughly 50 people out of jail. It costs \$5 million to put 50 people in jail for a year, and this programme costs \$1.5 million a year to run. So, as far as I’m concerned it’s not a question of can we afford more Drug Courts, it’s can we afford not to have them?¹¹⁵⁴

Drug Courts for juveniles?

Because of the ‘hard end’ nature of the offenders who appear before the drug courts, they are not usually applicable to juvenile offenders. Indeed, the only specialist drug court for young people in Australia is the Youth Drug Court in New South Wales. In Victoria there is no specialist Youth Drug Court. Whilst the Children’s Court of Victoria relies heavily on the Children’s Court clinic to provide assessments of young offenders with a drug-related problem and in some limited cases provide treatment, it does not fulfil the role of a Drug Court per se. Young offenders may also access counselling, rehabilitative and treatment services from an agency such as YSAS, as part of a bail program or a sentencing order.

Whether a specialist Drug Court is appropriate for young people is difficult to determine. Evaluations of adult drug courts generally and the NSW Youth Drug Court in particular have been mostly favourable, with lower levels of drug use observed over time in offenders sentenced through the Drug Court as opposed to through more conventional methods (Wundersitz 2007). Yet there is less evidence or at least insufficient data to show that such a court will necessarily have a positive effect in reducing levels of recidivism amongst young people. The Secretariat has become aware of a recent pilot being initiated in the civil (child welfare) division of the Children’s Court that operates in similar ways to a juvenile Drug Court. The objective is to address the young person’s drug issues with the ultimate aim of

1151 Mr Tony Parsons, Presiding Magistrate and Mr Peter Lauritsen, Chief Magistrate, Drug Court of Victoria, Submission, 22 October 2013.

1152 See also King and Hales 2004. In New South Wales an independent evaluation of the comparable NSW Drug Court Completion Program found participants to be 37 percent less likely to be reconvicted of comparable crimes during the follow up period (Weatherburn et al. 2008). See also Ziersch & Marshall 2012.

1153 Mr Tony Parsons, Magistrate, Drug Court of Victoria, Public Hearing, Melbourne, 9 December 2013.

1154 Mr Tony Parsons, Magistrate, Drug Court of Victoria, Public Hearing, Melbourne, 9 December 2013.

achieving reconciliation between the child and his or her family. The Secretariat has written to the Children's Court seeking further information about this program.

The use of methamphetamine by drug court clients

The submission received from the DCV did not specifically discuss the issue of methamphetamine. The most common drug for people on DTOs is heroin; however the submission acknowledges that the use of methamphetamine is growing:

Six years prior, methamphetamine use was rarely an issue for DCV participants. However, this substance is emerging with alarming prevalence and devastating individual and community effects. Currently, just under half of the participants have issues with methamphetamine and half of those have serious problems with both methamphetamine and heroin.¹¹⁵⁵

The DCV has responded to the emerging issue of methamphetamine use with a range of specialist clinical interventions:

Examples of this include the commencement of specialist methamphetamine groups for participants based on an evidence-based model from the United States of America, on site narcotics anonymous meetings, reinforcement of harm minimisation strategies and one-on-one clinical interventions as appropriate. In addition, participants are encouraged to engage in meaningful pro social activities such as vocational training, community groups or employment to establish positive social support networks.¹¹⁵⁶

With regard to the forthcoming evaluation of DCV, the evaluator, whilst undertaking the general evaluation, will also specifically measure the effectiveness of the program in addressing methamphetamine abuse.¹¹⁵⁷

The expansion of Drug Courts in Victoria?

Numerous witnesses to the Inquiry have commented favourably on the operations of the DCV as a diversionary measure to address and stop or at least reduce drug-related offending.

As with the CISP, many witnesses who gave evidence to the Inquiry praised the Drug Court and its diversionary processes, but were critical of what appeared to be such an arbitrary and limited catchment area. It was recommended by many of these witnesses that a number of similar courts be established throughout Victoria and at the very least another such court to serve the inner and northern areas of Melbourne.¹¹⁵⁸ In this respect Magistrate Clive Alsop told the Committee:

I sat in the Drug Court years ago when I worked in Dandenong. There is no greater joy than to see a person who was a hopeless addict — in those days it was all heroin — go through the process of the Drug Court and come out clean at the other end. It does not happen every time but, with the spectre of going straight back to gaol hanging over their heads, a lot of people who otherwise would not have made the effort do make the effort.

1155 Mr Tony Parsons, Presiding Magistrate and Mr Peter Lauritsen, Chief Magistrate, Drug Court of Victoria, Submission, 22 October 2013.

1156 Mr Tony Parsons, Presiding Magistrate and Mr Peter Lauritsen, Chief Magistrate, Drug Court of Victoria, Submission, 22 October 2013.

1157 Mr Tony Parsons, Magistrate, Drug Court of Victoria, Public Hearing, Melbourne, 9 December 2013.

1158 See for example Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol & Drug Association VAADA, Submission, 11 November 2013; Ms Karen Gurney, Managing Lawyer, Goulburn Valley Community Legal Centre, and Mr Peter Noble, Coordinator, Loddon Campaspe Community Legal Centre, Submission, 31 October 2013; Mr Clive Alsop, Regional Coordinating Magistrate Gippsland, Magistrates' Court of Victoria, Submission, 28 October 2013; Mr John Rogerson, Chief Executive Officer, Australian Drug Foundation, Submission, 28 October 2013; Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates Court, Public Hearing, Traralgon, 28 January 2014. See also Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, Submission, 21 October 2013 in the general context of the need for drug diversion through the courts.

There is one aspect about the Drug Court that is not widely known...and that is the fact that it returns 500 percent on the capital investment, if you look at the services that it saves and the cost that it saves the community... The other aspect to the Drug Court is that whilst the offenders have to be sentenced to a term of imprisonment which is effectively suspended while they are on a drug treatment order and complying with their requirements, for a part of their sentence they are out of gaol and at the moment, as we all know, there is standing room only in the current prison system in this state. 'Do I think it would be useful to have additional specialist and Drug Courts available in regional Victoria?' The answer is yes. I think the rationale is obvious.¹¹⁵⁹

In short, the DCV and its use of a therapeutic based jurisprudence to address drug-related offending appears to be making small inroads into breaking the cycle of drug use and related offending. The DCV's submission to this Inquiry, however, sounds a cautionary note:

What is abundantly clear from... research is that if a drug court is operated faithfully in accordance with the key components, it will successfully reduce substance abuse, reduce drug-related crime and reduce the cost of crime borne by the community. Drug courts that dilute the model, or omit, overlook or modify the key components inevitably pay the price with lower graduation rates, higher criminal recidivism and lower cost savings.¹¹⁶⁰

The Koori Court of Victoria

In May 2000 the Victorian Government and representatives of the Victorian Aboriginal community entered into the Victorian Aboriginal Justice Agreement (VAJA). One of the proposed initiatives of the Agreement was the establishment of a Koori Court in Victoria. The development of a court with participation of the Elders and Respected Persons from the Koori community was seen as one part of a comprehensive strategy to address Aboriginal over-representation in the criminal justice system.

As a result of the *Magistrates' Court (Koori Court) Act 2002*, pilot Koori Courts commenced in the adult jurisdictions at Magistrates' Courts at Shepparton in October 2002 and at Broadmeadows in April 2003.¹¹⁶¹

The Koori Court operates as a division of the Magistrates' Court, which sentences Aboriginal defendants. The Children's Koori Court was established under the *Children, Youth and Families Act 2005*. The Koori Court provides an informal atmosphere and allows greater participation by the Aboriginal (Koori) community in the court process. Koori Elders or Respected Persons, the Koori Court Officer, Koori defendants and their families can contribute during the Court hearing. This helps to reduce perceptions of cultural alienation and to ensure sentencing orders are appropriate to the cultural needs of Koori offenders, and assist them to address issues relating to their offending behaviour.

The Koori Court aims to:

- Increase Koori ownership of the administration of the law;
- Increase positive participation by Koori offenders;
- Increase the accountability of the Koori offenders, families, and community;
- Encourage defendants to appear in Court;
- Reduce the amount of breached court orders;

1159 Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates Court, Public Hearing, Traralgon, 28 January 2014.

1160 Mr Tony Parsons, Presiding Magistrate and Mr Peter Lauritsen, Chief Magistrate, Drug Court of Victoria, Submission, 22 October 2013.

1161 The Koori Court is currently located at Bairnsdale, Broadmeadows, Latrobe Valley, Mildura, Shepparton, Swan Hill and Warrnambool Magistrates' Courts. Children's Koori Courts are also located in Melbourne and Mildura.

- Deter offenders from re-offending;
- Increase community awareness about community codes of conduct and standards of behaviour; and
- Explore sentencing alternatives prior to imprisonment.¹¹⁶²

The Koori Court Model is significantly different than standard or mainstream Victorian Magistrates' Courts. In particular:

- The court is more informal.
- The Magistrate sits at a large table with all other participants in the case, not at the bench;
- The defendant will sit with his or her family at the table, not in the dock; and
- Participants will talk in 'plain' English rather than using technical legal language.¹¹⁶³

The Koori Court magistrate retains all the sentencing options available to him or her in a conventional Magistrates' Court. This includes the power to send the accused to prison. However, the primary goal of the court is to create sentencing orders that are more culturally appropriate to Koori offenders, thereby reducing the rate of re-offending. All offences that can be heard in a Magistrates' Court can be heard in the Koori Court, except for some family violence offences and sexual offences.¹¹⁶⁴

The eligibility criteria for using the court's services are as follows:

- The accused should be a Koori person who pleads guilty to an offence
- Lives within, or have been charged within, the boundary area of a Koori Court
- The accused should be willing to go to the Koori Court and join in the Koori Court process (Magistrates' Court of Victoria 2014, p.28).

As in conventional Magistrates' Courts, the ultimate decision regarding the sentencing order is left with the magistrates. However, in the Koori Court, the Koori Elders or Respected Persons will provide the court with advice relating to cultural matters. The Magistrate considers this advice when handing down the most appropriate sentencing order.¹¹⁶⁵

The Koori Court in the context of drug-related offending

The Koori Court is not a specialist Drug Court. It does, however, have the ability to make dispositions in the sentencing process that can refer Aboriginal offenders guilty of drug-related crimes to treatment and rehabilitation programs. This is particularly important given the Drug Court of Victoria has, as discussed, an extremely limited geographical catchment and does not have a particularly high level of Aboriginal residents compared to other areas of Melbourne and rural Victoria.

In the context of methamphetamine abuse by Aboriginal people, Mr Wayne Muir of the Victorian Aboriginal Legal Service told the Committee, whilst not criticising the good work of the Drug Court, the Koori Court also offered a better opportunity for Aboriginal offenders because it offers therapeutic and restorative options that are more culturally appropriate than those the Drug Court currently provides.¹¹⁶⁶ Magistrate Clive Alsop also

1162 See <http://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/koori-court>

1163 <http://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/koori-court>

1164 See Magistrates' Court of Victoria *Guide to Specialist Courts and Court Support Services* 2014.

1165 The Koori Court operates in conjunction with the Koori Liaison Officer Program (KLOP) whereby Koori defendants who have been charged with an offence and are on bail or remand may be provided with support and case management services to address particular problems including drug and alcohol dependency or misuse related to their offending. The KLOP operates in conjunction with CISP.

1166 Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Public Hearing, Melbourne, 17 February 2014.

believed the Koori Court was of great value in dispensing culturally appropriate justice to Aboriginal clients.¹¹⁶⁷ He told the Committee:

The Koori Court is a very active part of the jurisprudence that is applied within the Magistrates Court throughout Gippsland. It is actively supported by a group of absolutely outstanding elders and respected persons. It is actively encouraged by people providing advice and guidance to Koori communities to take part in the Koori Court, and it is no picnic. The Koori Court was criticised by people who had not bothered to go and have a look at it when it first came into existence. They were saying, 'It's a soft option for Kooris'. No soft option. I have sat there and I have listened to a number of elders and respected persons give what I would refer to as 'both barrels' to an offender. It is not easy. The success rate within the Koori Court has to be measured by two things. One is the therapeutic advantage of having been able to put on Koori specific programs. The other is the reuniting of the Koori population with part of their culture. Those people who sit as respected persons and elders assisting the magistrate in the Koori Court do an outstanding job of contributing towards that.¹¹⁶⁸

An evaluation of the two longest operating courts — Shepparton and Broadmeadows — found positive results with reduced recidivism rates, reduced failures to appear on bail and reduced breaches of correctional orders. The Koori Court has also encouraged successful coordination of support services to particular defendants including referrals to drug treatment services (Grant 2008).¹¹⁶⁹ Wherever possible the support services offered to an Aboriginal offender through the Koori Court's diversion processes must be culturally appropriate and address the needs of Aboriginal people.

The Neighbourhood Justice Centre

The Neighbourhood Justice Centre (NJC) is a 'community court', the first of its kind in Australia. It was established through the *Courts Legislation (Neighbourhood Justice Centre) Act* 2006 in August 2006 and is located within the municipality of Yarra, inner city Melbourne.

The concept of community is central to the NJC. It has a strong focus on making reparation to individuals and communities affected by crime. It draws strongly from community justice court models overseas, including the Red Hook (Brooklyn, United States) and North Liverpool (United Kingdom) centres (Bassett 2007). The NJC aims to enhance community involvement in the justice system. The NJC may, however, include state-wide referrals to a drug rehabilitation program where the offending is drug-related or drug dependence is part of the offender's profile.¹¹⁷⁰

The NJC provides:

- ◆ A court (including a children's court)
- ◆ On-site support services for victims, witnesses, defendants and local residents
- ◆ Mediation and crime prevention programs for the City of Yarra
- ◆ Community meeting facilities.

The NJC works closely with the City of Yarra community to:

- ◆ Address the underlying causes of offending

1167 Other witnesses have also spoken of the valuable work done by Aboriginal Community Liaison Officers in complementing the work of the Koori Court, Victoria Police and the mainstream criminal justice apparatus. See for example, Superintendent Paul Naylor, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013.

1168 Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates' Court, Public Hearing, Traralgon, 28 January 2014.

1169 For an academic critique of the Victorian Koori Court and its relationship to therapeutic justice, see Mark Harris — *The Koori Court and the promise of Therapeutic Justice* at https://elaw.murdoch.edu.au/archives/issues/special/the_koori_court.pdf.

1170 For a general discussion of the background to and evolution and operation of the NJC, see Sarah Murray 2009, 'Keeping it in the Neighbourhood? Neighbourhood Courts in the Australian Context'.

- ◆ Provide opportunity, education and support for victims, witnesses, defendants and local residents
- ◆ Assist in preventing crime
- ◆ Stop the 'revolving door' of crime and punishment
- ◆ Increase the community's involvement in the administration of justice
- ◆ Increase access to justice.

The Court jurisdiction

The *Courts Legislation (Neighbourhood Justice Centre) Act 2006* Act establishes the court's sentencing procedures and reinforces the court's commitment to therapeutic and restorative justice approaches.

A range of civil and criminal cases arising in the City of Yarra are heard in the NJC Court including:

- ◆ The Magistrates' Court which includes the Victims of Crime Assistance Tribunal and a Crimes Family Violence List
- ◆ The Children's Court Criminal Division
- ◆ Some Victorian Civil and Administrative Tribunal matters, such as civil claims, guardianship and administrative and residential tenancies.

As with the Drug Court of Victoria, a criticism of the NJC is that it has a geographical catchment limitation. The NJC magistrate hears criminal matters only where the defendant lives in the City of Yarra. Civil matters are heard in a range of circumstances, but again the subject matter must ordinarily arise in the City of Yarra.

The underlying ethos of the NJC, as with many of the alternative justice approaches discussed in this chapter, is that it 'tr[ies] to address the underlying causes of offending, rather than merely responding to crime after it has occurred'.¹¹⁷¹ This includes the delivery and coordination of 'wraparound' justice and support services, including diversionary programs, at a local community level. The NJC may however include statewide referrals to a drug rehabilitation program where the offending is drug-related or drug dependence is part of the offender's profile.

Mental Health Court Liaison Service

The Mental Health Court Liaison Service (MHCLS) is a court-based assessment and advice service. In Melbourne metropolitan court locations the service is provided by Forensicare at the Victorian Institute of Forensic Mental Health and in rural and regional areas by local area mental health services.

The metropolitan MHCLS was first established at the Melbourne Magistrates' Court in November 1994. Due to the increasing demand on the service, the Broadmeadows, Dandenong, Frankston, Heidelberg, Ringwood and Sunshine Magistrates' Courts also have a MHCLS. There are five part-time, country-based MHCLS positions that are provided by the local area mental health services at the Geelong, Shepparton, Bendigo, Ballarat and Latrobe Valley Magistrates' Courts.

The aims of the MHCLS are to:

- divert offenders with a mental illness from the criminal justice system into appropriate mental health treatment

1171 See Neighbourhood Justice Centre — Community Justice at:

<http://www.neighbourhoodjustice.vic.gov.au/home/about+us/community+justice/#sthash.sgrQCrDn.dp>

- reduce rates of recidivism in offenders with a mental illness through facilitating access to appropriate mental health treatment services
- reduce the frequency and length of custodial remands to obtain a psychiatric report.¹¹⁷²

Responsibilities of the MHCLS include:

- identification and assessment of people coming before the court who may suffer from a mental illness, and make linkages to an appropriate mental health facility in the community or prison system, for treatment and support
- providing immediate impartial mental health assessment, to determine whether or not a person before the court is suffering from a mental illness
- assessment to determine if a person is fit to plead
- reassessment of the mental state of a person with a known psychiatric history
- providing a consultancy and advice service on mental health issues to all metropolitan Magistrates' Courts and their users
- consultation with family members involved in the person's care.¹¹⁷³

The MHCLS complements the other court support services established or provided by the Magistrates' Court of Victoria.¹¹⁷⁴

Youth Justice Court Advice Service

The Youth Justice Court Advice Service (YJ CAS) is a specialised state-wide youth-focused service provided by the Department of Human Services, Youth Services and Youth Justice Branch, for young people between the ages of 18 and 20 years of age who are appearing in the Magistrates', County and Supreme Courts in relation to criminal matters. The primary focus of the YJ CAS service is the diversion of young offenders from the criminal justice system.¹¹⁷⁵

Amongst other functions the YJ CAS worker can assess and give advice to the court with regard to a young person's drug and alcohol treatment needs and identify any other appropriate diversionary strategies. Such advice may be used as the basis for pre-sentence and sentence referrals to appropriate support services including drug treatment centres.

Community Offenders Advice and Treatment Service

The Community Offenders Advice and Treatment Service (COATS) was established in November 1997 and is provided by the Australian Community Support Organisation (ACSO). It remains the largest of the forensic community drug and alcohol treatment initiatives in Victoria.¹¹⁷⁶

As a result of referral from the courts, police or the Parole Board, COATS undertakes

- ◆ an assessment,
- ◆ provides an alcohol and drug treatment plan; and

1172 See Magistrates' Court of Victoria *Guide to Specialist Courts and Court Support Services* 2014.

1173 See Magistrates' Court of Victoria *Guide to Specialist Courts and Court Support Services* 2014.

1174 See also in this context the Assessment and Referral Court List (ARCL). The ARCL is a specialist list used in the Magistrates' Court of Victoria which works in conjunction with CISP. It aims to meet the needs of defendants with mental illness and/or cognitive or intellectual impairment. As with CISP, defendants may be referred to the ARCL to receive a period of specialist case management relevant to their particular needs. See Magistrates' Court of Victoria *Guide to Specialist Courts and Court Support Services* 2014.

1175 Magistrates' Court of Victoria *Guide to Specialist Courts and Court Support Services* 2014.

1176 A submission has been made to this Inquiry from ACSO/COATS. It is noted that approximately 32 percent of people currently coming into COATS programs may be reporting amphetamines as their primary drug of concern and as far as is ascertainable 38 percent of that cohort are reporting crystal methamphetamine or 'ice' as the particular form of methamphetamine.

See Ms Heather Carmichael, Community Offender Advice and Treatment Service (COATS) Manager, Australian Community Support Organisation (ACSO), Submission 12 November 2013.

- ♦ purchases any necessary treatment from community-based alcohol and drug treatment agencies.¹¹⁷⁷

for parolees and offenders who receive community based dispositions or a Combined Custody and Treatment Order (CCTO).

In some cases, COATS can undertake pre-sentence assessments for the Court, particularly where the Court is considering a CCTO. COATS is also responsible for the brokerage, data collection and financial reporting of the Commonwealth Government's National Illicit Drug Strategy (NIDS) Diversion Initiative.

COATS remains the largest of all Victoria's treatment programs, with over 6000 offenders per annum either assessed or referred to treatment by COATS. The majority of these offenders are men aged in their 20s who are subject to a Community Based Order. Ms Michele Wood of the Department of Justice explained the practical workings of the COATS system in evidence to the Committee as follows:

COATS/ACSO undertakes all offender alcohol and drug assessments upon referral from community corrections. It is the ACSO assessors who develop individual treatment plans and broker appropriate services with treatment agencies in the community. The service agreements and brokerage funding between ACSO and community treatment agencies are managed by the Department of Health. This service framework is very much a partnership between the Department of Justice and the Department of Health, between community corrections and the ACSO/COATS program.

Effectively what happens is that once the court makes an order with a condition around requiring assessment and treatment, then it is the responsibility of the community corrections [CCS] case manager to refer that offender to the ACSO/COATS program. We rely on their drug and alcohol assessment staff to make those individual assessments and develop a treatment plan. Having been a practitioner in CCS many years ago, before those statewide protocols existed, I know firsthand how difficult it was as a case manager to scout around local community agencies to access services for an offender and then try to make sure that we had the right kind of services for the needs of that offender. Effectively that is a statewide protocol, which is in place now. It takes responsibility away from the case manager to individually formulate what that person needs and has someone who is trained in drug and alcohol assessment actually formulate a treatment plan. Centrally, Community Correctional Services works closely with the Department of Health around making sure the protocol that exists between community corrections and ACSO is regularly updated and maintained so that it can deal with issues that emerge over time.¹¹⁷⁸

A lack of post-prison release drug treatment services

As discussed in Chapter 14 prisoners released into the community after having served their sentence face many problems associated with readjusting to life on 'the outside'. This is particularly the case if the offender has a history of drug-related problems including dependence issues. Reports from the Victorian Ombudsman and Victorian Auditor-General's Office have documented the paucity of programs and support services for prisoners and ex-prisoners who have drug-related problems.¹¹⁷⁹

Whilst some drug rehabilitation services for released offenders are privately provided through charitable organisations such as the Salvation Army, there are relatively few that provide an intensive and coordinated approach that attempts to address the prisoner's needs

1177 Clients who are sent to treatment through COATS brokerage are mandated clients, in some cases involuntary clients through the justice system where the alternative may have been a term of imprisonment. However, a witness working in the sector told the Committee that once clients, particularly young people, are engaged in treatment there is a certain amount of success. Ms Melinda Grady, Youth Worker, Barwon Youth, Public Hearing, Geelong, 28 October 2013.

For a discussion of the worth of involuntary or mandated versus voluntary drug treatment, see discussion in Chapter 27.

1178 Ms Michelle Wood, Assistant Director, Community Correctional Services, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014.

1179 See Victorian Ombudsman 2014, Reports into Deaths and Harms in Custody, March, Office of the Victorian Ombudsman. Online at: <https://www.ombudsman.vic.gov.au/>; Victorian Auditor General's Office 2013. See also the discussion in Chapter 14 of this report.

for life in the community whilst he or she is still serving their sentence. One program that does take such a holistic approach is the intensive post-prison release drug treatment service, known as Stepout, (established in October 1997 by Moreland Hall now Uniting Care ReGen). Stepout is now operated by COATS. COATS has the role of assessment, referral and treatment brokerage for persons due for release from custody.

The service provides in-prison assessment and, where appropriate, intensive counselling and case management to people on release from prison who are high risk or for whom a further period of counselling and support will consolidate the outcomes of treatment received in prison.

Drug treatment services are brokered for all clients assessed, however it is often difficult to encourage offenders to attend treatment on a voluntary basis. COATS continues to promote the program on a statewide basis, with particular emphasis on the need for assertive follow up.

The New South Wales Compulsory Drug Treatment Correctional Centre and Program

The New South Wales Compulsory Drug Treatment Correctional Centre (colloquially referred to as the 'drug prison') merits some discussion as an innovative approach to drug-related offending. An extension of the New South Wales Drug Court, the Centre is the first penal institution in Australia focused on treatment and rehabilitation.¹¹⁸⁰

The Compulsory Drug Treatment program (CDTP) began in August 2006 and operates as a five-stage post-sentencing program. Drug treatment and rehabilitation is provided in Stages 1-3 primarily from the Compulsory Drug Treatment Correctional Centre (CDTCC) located in Parklea, Sydney, approximately 40km north-west of the Sydney central business district. The CDTCC houses up to 70 participants who have been sentenced to a Compulsory Drug Treatment Order by the Drug Court in Parramatta.

Stage 1 involves closed detention at the CDTCC. This stage aims to stabilise participants and to address physical and mental health needs, while providing adult education, work readiness and skills programs, and therapeutic programs that target dynamic risk factors for drug-related offending.

In Stage 2 participants are permitted to leave the CDTCC to attend employment, training and approved social activities. Stage 2 involves programs designed to maintain positive behaviour change and assist in effective re-integration into the community. In Stage 3, participants reside outside of the CDTCC but under intensive supervision from CDTCC staff.¹¹⁸¹ This is followed by Stage 4 (parole) and Stage 5 (voluntary case management) in the community where appropriate.¹¹⁸²

Evaluation of the CDTCC

1180 For a general discussion of the establishment of the CDTCC, see Birgden and Grant 2010, 'Establishing a compulsory drug treatment prison: Therapeutic policy, principles, and practices in addressing offender rights and rehabilitation'.

1181 See http://www.bocsar.nsw.gov.au/bocsar/bocsar_mr_120.html

1182 The *Compulsory Drug Treatment Correctional Centre Act 2004* (NSW) amended the *Drug Court Act 1998* to establish compulsory drug treatment orders and the CDTCA, as amended. Compulsory drug treatment orders are found in s18B of the *Drug Court Act*. This places a "duty" on a sentencing court to:

- ascertain whether the Drug Court might find a person eligible; and
- if so, refer the person to the Drug Court to determine if the person should be subject to a compulsory drug treatment order.

An evaluation of the CDTP by the New South Wales Bureau of Crime Statistics and Research (BOCSAR) found that the Program 'has had a positive effect on the physical and mental health of offenders who enter it' (Dekker, O'Brien & Smith 2010).¹¹⁸³

The evaluation research undertaken by BOCSAR involved a series of face-to-face interviews with CDTP participants. Baseline interviews were conducted with 95 participants at the commencement of their time on the program. Three follow-up interviews were conducted as close to the time that participants finished Stages 1, 2 and 3, as was practicable. By the time data collection ceased, 78 percent of the baseline sample (74 participants) had completed Stage 1 and participated in one follow-up interview (end of Stage 1), and 41 percent of the baseline sample (39 participants) had completed both Stages 1 and 2 and participated in two follow-up interviews (end of Stages 1 and 2). Of the baseline sample, 13.5 percent (13 participants) had completed all three follow-up interviews (end of Stages 1, 2, and 3).

The evaluation reported that significant improvements were found for outcome measures of mental and physical health. For those 38 participants who completed an end of Stage 2 interview, mental health was significantly higher at the end of Stage 2 than at baseline. Physical health amongst this sample of participants also improved from baseline to the end of Stage 2. There was also evidence that improvements in physical health occurred during the first month of being on the program (Dekker, O'Brien & Smith 2010).

Interestingly, despite the compulsory nature of the CDTP, 'the vast majority of participants perceived that their admission to the CDTP was voluntary' (Dekker, O'Brien & Smith 2010, p.viii). Evidence also suggested that participants' negative affective reactions to being sentenced to the treatment program decreased significantly from sentencing to the baseline interview and did not significantly change thereafter.

Across the program, the vast majority of participants were 'sure' they wanted to attend the program, 'sure' that the CDTP would be helpful to them and satisfied with most aspects of the CDTP. The programmatic aspects that the majority of participants did not like were non-contact 'box' visits (visits where the offender and the visitor cannot make contact with one another) or the possibility of being regressed from a later stage to an earlier stage (e.g. for non-admitted drug use).

When asked for open-ended comments about the program, participants were largely positive about the program, although some participants made negative comments and suggestions for change regarding box visits, sanctions and employment (Dekker, O'Brien & Smith 2010, p.ix).

Overall the evaluation authors acknowledged that due to the lack of a comparison group it was difficult to draw any firm conclusions about the effectiveness of the program. Nonetheless, they added that there were certainly some promising aspects to the program which were encouraging:

Participants' health and wellbeing appeared to improve over time on the program. Although the program was coercive, the vast majority of participants felt that their participation in the CDTP was voluntary. Participants made positive comments about the program and consistently expressed their desire to be in the program regardless of what stage they were in. This is encouraging evidence that offenders in the program genuinely wanted to change their behaviour. These positive findings, however, have to be set against the fact that illegal and non-prescribed drug use was detected in at

1183 There were however significant methodological and other limitations that made the evaluation less comprehensive than it might have been. In particular, the number of offenders eligible for the CDTP was never large enough to conduct a meaningful randomised controlled trial as requested by the New South Wales Government: In addition:

'The number of offenders dealt with on the program was also too small to evaluate its effect on rates of re-offending. The evaluation was therefore limited to assessing the impact of the CDTP on the health and wellbeing of participants' (Dekker, O'Brien & Smith 2010, p.vii).

least one of the drug tests for the majority of participants, despite 'positive' tests accounting for only a very small proportion of the overall tests conducted (Dekker, O'Brien & Smith 2010, p.ix).

Justice reinvestment

A relatively new approach in addressing crime, including drug-related offending is that of justice reinvestment (JR).¹¹⁸⁴ 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'.¹¹⁸⁵

Justice Reinvestment involves the redirection of resources from Corrections budgets to various forms of community provision such as education, housing, drug and alcohol, employment, healthcare and other resources in high crime communities from which many prisoners come and to which many prisoners will return. Its growing popularity stems from a range of factors, including recognition across the political spectrum that increasing imprisonment rates and populist law and order strategies have failed to prevent crime and ensure public safety. Indeed the criminogenic, or crime producing nature of imprisonment is being recognised as recidivism rates have become a political issue (Brown 2013, p.36).

Increasingly in countries such as the United States and the United Kingdom,¹¹⁸⁶ 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 (Brown 2013). For example:

A report by the Australian National Council on Drugs [ANCD] found that the cost per prisoner per day including net operating expenditure, capital expenditure per prisoner and transport and escort services expenditure ranged from \$243 in the Northern Territory to \$595 in the Australian Capital Territory. The average cost per prisoner per day in Australia was \$315 or \$114,832 a year. According to the most recent Productivity Commission Report on Government Services the total real recurrent expenditure (less revenue from own sources) on corrective services by State and Territory governments in 2011-2012, was over \$3 billion. The average growth rate of this expenditure is 2.9 percent, an increase of approximately \$90 million a year (National Association of Community Legal Centres 2013, p.7).¹¹⁸⁷

Justice reinvestment reflects an understanding that, whilst a period of imprisonment may deter some offenders, in many cases it can foster further offending or recidivism. This may particularly be the case for low level or first time offenders:

The purpose of justice reinvestment is to manage and allocate criminal justice populations more cost-effectively, generating savings that can be reinvested in evidence-based strategies that increase public safety while holding offenders accountable. 'States and localities engaging in justice reinvestment collect and analyse data on drivers of criminal justice populations and costs, identify and implement

1184 The term is that of Tucker and Cadora first coined in 2003. See Susan Tucker & Eric Cadora, 'Ideas for an Open Society: Justice Reinvestment', *Open Society Institute* 3(3) (2003).

1185 Ms Karen Gurney, Managing Lawyer, Goulburn Valley Community Legal Centre, and Mr Peter Noble, Coordinator, Loddon Campaspe Community Legal Centre, Submission, 31 October 2013.

1186 For a discussion of JR approaches in the United States and United Kingdom, see National Association of Community Legal Centres, *Submission to the Senate Standing Committee on Legal and Constitutional Affairs, Inquiry into the value of a justice reinvestment approach to criminal justice in Australia*, NAACL 2013.

1187 See also evidence of Mr Gino Vumbaca of the Australian National Council on Drugs, Mr Vumbaca told the Committee that the cost of putting a non-violent person with drug-related problems into prison compared to rehabilitation was 'far more expensive':

'If a non-violent drug offender goes to prison and a non-violent drug offender goes to residential rehab...what are the cost implications? What are the cost-benefit ratios of these and the long-term outcomes? [Economic evaluations] come down on the side that you get much better outcomes from residential rehab than you do from prison... The reality is that if you put people in prison, sure they are not on the streets offending or using at the time, but they are going to come out. You have to release those people after an average of six to nine months, depending on what jurisdiction you are in. You are not improving the lot of the community or that individual or their family if you do not deal with the drug use problem and they are released from prison.'

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

changes to increase efficiencies, and measure both the fiscal and public safety impacts of those changes.”¹¹⁸⁸ In effect, it means a change in bail, sentencing, parole and release policies that see more low-level offenders (in particular) released into the community on programs and the resulting financial savings invested in improving their neighbourhoods, especially housing opportunities, and the provision of better health, job training, education and sporting facilities. Limited government resources are effectively targeted at communities where most offenders come from and return to... [t]he logic of JR as a means of breaking the cycle of recidivism and averting the rapid growth in costs of the prison industry while making the community a safer place for all [is attractive].¹¹⁸⁹

Key aspects of justice reinvestment

The mechanics of justice reinvestment rely on the twin features of *justice mapping* and *asset mapping*. Justice mapping involves compiling and analysing data on the geography of criminal offending including identifying the high risk, high crime neighbourhoods to which many people return after prison. Asset mapping on the other hand involves identifying social capital — the various community assets in these at-risk neighbourhoods which are potentially a source of strength and social cohesion, including governmental, non-government, civic, cultural, sporting, or religious organisations.¹¹⁹⁰ These may include specialist or culturally specific agencies such as Aboriginal or ethnic groups:

Consideration is given to how these assets might be strengthened through policies and programs which engage with offenders, such as job creation programs, mentoring schemes, educational or drug and alcohol programs (Brown 2013, p.36).

The concept of JR has generally been well received from a disparate range of stakeholders, including community workers, lawyers and economists. For example, Magistrate Peter Mellas from Warrnambool told the Committee that even on a basic economic level the approach made sense:

If you can spend money preventing a problem arising, or preventing something becoming a problem, you are going to spend less dealing with the consequences of it over time. It is a good use of economic resources, if you can identify the good programs... Places like Texas, states right across the United States which were previously quite focused on locking people up, and now their own people are saying, ‘This is costing us a lot of money, there has to be a better way of allocating the resources’. In some ways it is a purely economic decision. What is the best way to spend the money that we have in terms of outcomes? Whether you call it justice reinvestment, or [therapeutic justice] with courts like the drug court, the mental health court, the Justice Centre in Collingwood, they can all point to the benefits of having spent money there.

This is not to say that you shut the jails because there will always be cases where a term of imprisonment should be imposed, should be served and is absolutely appropriate, but if there are other ways of doing it, then you are really benefiting the community on a much wider basis, I think.¹¹⁹¹

There have, however, been some caveats to this endorsement. It has been argued for example that for JR approaches to be successful they must also be culturally appropriate or sensitive to the needs of specific populations, including Aboriginal and disabled offenders, young people, people in rural and regional areas, and women.¹¹⁹² Moreover, JR resource allocation should not be ‘used as a screen behind which a strategy of disinvestment in prison programs and services takes place’ (Brown 2013, p.38). Nonetheless, as a concept and a practical

1188 Council of State Governments <http://csgjusticecenter.org/jr/> (viewed 25 October 2013).

1189 Ms Karen Gurney, Managing Lawyer, Goulburn Valley Community Legal Centre, and Mr Peter Noble, Coordinator, Loddon Campaspe Community Legal Centre, Submission, 31 October 2013.

See also the comments of Mr Peter Mellas, Warrnambool Magistrates’ Court, Public Hearing, Warrnambool, 3 March 2014.

1190 See discussion in Chapter 22.

1191 Mr Peter Mellas, Warrnambool Magistrates’ Court, Public Hearing, Warrnambool, 3 March 2014.

1192 National Association of Community Legal Centres, *Submission to the Senate Standing Committee on Legal and Constitutional Affairs, Inquiry into the value of a justice reinvestment approach to criminal justice in Australia*, NACL 2013.

strategy to address criminal offending particularly in the current economic climate, JR is increasingly being viewed by policy-makers as an option worth considering.

In particular, in the context of drug-related offending, the reassignment of financial allocations from the housing of offenders in prisons to their diversion to treatment and support services is viewed as not only a way of reducing prison populations and stopping recidivism; it is also seen as a relatively cost-effective way of addressing the *causes* of drug-related crime rather than dealing with the symptoms in the short term¹¹⁹³ (Smart Justice 2014).

Conclusion

Diversionary programs and alternative justice approaches such as specialist courts and support services cannot be the ‘magic bullet’ that will prevent or reduce drug-related offending. Nonetheless, the types of programs outlined in this chapter may give drug-related offenders a ‘window of opportunity’ to turn their lives around. Dr Roger Volk of the SEADS program told the Committee that the beauty of diversion programs, be they police cautioning, structured programs such as CISP or alternative courts such as the Drug Court is that they ‘get people through the door’ as a way of having a conversation with offenders about their ice or other addictions.¹¹⁹⁴

Diversion programs, partnership policing, alternative courts, therapeutic justice and justice reinvestment are ways of addressing the problems related to relatively low level drug offending from a different perspective. As Magistrate Peter Mellas told the Committee:

Once upon a time there was a very blunt tool kit: you did something wrong, you got punished, and it was something that either hurt you financially or hurt you in terms of taking away your liberty. We moved on from that to then trying programs that addressed the reasons why you were offending, and that became probation and community corrections orders. We have now come to the conclusion that perhaps even before you do that, that whilst the person is before the court and under the court’s control you try something at the bail stage and therefore you have programs like CISP, you have programs like CREDIT/bail, the therapeutic justice ideas... The more tools we have, the more you can tailor them to a particular person’s needs.¹¹⁹⁵

Despite there being some excellent diversionary processes and alternative dispositions to incarceration in Victoria at both the arrest, pre-trial, trial and sentencing stages, the programs and interventions can only work in as much as there are sufficient support and treatment services to be referred to. Intensive wraparound programs that address criminal offending in a holistic manner are needed to support such diversionary interventions. But many witnesses have told the Committee that, particularly in rural and regional areas, these services are relatively few.¹¹⁹⁶

Some witnesses have also noted a system of ‘postcode justice’ or a two-tiered justice system whereby different approaches are available to and used by, or not as the case may be, by magistrates and judges in Victoria depending on the sentencing and support options

1193 For example, after successfully implementing a justice reinvestment program, the conservative American state of Texas achieved a saving of \$210.5 million in 2008-2009 in their justice expenditure. It halted the growth of its prison populations by undertaking policies including funding for substance abuse programs and halfway houses for those on parole and increasing access to education opportunities in prisons. It also rechannelled monies it saved from not incarcerating prisoners into expanded specialist courts such as drug courts thereby addressing the causes of offending (Smart Justice 2014).

1194 Dr Roger Volk, Forensic and Other Drugs Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

1195 Mr Peter Mellas, Warrnambool Magistrates’ Court, Public Hearing, Warrnambool, 3 March 2014.

1196 See for example, Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Public Hearing, Melbourne, 17 February 2014.

available to them.¹¹⁹⁷ For example, the CISP is only available in three Magistrates' courts and the Drug Court of Victoria is limited by a fairly restricted catchment area. Again this can adversely impact upon people in rural and regional centres of Victoria. 'People in those environments will get different outcomes and probably have different success in terms of addressing their drug use and their social issues just because of where they live.'¹¹⁹⁸

Notwithstanding these criticisms, there has certainly been a marked shift in conceptual approaches to addressing drug-related crime. The move towards therapeutic justice and justice reinvestment models including the establishment of specialist courts and support services shows great hope as a 'circuit breaker' in attracting bipartisan approach to criminal justice policy that moves away from the 'law and order auction' and reinvests in social capital (Brown 2013).

Such approaches not only contribute to safer communities by addressing the underlying social issues that contribute to offending behaviour, they are arguably also more cost-effective as they may not require extra expenditure but merely reallocation of funding that has already been assigned to corrections.¹¹⁹⁹

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).

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.

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.

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.

1197 Postcode justice was examined by the Rural and Regional Committee of the Victorian Parliament in 2010.

That Committee recommended that strategies be developed to ensure access for rural and regional Magistrates' Court participants at locations which do not have access to the specialist courts and court programs available at larger centres. The Government supported in principle this recommendation and committed to examining ways in which access to specialist courts and court programs in regional areas could be extended.

See *Victorian Parliamentary Inquiry into the Extent and Nature of Disadvantage and Inequality in Rural and Regional Victoria 2010* and Coverdale, R (2011) and the Government Response to its recommendations at:

http://www.parliament.vic.gov.au/images/stories/Victorian_Government_Response_to_the_Inquiry_into_the_Extent_and_Nature_of_Disadvantage_and_Inequity_in_Rural_and_Regional_V.pdf

See also *Postcode Justice: Rural and Regional Disadvantage in the Administration of the Law in Victoria*, Centre for Rural and Regional Justice, Deakin University.

1198 Mr Peter Noble, Coordinator and Lawyer, Loddon Campaspe Community Legal Centre, Public Hearing, Bendigo, 25 October 2013.

1199 National Association of Community Legal Centres, *Submission to the Senate Standing Committee on Legal and Constitutional Affairs, Inquiry into the value of a justice reinvestment approach to criminal justice in Australia*, NAACL 2013.

PART G

Prevention, Education, Training and Information Provision

22. Prevention Strategies to address Methamphetamine Use — Promoting Resilience and Reducing Risk Factors

Introduction

Addressing methamphetamine use and abuse is more than dealing with the problems once they have occurred. Prevention strategies should be paramount. However, prevention is more than simply supplying information about a drug in the hope that it will deter people from commencing or continuing its use. It requires whole of community strategies that reduce the risk factors leading to problematic drug use whilst promoting the factors that may contribute to wellbeing and healthy lifestyles.

In 2001 the Ministerial Council on Drug Strategy commissioned the landmark research review *The Prevention of Substance Use, Risk and Harm in Australia*. This comprehensive work, written by some of the foremost experts in drug policy in the country:

[t]rawls the existing evidence base to capture the essentials regarding ‘what works’ in the prevention of substance abuse problems [including alcohol]. It brings together what is known about the prevention of drug use, risk and harm in the Australian community (Loxley et al. 2004, p.3).

Prevention refers to those 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). Delaying the onset of drug use is one of the most important aspects of prevention approaches as:

[d]rug use and heavy drug use in the early years have been associated with a range of harms (young people may be more socially, physically and mentally vulnerable to some risks associated with drug use) and higher risk of a range of problems later in life (such as continued drug use, criminal involvement, poor educational outcomes, mental health problems) (Allsop 2012, p.173).

Prevention strategies are particularly important in the context of young people, especially vulnerable young people whose life circumstances may act as powerful incentives to experiment with, or even become dependent on, drugs such as ice. As such, much of this chapter examines how strategies can reduce the risk factors associated with adolescent drug use. Such strategies may also increase the protective factors that can boost a young person’s resilience and sense of self-worth.

Levels of prevention

Prevention models for addressing drug use have traditionally invoked three levels of prevention:

Primary prevention (e.g. preventing the uptake of any illicit drug use); *secondary prevention* (e.g. reducing the uptake of risky methamphetamine use, such as preventing the transition from oral to injecting drug use; and *tertiary prevention* (e.g. reducing behaviours or practices that lead to significant social and/or individual harms, such as reducing the risk of overdose) (Allsop 2012, p.174).

Allsop observes that an alternative structure has been used in the United States that also employs three levels of intervention. These are:

universal prevention (targeting whole populations); selective prevention (targeting specific groups who have above average risk); and indicated prevention (targeting individuals with emerging problems) (Allsop 2012, p.174).

There is significant overlap between these systems and both approaches have been used in Australia. However, as Allsop indicates, the important point to note is that irrespective of the favoured model:

[i]t is evident that there is no single approach to prevention and there is a need to consider diverse approaches and strategies targeting distinct issues, contexts, behaviours and/or populations. Effective prevention in relation to [methamphetamine] use is likely to include a range of strategies, from whole-of-community approaches that aim to prevent the uptake of [methamphetamine] use, to more targeted programs aimed at those who are currently using (Allsop 2012, p.174).

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 and harm reduction measures. For example, Mike Sabin, MP, who contributed to the development of New Zealand’s *Tackling Methamphetamine Action Plan*, stressed how incredibly important prevention was as a strategy to address crystal methamphetamine use. He believed that it was often ignored in favour of supply side and treatment approaches:

What you typically find, if you look across countries like Australia and New Zealand, is some tried and true supply reduction initiatives. You see — well, not tried and true but — a number of treatment initiatives, and then you see a smattering of demand reduction initiatives. What we tend to find, in my view, is that the vast amount of resources tends to be put into reactive stuff around supply reduction and reactive stuff around treatment because obviously treatment is occurring because people have gone on to use. There is very, very little emphasis on and effort in the prevention of drug use in the first place. It is a highly preventable problem.¹²⁰⁰

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.¹²⁰¹

Geoff Munro from the Australian Drug Foundation also spoke to the importance of prevention in addressing methamphetamine and other drug use when he gave evidence to the Committee:

[You need to make] investment in *prevention*. If you look at the three pillars that underpin the Australian drug strategy, they are harm reduction, demand reduction and supply reduction. If you look at the history in Australia, you can see the police have been funded enormously to deal with issues around supply. They have done some amazing work. We have also done some really good work around harm reduction through the treatment services... The area where we struggle quite a lot is investing in prevention. We actually need to move upstream on this issue; we need to be talking about the issues and actually stop people getting into harm and stop people getting into problems with drugs, and we need a systematic, integrated, long-term approach to the prevention of drug problems.¹²⁰²

As Mr Munro indicated, prevention strategies are a key part of the demand reduction pillar of the National Drug Strategy. The Strategy recognises that demand reduction/prevention

1200 Mr Mike Sabin MP, Member for Northland, New Zealand Parliament, Public Hearing, Melbourne, 5 June 2014.

1201 Mr Mike Sabin MP, Member for Northland, New Zealand Parliament, Public Hearing, Melbourne, 5 June 2014.

1202 Mr Geoff Munro, National Policy Manager, Australian Drug Foundation, Public Hearing, Melbourne, 14 October 2013.

See also the comments of Dr Andrew Crellin, Director of Emergency, Ballarat Health Services, Public Hearing, Ballarat, 18 November 2013, on the importance of having good prevention models in the context of methamphetamine use.

approaches, particularly those based on education provision, will vary by drug type. Whole of population strategies may be appropriate for widely used legal drugs such as alcohol and tobacco. However, *targeted* strategies aimed at 'at risk' groups are more appropriate for drugs such as methamphetamine, which are used by only a small section of the population (Ministerial Council on Drug Strategy 2011).¹²⁰³

In particular, modern approaches to prevention strategies focus on a number of issues and factors that are not specifically related to 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).

The Principles for School Based Drug Education, for example,¹²⁰⁴ recognise that preventing young people from commencing drug use requires more than just didactic classroom instruction. It requires a comprehensive approach to prevention that understands this interaction of risk and protective factors:

The Principles draw on more recent research literature on youth development and resilience in determining the health of young people. This research stems from a range of disciplines that are now beginning to overlap, including epidemiology, social capital and life trajectory studies. It is now clear that young people's attachment and connection to others, through the quality of their relationships and their social environments, affects their health and academic achievement. We now know that the culture, relationships and opportunities in schools contribute to young people's social and academic outcomes and that these are relevant to a range of behaviours including drug use. Without reducing the role of drug education programs, research is demanding a shift in focus so that curriculum and classroom learning is seen as part of a broader and comprehensive approach to drug prevention and minimising drug-related harm for students and the school community (Commonwealth of Australia 2004, p.6).

Approaches to drug prevention

A variety of prevention models have been used which centre on reducing risk factors that may lead someone to use drugs and augmenting the protective factors that may stop the uptake of such drug use.¹²⁰⁵ Social capital investment, public health systems and developmental pathway models are three such key approaches. These approaches are particularly important in the context of children and young people.

Social capital

Social capital is based on the idea that societies need to invest in the developmental health of human populations and communities at each level (national, state and local). It argues that any social policy addressing human needs (including those addressing substance abuse) must take into account the developmental needs of children. In other words, to address simply the symptom of the problem (using crystal methamphetamine) will do little to address the underlying causal issues. Healthy communities are assisted to support their youth from an early age. Keating, one of the key theorists of the development of social capital, argues that:

- The key necessities for supporting healthy child development are income, nutrition, childcare, stimulation, love/support, advocacy and safety.

¹²⁰³ See also the discussion on targeted versus general models of drug education in Chapter 23.

¹²⁰⁴ Discussed extensively in Chapter 23.

¹²⁰⁵ See discussion in Chapter 13 for an account of risk and protective factors.

- Our societies have under-invested in development in the early years (0–5 years), compared to the school-age years, despite research that identifies that these early years are most important.
- To improve the quality of human development, attention needs to be paid to all levels of social aggregation: family, neighbourhood, school and the national socioeconomic environment (Keating cited in ANCD 2001, p.22).

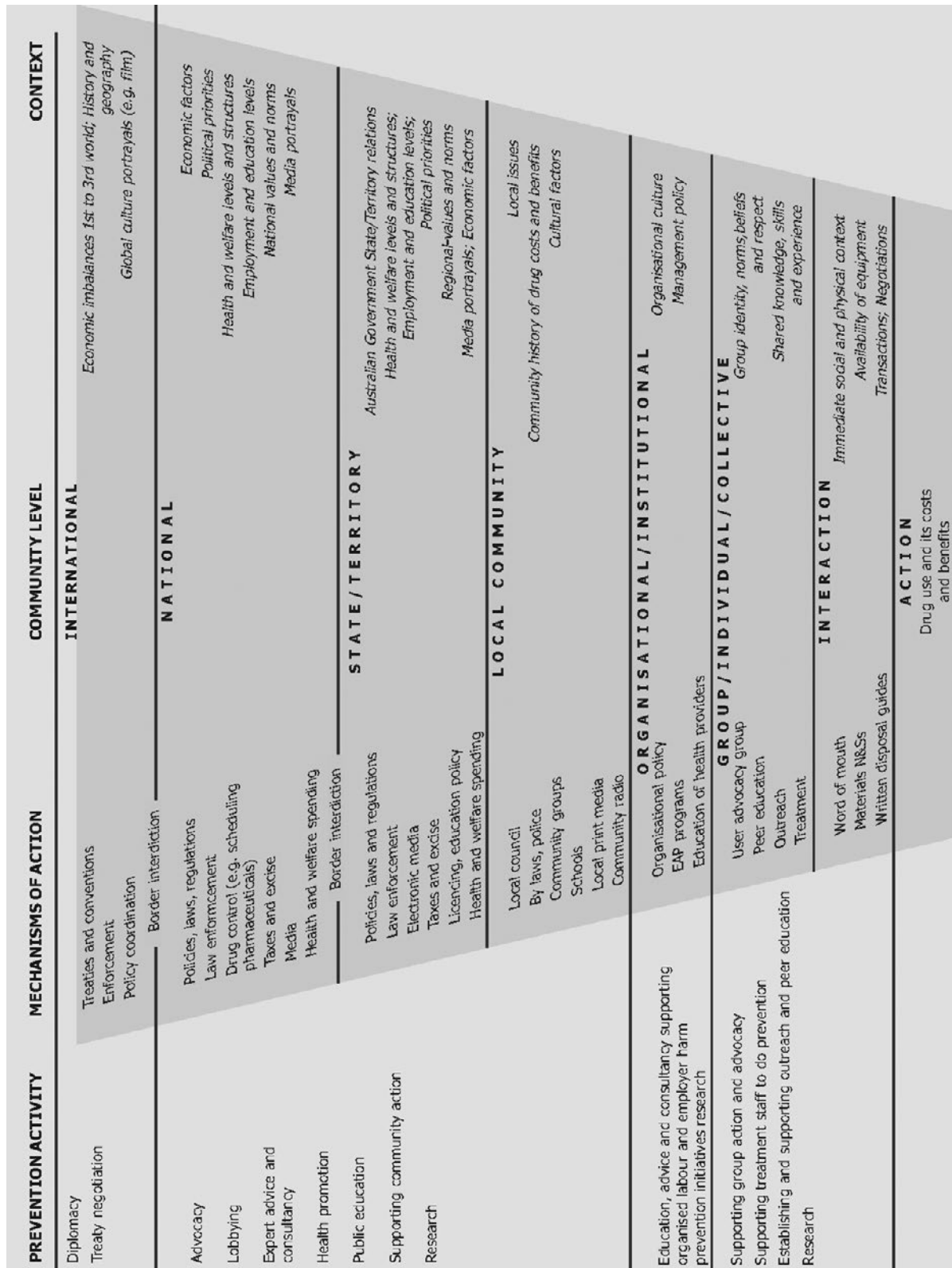
Keating examined the costs of failing to provide supportive contexts for developmental health, in terms of reduced school performance, increased antisocial behaviour, and reduced work participation:

He identified significant cost benefits from investing in child development. These cost benefits were greatest, up to \$7 return for every \$1 invested, when the investments were made in the deprived sectors of the population. This finding is consistent with other reviews of the cost benefits of early childhood interventions (ANCD 2001, p.22).

The public health systems model of drug prevention

Another key drug prevention model promoted by Australian academics and policy makers is the public health systems model of drug prevention. Dr Simon Lenton of the National Drug Research Institute (NDRI) developed the public health systems model from an earlier model by American academic Harry Holder. The model is presented as Figure 22.1.

Figure 22.1: A Systems model for the prevention of alcohol and other drug problems



Source: Adapted from Lenton 1996, cited in Loxley et al. 2004, p.9.

The basic concept and relevance of the model is to illustrate the breadth and complexity of drug use prevention, and strategies to achieve it. It demonstrates how prevention initiatives

can be conceptualised and implemented at all levels of society from international treaties to local community action:

The model conceptualises determinants of health and drug use on a continuum from macro to micro: social and structural determinants are distal influences while risk and protection factors are more proximal. The model is both top-down and bottom-up: the macro clearly influences the micro, but equally clearly the micro influences the macro. Activity at any one of the levels can influence not only that level but, indirectly all other levels. This approach allows the mapping of systems, pathways and strategies that connect among and between risk factors, protective factors and drug use outcomes (Loxley et al. 2004, p.6).

Models such as Lenton's exemplify how people live and interact (or don't as the case may be) within local communities:

These systems are often regulated and the regulations are enforced at several levels...[there are] multiple levels of intervention that can contribute to reducing drug-related harms... The jurisdictions in which these apply can vary in scale from shire or town councils, through regional, provincial and national governments and up to the international level (Stockwell et al. 2005, p.10).

The public health systems model places great emphasis on community and environmental prevention strategies to prevent harmful drug use at both an individual and population or community level. Another powerful prevention model taken particularly from the fields of public health, mental health and child development is the developmental pathways model. This model places more emphasis on influencing a young person's psychosocial development to prevent the uptake of licit or illicit drug use.

Risk and protection (developmental pathways) model

The developmental pathways approach to drug prevention examines some of the early pathways to a variety of psychosocial and antisocial problems and behaviours including crime, mental illness, and suicide and drug abuse. The model is particularly applicable to preventing the onset of drug abuse and the manifestation of antisocial behaviour in children and adolescents.¹²⁰⁶ Just as the public health systems model concentrates on the wider context of raising healthy, cohesive and productive communities, so too the developmental pathways model does not necessarily concentrate on alcohol or other drug use per se. Rather its emphasis is on developing healthy and resilient children who will not feel the need to use illicit drugs. However, while the optimal situation may be to start developmental prevention programs at a very early age, evidence suggests that prevention interventions can be beneficial even up to adolescence and beyond (Stockwell et al. 2005; Loxley et al. 2004).

The developmental approach to prevention suggests that there are different and varied 'pathways' that people, particularly young people, can choose in life which are shaped by the choices and experiences offered them:

Pathway changes or 'transition points' occur that can be either supported or undermined by a range of risk and protective factors. Effective approaches to prevention that seek to intervene at these transition points and increase protective factors, reduce risk factors and build *resilience* can result in positive outcomes across a range of health and social problems, including drug misuse. Such interventions will be most effective if they address risk and protective factors across multiple levels including economic, social and cultural factors (Alcohol and other Drugs Council of Australia (ADCA) 2003 pp.1-2).

Toumbourou and Catalano define the concepts of risk and protective factors as follows:

Developmental risk factors can be defined as prospective predictors that independently increase the probability that an individual or group will engage in patterns of drug use that have been linked to

¹²⁰⁶ As opposed to what are sometimes called tertiary prevention initiatives, which are aimed at reducing the harms to people with existing drug problems. See Chapter 26.

drug-related harm. Developmental protective factors are those factors that mediate or moderate the influence of risk factors (2005, p.53).

Risk factors in this model range from the:

distal (e.g. early developmental and social) to more proximal (patterns and places of drug use) factors that can be shown to predispose towards harmful drug use. Similarly, protective factors have been identified in the early developmental and social literature that are associated with a lowered likelihood of later drug-related harms for those with a high number of risk factors. This concept of protection can be expanded to incorporate more proximal factors such as reduced drug availability and low risk patterns of use (including abstinence). Many harm minimisation strategies can also be defined as protective factors (Loxley et al 2004, p.7).

A list of the major protective and risk factors associated with the use of illicit drugs is attached in Chapter 13, Table 13.2.

Developmental prevention strategies

To address risk factors that can lead to drug abuse, strategies need to be developed that are not, or not only, directed to the substance use per se. Developmental prevention programs that have the ultimate aim of making children (and adults) resilient to drug taking and other forms of antisocial behaviour need to target different age groups and social settings.

A number of such strategies have been developed to address these types of developmental risk factors in order to prepare children to avoid drug or alcohol use later in life. Many of these are not drug or alcohol specific. For young people they may involve life skills programs taught in schools and recreational and leisure opportunities. For parents, parental guidance education and strategies may be helpful (Midford 2009).¹²⁰⁷ For children and adolescents of all ages, mentoring programs have proven worthwhile.¹²⁰⁸ And for children who have become disengaged from school, appropriate employment opportunities might reduce the risk associated with drug use. These types of approaches rather than didactic 'Just say no' interventions are more suitable prevention approaches in the long term according to health promotion and marketing expert Professor Melanie Wakefield:

I am quite impressed by some of the school based programs that are much more about resilience training for kids, social skills training, not just programs to sort of 'Say no to drugs'. I think they are too shallow. More the core skills of being an adult — respecting yourself, knowing what your values are and those sorts of things. I think there are some of those programs out there that could be fairly generic but very useful for not just methamphetamine use but have other benefits as well. You could frame it from that point of view and introduce them as they come into secondary school.¹²⁰⁹

One innovative school based approach that addresses the healthy development of young people is that introduced into Mildura schools by the Tristar Medical Group to engage with young people who were at risk of developing mental health problems or of using drugs. Brett McKinnon explained how the program worked in evidence to the Committee:

We have a school model that we started in the last 12 weeks, where we have supplied a mental health nurse and a GP to one of the local senior colleges that is, the years 11 and 12 cohort. We provide education and training for the education staff and for the student cohort in and around mental health issues but also drug and alcohol issues... the education and training is in and around mental health

1207 Such programs have been developed on the basis that 'parents can have a major influence on their children's drug use behaviour through modelling, attitudes and family relationships and there has been increasing support for this approach as effective primary prevention for young people' (Midford 2009, p.1689). One such program discussed by Midford is the *Strengthening Families Program for Parents and Youth* developed by Spoth. This evaluated program showed that providing brief family skills training increased parenting skills, strengthened family relationships and reduced drug use by young people (Midford 2009, p.1689).

1208 See discussion below.

1209 Prof. Melanie Wakefield, Centre for Behavioural Research in Cancer, Cancer Council Victoria, Public Hearing, Melbourne.

conditions but also the negatives of drug and alcohol use and abuse in the longer term. We are effectively saying you are playing Russian roulette with your brain by partaking in some of these recreational drug-taking habits.

...that is where it needs to start; getting in early and educating people as adequately as possible as a preventive measure, rather than playing catch-up at the back end where you have people who are already affected by the substances.

In senior college –[this] is often the time we are seeing the first onset of illness, and it is often the time when people are first starting to dabble in some of these recreational substances as well. We are hoping to have a huge impact. We already have a similar model up and running in Bendigo Senior Secondary College, and it has been getting rave reviews from the college community. Other secondary colleges within the district have also approached us to see if they can have a mirror service operating out of their schools and so forth.¹²¹⁰

Recognising that drug use may commence earlier for some students Mr McKinnon told the Committee that they plan to expand the program to younger students in the Year 7 to 10 demographic.¹²¹¹

Holistic approaches

It is imperative that developmental strategies need to work across and, where relevant, be coordinated with different government and non-government sectors such as health promotion, education, crime prevention and recreation and leisure. A multi layered community wide approach rather than narrowly restricting drug and life skills education to the school classroom are optimal (Midford 2009).

Table 22.2 sets out a range of multilayered prevention strategies that can be applied in different settings.

1210 Mr Brett McKinnon, Manager Mental Health Services, Tristar Medical Group, Public Hearing, Mildura, 5 December 2013.

1211 Mr Brett McKinnon, Manager Mental Health Services, Tristar Medical Group, Public Hearing, Mildura, 5 December 2013.

Table 22.2: Definitions of prevention strategies

Prevention strategies (Settings)	Definitions
Family setting — family services Preventing and delaying pregnancy in young and vulnerable mothers	The use of a broad range of programmes designed to prevent pregnancy among teenagers and vulnerable mothers. Strategies include delaying the initiation of sexual activity, encouraging the use of contraception, reducing risky sexual behaviour and providing access to pregnancy termination.
Family home visiting	A professional such as a nurse developing a relationship with a vulnerable family over a period of time in the context of offering, support, information and advice on pregnancy, infant health, maternal health, and advocacy for service access.
Parent education	One or more parents (or carers) receiving information and/or engaging in a course of instruction aimed at encouraging healthy child development.
Family intervention	One or more parents (or carers), children and other family members receiving information, engaging in a course of instruction and/or obtaining therapeutic assistance together aimed at encouraging healthy family development.
School setting — school services School preparation programmes	Programmes aimed at better preparing children for the transition to school.
School organisation and behaviour management	Includes interventions to maximise learning opportunities, encourage positive interpersonal relationships at school, and policies and procedures to ensure effective discipline.
School drug education (curricula)	Delivery of a structured social health education curriculum within the school usually by classroom teachers, but in some cases by visiting outside professionals.
Peer settings	
Peer intervention and peer education	Youth peers of common identity provide support or deliver a health message.
Youth sport and recreation programmes	Provision or utilisation of recreational opportunities outside the school setting to promote the positive development of children and young people.
Mentorship	Strategies to develop prosocial relationships between youth and positively functioning adults within the community.
Community setting — Locally, Regionally or State coordinated programmes	
Community-based drug education	Adolescent drug education curricula or information delivered in a community setting other than in schools.
Preventative case-management	Coordinated delivery of more intensive services tailored to meet a range of developmental needs. Generally targeted to children and adolescents with multiple risk factors.
Community mobilisation	Campaigns to initiate or strengthen an explicit strategy of coordinated community action aiming to advance community conditions for healthy development in children and young people
Health service reorientation	Includes reorientation of existing health services to enhance service access for vulnerable families and to modify factors that can otherwise disrupt healthy development.
Employment and training	Includes provision of pre-employment assistance, employment experience, training or intervention in a post-school training setting, with the aim of ensuring developmental outcomes.
Law, regulation, policing and enforcement	Modification to and enforcement of legislation or regulations, policing strategies and procedures for dealing with offenders aimed at reducing access to substances and preventing initiation or escalation of youth behaviour problems.
Social marketing	Use of the mass media to promote a health message.

Source: Adapted from Toumbourou et al. Cited in Stockwell et al. 2005, p.89.

Developmental strategies to prevent the ‘snowballing’ of risk factors

It would seem obvious to state that the more risk factors that accumulate in a person’s life over a long period of time the greater will be the developmental impact. Conversely, it is rare that any single risk factor ‘lies at the heart of developmental problems’ (Loxley et al 2004. p.72). However, as Loxley et al. state, it is undeniable that the cumulative effect of multiple risk factors can be likened to a ‘snowball effect’, with subsequent risk factors building upon any earlier problems. The higher number of risk factors the greater the chance that children may subsequently progress to harmful drug use (Toumbourou & Catalano 2005).

Conversely, however, if interventions are implemented to reduce or eradicate one risk factor this may prevent the acceleration or accumulation of consequent problems:

For example, the reduction of a risk factor such as academic failure is likely to lead to greater completion of high school, increased attendance at college and greater job opportunities, all of which can be costed as benefits of early school-based prevention efforts. Likewise, pre and postnatal home visits by public/community health nurses not only reduce material substance use and arrest rates, of the mother and eventually the child, but also reduce rates of substantiated child abuse and neglect that represent additional cost savings of this approach (Loxley et al 2004. p.243).

In addition, an important finding coming from developmental prevention studies is that by improving key developmental environments such as prenatal services, preschools and parenting programs there can be benefits for *all* children, even if the greatest benefits may be for those most vulnerable and disadvantaged (Stockwell 2005).

Promoting resilience in early childhood

A key aspect of the developmental pathways model is the promoting of childhood resilience as a protective factor in preventing antisocial behaviours such as drug abuse in later life.

The importance of early childhood interventions including the nurturing of protective factors and the reduction of risk factors was raised by a number of witnesses to the Inquiry.

For example, Dr Paul MacCartney from Primary Care Connect in Shepparton told the Committee that strengthening the protective factors in young people needs to start almost at birth:

The question is, and it is an age-old question: what can we do to prevent these kids using drugs? The first thing, in my opinion, is that you have to identify the children who are most at risk. While I am sure you have heard evidence that there are all sorts of people in the community who are at risk of using this drug, the significant proportion of people in those who end up fronting the courts and those sorts of things are from a particular demographic, where there might be intergenerational unemployment and intergenerational drug use. I do not believe that we do enough to identify those children who are in that environment.

The evidence around the world is that drug education does not make that much difference in schools, but what does make a difference, 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... people who did not receive that support.¹²¹²

Dr MacCartney suggested that a program where a hospital or maternal health care service assisted an ‘at risk’ or vulnerable mother from the time of the child’s birth with a variety of ongoing parent guidelines and child raising strategies could do much to prevent problems for both parent and child further down the track.

1212 Dr Paul MacCartney, Medical Practitioner, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014.

Rudolph Kirby, Chief Executive Officer of Mallee District Aboriginal Services (MDAS) also stressed the importance of nurturing children and their parents from birth to avoid problems relating to child development later in life:

I think in our organisation, our priority at the moment is that we are investing upstream. Our biggest priorities are from conception to four years of age, and to eight years of age. This is where the least investment is made by government. We know that, if we can invest there, we can change the next generation.

‘Key ages and stages’, it is a model that we have just won a number of awards on. We know that, if we get the attachment theory right with mum and dad, the protective factors kick in where mum and dad want to protect the child. We know that the brain develops from nought to four. We know that, if you get it right there, all those other things downstream we can deal with. We cannot say it is not going to happen but as an organisation we believe that we need to invest in the next generation to close the gap.¹²¹³

Mr Kirby told the Committee that MDAS had developed an intensive support program based on social capital and social development principles for vulnerable parents in the local Aboriginal community — the *Bumps to Babes and Beyond* program:

We have this model called *Bumps to Babes and Beyond*. It is an intense case management model, and it works as a wraparound service. At MDAS we have a one-stop shop. We provide everything from housing to health to family services, child protection — you name it, we do it. What we provide is intense support. We were working with 10 families in particular. Only the high-risk ones, and if you take into consideration all the other vulnerable factors in the Koori community, we work with 10 of the most high-risk mums and dads. Extremely vulnerable first-time young mums, 17-year-old homeless people. Not one child was removed under this program in the two years it has been running.

This model is about what is in the best interests of the child. So we support mum and dad and link them into all the support services. The reason we set this program up is because when I first became CEO at MDAS I had the case of a 17 or 18-year-old pregnant girl with her first child who committed suicide four days away from giving birth, and ice could have been a contributing factor.

We provide an intensive case management model. Yes, it is cost-intensive, but it actually works. It provides all the support services around housing, health, providing intense support for mum, understanding how to support the child and the key milestones for the child. If you get it right here, if you really want to turn things around in the Koori community around closing the gap, the area to do it in is nought to four. Everything else is bandaid solutions and bandaid responses.¹²¹⁴

John Thompson from Mitchell Partners Advertising also told the Committee that it was essential that instruction on parenting skills for parents and life skills training followed by graded steps in drug education were provided to children:

I would agree that we could start targeting children much earlier by targeting parents-to-be through doctors, through maternal health nurses when they have their children, about the issue of drugs and their impact of taking drugs when they are planning to have children or when they have children. That is the first point. Again, kindergartens could push that gently through, of course... Then at school age you start to introduce some of the more harmful effects of drugs and be a little bit more graphic. I can remember in the eighties being shown pictures of lungs, because they were trying to tackle the issue of childhood smoking. They were quite graphic. However, I do not think I am that disturbed as a result of it.¹²¹⁵

1213 Mr Rudolph Kirby, Chief Executive Officer, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013.

1214 Mr Rudolph Kirby, Chief Executive Officer, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013.

1215 Mr John Thompson, General Manager, Mitchell & Partners, Public Hearing, Melbourne, 24 March 2014.

Prevention for young people — Schools and engagement

There is considerable research-based evidence to demonstrate the links between a lack of education, (or training and employment) and drug taking behaviour. This research suggests that for older adolescents and young adults, being either employed or engaged in vocational training reduces the risk of drug taking. Similarly, for younger adolescents and children, being positively engaged in the education process provides a protective influence in their lives, while disengagement from education is a significant risk factor for antisocial behaviour such as drug use.

Particularly a young person's experience of school can be either protective or exacerbate risks. Indeed, it could be argued that the second most pervasive influence on a child or young person's life, after their family, is their experience with the education system given they spend so much of their time at school.

Schools therefore play a very significant role in the life of most children and young people. A positive experience of school can help a child to overcome developmental deficits and risk factors associated with economic disadvantage, child abuse and neglect, family conflict, and experiences of out-of-home care.¹²¹⁶ Given the significant amount of time children spend in school and the essential role schools can play in building resilience, what happens when a child or young person's experience of education is not so positive? What impact does disengagement from education have on young people who may be at risk of commencing illicit drug use?

The problems of disengagement and poor educational outcomes

According to the *Accountability and Improvement Framework for Victorian Government Schools*, 'Promoting students' engagement in learning and wellbeing at school is an essential goal for all schools' (Department of Education and Early Childhood Development (DEECD) 2009, p.5). The Victorian Education Department defines student engagement as consisting of the following three interrelated components:

Behavioural engagement refers to students' participation in education, including the academic, social and extracurricular activities of the school.

Emotional engagement encompasses students' emotional reactions in the classroom and in the school. It can be defined as students' sense of belonging or connectedness to the school.

Cognitive engagement relates to students' investment in learning and their intrinsic motivation and self-regulation (DEECD 2009, p.7).

These components imply that students who are engaged will attend school regularly, will feel safe and connected to their school and will be motivated to learn. Unfortunately, for many children whose lives are already impacted by family, community and individual level risk factors, fitting in and achieving at school presents another challenge and arena of risk. Thus, while schools can encourage resilience, they can also exacerbate vulnerability when children and young people do not engage with education.

The Committee received evidence indicating that disengagement from school is widespread amongst children and young people who are 'at risk'. Such children do not feel a sense of connection or belonging in the school system; some do not feel safe at school; and many

¹²¹⁶ 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.

struggle with learning. Such children ‘fall through the cracks’ and are not necessarily picked up by the system.¹²¹⁷

The Australian Drug Foundation sees disengagement from school as a significant problem, and suggests that more emphasis needs to be placed on school retention, as disengagement from school, truancy, early school leaving and/or expulsion are common factors contributing to substance use and offending.¹²¹⁸ The Youth Support + Advocacy Service (YSAS) agrees, noting high levels of disengagement among their client population: ‘and significant disconnection from school and educational opportunities’.¹²¹⁹ As discussed later in this chapter, children and young people in out-of-home care face particular difficulties in relation to obtaining a good education.

Why does disengagement occur?

The causes of disengagement from school are myriad and complex. Nonetheless, evidence collected by the Committee emphasised a number of contributing factors that indicate possible opportunities for intervention strategies.

Family background

A child or young person’s family background will influence their level of engagement with the education system. Families vary in the extent to which they can and do provide early experiences conducive to engagement and success at school.

Young children whose parents or carers play with them, read to them, provide stimulating experiences, and set appropriate boundaries on their behaviour, will find the school environment more familiar than those whose parents or carers do not. They are also more likely to have verbal and social skills conducive to school-based learning. Without these skills a child may face difficulties likely to affect engagement at a number of levels (Berthelsen & Walker 2007; Cronin 2008; Bempechat & Shernoff 2012).

Children who come from abusive and neglectful backgrounds are likely to have particular difficulties forming trusting and positive relationships with peers and teachers. They are less likely to feel a sense of belonging and fitting in at school. This can contribute to behavioural, emotional and cognitive disengagement. Even in the absence of actual abuse or neglect, children who come from families where parents lack interest in education can also experience a lack of educational engagement (Berthelsen & Walker 2007; Department for Schools, Education and Families (UK) 2008; Muller 2009; Bempechat & Shernoff 2012).

Springvale Monash Legal Service in evidence to a previous inquiry pointed to the specific problems faced by young people who come from culturally and linguistically diverse (CALD) backgrounds, particularly some students from refugee backgrounds who may have little prior experience of education. They further noted ‘a strong connection between English proficiency, school retention and inclusion in the Australian education system’, which presents a further challenge to CALD students.¹²²⁰

1217 See for example: Mr Les Twentyman, Outreach Youth Worker, 20th Man Fund Youth Services, Submission, 2 October 2013; Ms Micaela Cronin, Chief Executive Officer, MacKillop Family Services, Submission, 21 October 2013; Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS, Submission, 21 October 2013; Mr Rudolf Kirby, Chief Executive Officer, Mildura District Aboriginal Services, Submission, 21 October 2013; Ms Jacqui Watt, Director Client Services, Anglicare Victoria, Submission, 21 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; Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014.

1218 Mr John Rogerson, Chief Executive Officer, Australian Drug Foundation, Submission, 28 October 2013.

1219 Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS, Submission, 21 October 2013.

1220 Submission from Springvale Monash Legal Services to the Drugs and Crime Prevention Committee, *Inquiry into Strategies to Prevent High Volume Offending by Young People*, September 2008.

Learning difficulties

Another factor contributing to disengagement, either on its own, or as a compounding factor, is learning difficulties. Even among children who do not have a specific disability, there is still a wide range of achievement levels and common learning difficulties. As noted above, children who have not been read to, or whose language skills are not well developed, may find learning to read more difficult than others.¹²²¹ Once they begin to fall behind in a key area such as reading, they may struggle to keep up across the board. A lack of academic success early in a child's school life can contribute to cognitive disengagement where they lose interest and motivation for learning. Poor levels of achievement and the cognitive disengagement associated with it are likely to compound over the years as young people find themselves falling further behind their peers. Unless these learning deficits are picked up and remedied, cognitive disengagement may contribute to further emotional and behavioural disengagement, often manifesting as antisocial and bullying behaviour and/or truancy (Department of Human Services 2008).

Transitions

The developmental pathways approach identifies particular periods in a child or young person's life as times of potential heightened risk — for example, when a child starts school, or moves from primary to secondary school. At these transitional times the potential for a child to become disengaged from education is heightened. Where engagement is already weak, transitions will be particularly risky and mild disengagement may deepen. Truancy can become entrenched and in some cases lead to total disengagement.¹²²²

School culture, policies and practices

Schools themselves, through their cultures, policies and practices, can contribute to disengagement. As discussed below there have been concerns expressed that schools rely too heavily on suspension and expulsion as a way of dealing with antisocial behaviour.

Improving engagement and reducing disengagement within mainstream schools

Much of the concern expressed during this Inquiry about disengagement focused on people younger than the compulsory school leaving age of 17 not attending school on a regular basis, with some dropping out of the system completely well before that age.¹²²³

For some of these young people, the emotional, cognitive and behavioural disengagement from education leave them at a severe disadvantage in finding employment in later years.¹²²⁴

The Committee believes it is also important to put in place preventative measures that address disengagement at the earliest stages, before it is entrenched. Doing so will involve both targeted and universal strategies, from the earliest years of schooling through to further education and training, to ensure all children and young people have the best chance of receiving a quality education. Accordingly, the strategies brought to the attention of the Committee are discussed below.

The DEECD has a variety of student engagement and student inclusion policies that seek to wherever possible keep young people part of the school community even where they have been involved in (minor) transgressions of school policies and rules. The following sections outline some of the main policies, guidelines and documents that endeavour to engage

¹²²¹ *The Out-of-Home Care Education Commitment Partnering Agreement*, 2011.

¹²²² See *The Out-of-Home Care Education Commitment Partnering Agreement*, 2011.

¹²²³ See for example, Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Public Hearing, Shepparton, 25 February 2014; Ms Marg Bell, Senior Manager, Adolescent Specialist Support Programs, Shepparton, Berry Street, Public Hearing, Shepparton, 25 February 2014; 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; Mr John Rogerson, Chief Executive Officer, Australian Drug Foundation, Submission, 28 October 2013.

¹²²⁴ Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

students in the school system. Recognising that on occasion circumstances may require the temporary or permanent disengagement of students who have displayed unacceptable behaviours, a discussion of the current provisions with regard to suspension and expulsion from Victorian schools is also given.

Student Engagement Policy

The development of a Student Engagement Policy (SEP) is a requirement of all Victorian government schools. It is the overarching policy concerning student engagement. Principals are responsible for leading the development of the policy in consultation with the whole school community including school councils, students and parents/carers.

Every school is required to have a Student Engagement Policy that articulates the expectations and aspirations of the school community in relation to student engagement, including strategies to address bullying, school attendance and behaviour.

Given that students have varied needs and vulnerabilities a high quality Student Engagement Policy should incorporate a range of universal (school-wide), targeted (population-specific) and individual (student-specific) strategies needed to positively engage students in learning and engage them in the school community.

A high quality policy should also be built on the knowledge that student engagement is influenced by a wide range of factors.¹²²⁵

In reflecting on their engagement strategies and developing or reviewing their SEPs, schools are required to consider the following questions and issues:

- Do school leadership and staff promote a culture of respect, fairness and equality, and foster respectful relationships?
- Is the school environment inclusive and empowering, valuing the positive contributions of students and creating a sense of belonging and connectedness that are conducive to positive behaviours and effective engagement in learning?
- Are there multiple opportunities for students to take responsibility and be involved in decision-making?
- Are there school-wide and classroom processes to identify vulnerable students and those at risk of disengagement from school?
- Are there school-wide and classroom processes for ongoing collection and use of data for decision-making?
- Is there social/emotional and educational support for at risk and vulnerable students?
- Are the school-wide and classroom expectations and consequences for problem behaviour clear?
- Are there multiple opportunities for students to take responsibility and be involved in decision-making?
- Has the creation of physical environments that are conducive to positive behaviours and effective engagement in learning been considered?
- Are the strategies backed by a solid evidence base?¹²²⁶

According to the SEP Guidelines, school based student engagement policies aim to create positive and engaging school cultures, and promote school attendance and positive behaviours through a staged response. Each of these areas is discussed in detail in the Guidelines along with suggestions on how schools might address them.

¹²²⁵ <http://www.education.vic.gov.au/school/principals/participation/Pages/engagepol.aspx>.

¹²²⁶ <http://www.education.vic.gov.au/school/principals/participation/Pages/engagepol.aspx>

Engagement strategies for individual students

As part of the Student Engagement Policy, the DEECD seeks to engage young people within the school system by providing a number of support services that can tailor individual supports to students experiencing difficulties at school.

These include Student Support Groups; Individual Education Plans, Behaviour Support Plans and Attendance Improvement/Return to School Plans.

Specific approaches to engage students in out-of-home care

Children and young people in out-of-home care are at greater risk of disengagement because their life circumstances, history of trauma, disrupted schooling, learning experiences and/or behaviours impact on their learning and school participation. In addition to the standard Student Engagement Policy, separate programs to address the needs of students in out of home care have been developed. The approaches recognise that students in out-of-home care may require particular attention and support to overcome these barriers and achieve positive educational outcomes.

Research indicates that children and young people in the out-of-home care system often have low levels of educational achievement. Studies generally indicate that children subject to guardianship or custody orders across all year levels have much lower mean test scores for reading and numeracy than the general student population.

There has also been a significant amount of international research on the impact of abuse, trauma and disrupted attachment on brain development which can impact on school engagement and performance. Abuse and neglect impact on academic performance in various ways, including reduced cognitive capacity, sleep disturbance, memory difficulties and language delays. There are also impacts on social functioning, including the need for control, attachment difficulties (including attachment to school), poor peer relationships and instability arising from frequent moving.¹²²⁷

To assist the retention of young people in out-of-home care in school, *The Out-of-Home Care Education Commitment Partnering Agreement* was introduced. The Partnering Agreement is a key strategy for addressing school and social disengagement amongst Victoria's most vulnerable children; some of whom may have problems associated with alcohol and drug-related issues:¹²²⁸

This agreement entered into between the Department of Human Services, the Department of Education and Early Childhood Development, the Catholic Education Commission of Victoria and Independent Schools Victoria 'commits all parties to improve the educational experience and outcomes of children and young people in out-of-home care in Victoria.'¹²²⁹

The Education Support Guarantee

As part of the Partnering Agreement, an Education Support Guarantee for children and young people in out-of-home care has also been established and commits schools and education-related health and wellbeing services and programs to provide an increased level of support and responsiveness to the educational needs of children and young people in out-of-home care. Specifically, the Guarantee provides for:

- Allocation of teacher or staff member as a learning mentor to each child or young person in out-of-home care enrolled in a school
- Prioritisation of referrals for children and young people in out-of-home care to education related health and wellbeing services to ensure that these services are highly accessible and responsive to the needs of this group

1227 *The Out-of-Home Care Education Commitment Partnering Agreement*, 2011, p.4.

1228 See Chapter 13 for a discussion of young people in out of home care and ice use.

1229 *The Out-of-Home Care Education Commitment Partnering Agreement*, 2011, p.1.

- An educational needs assessment for every student who has resided in out-of-home care for a period of three months or longer to identify their individual learning needs and to inform their Individual Education Plan
- Priority status for post-round applications to the Program for Students with Disabilities for children and young people in out-of-home care enrolled at a government school
- Checklists outlining the commitments and responsibilities for schools and case managers from DHS or community service organisations when a child or young person enters out-of-home care or when they are enrolled at a school.¹²³⁰

Learning Mentors

As part of the Agreement a system of ‘learning mentors’ have also been established. A learning mentor is a teacher or staff member within a school who is designated to support the educational needs of a child or young person in out-of-home care, help them stay connected to their schooling and overcome barriers that may be affecting their learning:

This person may not be directly involved in teaching the child or young person but should be a trusted staff member willing to take on this role. The learning mentor should be identified by the Principal or their delegate in collaboration with the child or young person. The Principal or their delegate should consider who is the most appropriate staff member to take on this role taking into account their skills, experience, workload and relationship with the child or young person. The staff member should then be approached to seek their agreement to take on the role, ensuring they understand the functions and responsibilities of the role. This role is voluntary and should not be imposed on a staff member or the child or young person.

The learning mentor is a role model, guide and advocate for the child or young person — someone who knows them well and takes an interest in their life and learning. The learning mentor is not a counsellor or person to send the child or young person to when they have behaved inappropriately. Unlike other types of mentoring, the learning mentor focuses on supporting the child or young person in their learning, academic achievement and wellbeing within the learning environment.^{1231 1232}

The allocation of a learning mentor is a strategy that has been shown to be effective in improving the learning, engagement and school experience for vulnerable children and young people. The use of learning mentors has been evaluated in the United Kingdom and shown to have had positive benefits for young people particularly from disabled and out-of-home care backgrounds. In particular, school retention and engagement and learning performance has been shown to be systematically improved when a learning mentor program is implemented in the school (Cruddas 2005).¹²³³

School suspension and expulsion

There may be circumstances when despite the efforts made to engage and retain at-risk students in formal education, the young person’s behaviour may be so problematic that it is thought there is little choice but to instigate disciplinary proceedings including suspension and as a last resort expulsion. *The Principles for School Based Drug Education*, for example, clearly state that wherever possible punitive measures such as suspension and expulsion should be used as a last resort particularly with regard to students who may have been using illicit drugs:

1230 *The Out-of-Home Care Education Commitment Partnering Agreement*, 2011, p.6.

1231 *The Out-of-Home Care Education Commitment Partnering Agreement*, 2011, p.37.

1232 For a full discussion of the responsibilities and roles of a learning mentor see *The Out-of-Home Care Education Commitment Partnering Agreement*, 2011, p.37.

1233 Learning mentors are to be distinguished from general or community mentors. For a discussion of community mentoring, see later in this chapter.

Some responses to drug use can marginalise and stigmatise students. Punitive-based school policies and responses to drug use are not productive and can lead to negative consequences. Schools can provide effective support to those who are at risk by working in cooperation with families and community support agencies to retain or reintegrate students who are experiencing difficulties related to drugs.

Continued participation in education is a key protective factor for young people; those who leave the school system face additional risks. Schools need to have in place well-developed structures for identifying and supporting at-risk students. The school health and welfare policy should address the management of drug-related incidents. Schools need to consider the wellbeing and safety of the school population in managing the interplay between welfare, support and disciplinary responses.

Precipitate action may label and marginalise a student, increasing the risk of alienation, truancy or early school leaving, each in its own right a risk factor (Commonwealth of Australia 2004, pp.37-38).

Current policies on suspension and expulsion

The rules regarding the suspension and expulsion of students have been recently changed and are now governed by the DEECD's *Student Engagement and Inclusion Guidance 2014*. The *Student Engagement and Inclusion Guidance* outlines how and when to implement appropriate disciplinary measures, and provides resources schools can access to support and improve student engagement.¹²³⁴

This Guidance is to be read in conjunction with *Ministerial Order 625 — Suspensions and Expulsions*, which took effect from 1 March 2014. There is a range of possible grounds for when a student may be suspended or expelled. These are included in detail in the Ministerial Order.¹²³⁵

In considering suspension or expulsion there are special provisions for both Aboriginal students and students in out-of-home care. With regard to Aboriginal students, a principal should engage a Koorie Engagement Support Officer (KESO). The KESO can support the student, school and the family to find the best outcome for the student and also connect the school and family to any local or regional resources that can assist. In all cases where a student residing in out-of-home care is being considered for expulsion, the relevant Regional Director must be notified so that the obligations in the *Out-of-Home Care Education Commitment Partnering Agreement* discussed previously can be met.

Community views on suspension and expulsion

The recent changes made by Ministerial Order 625 to the rules allowing suspension and expulsion have been greeted with concern by some health and welfare groups. For example, Geoff Munro of the Australian Drug Foundation told the Committee:

[w]e are very concerned by the latest report from the government that it is going to make it much easier to expel students from school. We understand that schools need to be places of learning, and we do not want schools disrupted by students who are unruly, but we also know that the same students who are at risk of being suspended and expelled from school are exactly the same demographic generally and are at the greatest risk of using tobacco, alcohol and other drugs.

If students are suspended or expelled from school, the question we would like to ask is: what resources and support are being provided to those young people and their families to help them to improve their situation so they can resume either school or training or employment? ...we know the young people who are most at risk, and we would like to see more resources go into them. It is an investment in schools; it is an investment in local councils, which are providing recreation and entertainment opportunities for those young people; and it is an investment in youth services. It is a great question,

1234 <http://www.education.vic.gov.au/school/principals/participation/Pages/studentengagementguidance.aspx>

1235 Specific provisions apply to the suspension and expulsion of Aboriginal students. In such cases See Ministerial Order 625, Department of Education and Early Childhood Development 2014.

and I think our answer is rather complex...there is certainly a need to educate, but also to support young people at most risk.¹²³⁶

Youth worker, Les Twentyman, whilst appreciating the many demands placed on schools administration, was also critical of the ease with which some schoolchildren ‘fell through the cracks’:

We are finding also that the kids who get expelled or suspended — there is no real effort to make them come back. We had two 13-year-olds — year 7s — suspended from a school. Two years later they were in a gang and in a major brawl at a shopping centre. When it ended up in court the magistrate said to the barrister, ‘What’s their school?’ He said they had not been to school for two years. The school’s thing was, ‘We thought they went interstate’. There is a disconnect of services all the way through.

In the case of a particular kid — she was five or six — her mum was drug dependent on ice and her dad was in and out of it and eventually took his own life. She went missing. The schools do not have the resources to be able to go and track every kid. There tends to be a cluster of parents who all have the same issues. They fall out and they are very difficult for services to contact. DHS cannot find them, and one of the problems with DHS is they have a lot of workers turn over, so it is not uncommon that in the case of this girl she has had eight social workers in the past four years. If there is no continuity, it becomes very difficult when the workers cannot get to physically speak to the mother and that, because they are always ducking and weaving and things like that. It is about giving the schools the resources, it is also about supporting the parents who are having difficulties.¹²³⁷

Providing alternatives — Connecting to the community

Mainstream school based approaches are important but not necessarily always appropriate for all young people who may struggle with academic learning. Alternative schools and alternative programs within or attached to mainstream schools attempt to provide a different type of educational program and setting to mainstream schools. Class sizes are often smaller, rules may be less strict (for instance uniforms may not be required, first names may be used for teachers), and teaching and learning strategies may be more experiential. Alternative schools and programs can be useful in providing the level of individualised and personalised support needed by vulnerable students and those who are seriously disengaged from mainstream schools.¹²³⁸

There are other ways outside of formal education and schooling of engaging young people in the community that may also reduce risk factors and augment protective factors. For example, according to Peter Wearne from YSAS there needs to be an equal emphasis placed on *vocational* education, training and trade apprenticeships:

Latrobe Valley for years has had poor employment opportunities for young people, and the further down the socio-economic order you are the harder it is to get work. We need to do something about that.

One of [our] responses, which we hope to enact in the next 18 months, is a community garden project that will lead to a social enterprise, which will see herbs and all sorts of things grown that can be sold into the local community to actually give young people somewhere they can come; work with people together; have meaningful activity... we are looking at building up social, economic and personal

1236 Mr Geoff Munro, National Policy Manager, Australian Drug Foundation, Public Hearing, Melbourne, 14 October 2013.

1237 Mr Les Twentyman, OAM, 20th Man Fund, Public Hearing, Melbourne, 9 December 2013.

See also evidence of Dr David Jacka, Addiction Medicine Specialist, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014 on the importance of not expelling young people.

1238 For a discussion of alternative schooling models that may help reduce the risk factors associated with adolescent drug use and antisocial behaviour, see Drugs and Crime Prevention Committee, *Inquiry into Strategies to Prevent High Volume Offending and Recidivism by Young People*, 2008.

recovery capital in these young people; things that they can look forward to, things that they can be connected to, things that they can find meaning in.¹²³⁹

As Mr Wearne's colleague, Christine May told the Committee:

The reality is that [our] kids do not fit into mainstream education. They have not been there since they were eight or 10, so they are never going to be educated enough. They can be linked into training through Centrelink, but that training does not afford them a job. It just keeps them off the books for a little while. If we had a social enterprise like a community garden, then we would be teaching them the infrastructure of life without them being in the classroom. So everything that they need to succeed — the adding, the subtracting, social interaction — is all there. That is what we are hoping for these young people, because if we do not, then there is no answer.¹²⁴⁰

Francis Broeckman of Brophy Family and Youth Services in Warrnambool also told the Committee that their agency strongly believes in utilising early intervention models with children and their families:

We take [use] an early intervention approach... What we try and do is work with the families from a positive strength base to say, 'We would like you to be involved in this particular program because we would like to get little Johnny through to year 10 because we think he has some fantastic talents and some great capacity to be able to get through'. All of a sudden you are starting to work on the strengths of the family... The idea then is not look at all the deficits but to look at what strengths we can build, what structures can we put in place with this family. One is as simple as having meals together and having discussions around the table, and how can that happen. It really looks at things from a very practical way.¹²⁴¹

Whether approaches are schools or community based, the importance of connection in a young person's life cannot be underestimated. Secure attachment to significant others is a basic human need and the development of self-esteem is based on the ability to form positive relationships and connections with others.

The Committee has heard much evidence that many young people who come into contact with drugs such as crystal methamphetamine lack a strong sense of connection to their families, schools or community.¹²⁴² A key strategy for addressing this lack of connection and assisting young people to build self-esteem are mentoring programs designed to link young people into the broader community.

Mentoring

Youth Mentoring as a strategy for improving young people's resilience and reducing the risk factors associated with antisocial behaviours including drug use has generally been well received.¹²⁴³ Mentoring can be defined as: 'the formation of a helping relationship between

1239 Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

1240 Ms Christine May, Manager Latrobe Valley, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

1241 Mr Francis Broeckman, Chief Executive Officer, Brophy Family and Youth Services, Public Hearing, Warrnambool, 3 March 2014.

1242 See for example, Ms Jacqui Watt, Director Client Services, Anglicare Victoria, Submission, 21 October 2013; Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS, Submission, 21 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; Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Submission, 10 April 2014.

1243 See the evaluation reports on mentoring detailed in the website of the Victorian Youth Mentoring Alliance (VYMA) at <http://www.youthmentoringvic.org.au/>.

In particular, the Research Synthesis Report (November 2011) considers national and international evidence on the value for investment and identifies evidence regarding the social and economic benefits for youth of quality one-to-one relationship based mentoring. This Report written by the Australian Housing and Urban Research Institute was commissioned by the VYMA, the Victorian Office for Youth and the Helen Macpherson Smith Trust to also provide an analysis of the key elements of effective youth mentoring programs.

a younger person and an unrelated, relatively older, more experienced person who can increase the capacity of the young person to connect with positive social and economic networks to improve their life chances'.¹²⁴⁴

Youth mentoring programs have been used extensively in the United States with at-risk young people, and are growing in popularity elsewhere. Stephenson et al. suggest:

The popularity of mentoring as an intervention with 'at-risk' young people has been growing for some years in the UK, following reports from the US that programmes such as 'Big Brothers Big Sisters' had achieved impressive results, for example in reducing drug/alcohol misuse and school non-attendance and in improving relationships with parents/guardians (Stephenson, Giller & Brown 2007, p.180).¹²⁴⁵

While mentoring is a strategy aimed at providing a trusting relationship with a caring adult for at-risk young people, it can also assist young people to identify their strengths, plan for their future and set goals. Mentoring programs also provide important links to community networks.

Mentoring programs

A large number of mentoring programs in Victoria are offered by a range of non-profit organisations, far too many to be discussed individually in this Report.¹²⁴⁶ As the Victorian Youth Mentoring Alliance pointed out in their submission for a previous inquiry, mentoring can take several forms including:

- traditional mentoring (one adult to one young person),
- group mentoring (one adult working with a small number of young people),
- team mentoring (several adults working with small groups of young people),
- peer mentoring (caring youth mentoring other youth),
- e-mentoring (mentoring via email and the internet).¹²⁴⁷

Most of the programs this Committee has been informed of are based on individual children and young people being paired with a single mentor. However, some programs involved group activities and additional support through counselling and other therapeutic interventions. The target age group also varies, with some programs providing mentors to secondary school aged or young adults, while others provided mentors to younger children as well. While all programs targeted vulnerable or at-risk children and young people, some provided the service specifically to young people who had contact with the youth justice system.

Whitelion mentoring program

Whitelion is a non-profit community organisation that provides youth-focused gender and culturally specific services in several areas including mentoring, employment, role modelling, specialist outreach support and education based prevention programs. Whitelion works with young people who are at risk and disconnected from the community due to abuse and neglect, drug addiction and poverty. It particularly works with young people from the youth justice and out-of-home care systems.

1244 See *Leading the Way, The Victorian Government's Strategic Framework on Mentoring Young People 2005–2008* quoted in Submission from Victorian Youth Mentoring Alliance to the Drugs and Crime Prevention Committee, *Inquiry into Strategies to Prevent High Volume Offending and Recidivism by Young People*, September 2008.

1245 Mentoring programs were put forward by a number of participants at the recent Rangatira High-Level Summit on Methamphetamine as excellent demand reduction interventions to reduce or prevent the uptake of ice use by young people.

1246 For a full list and description of mentoring programs operating in Victoria see the website of the Australian Youth Mentoring Network (AYMN) at http://www.youthmentoring.org.au/program_listings.php?selstate=6_

1247 Submission from Victorian Youth Mentoring Alliance to the Drugs and Crime Prevention Committee, *Inquiry into Strategies to Prevent High Volume Offending and Recidivism by Young People*, September 2008.

Mark Watt, CEO and co-founder of Whitelion, spoke to the Committee about their mentoring program. He observed that at least 60 to 70 percent of the young people involved in Whitelion programs may have issues relating to alcohol or illicit drugs.¹²⁴⁸ Whitelion is particularly dedicated to working in partnership with Aboriginal organisations to ensure Aboriginal children, particularly those involved in the juvenile justice system or residing in out-of-home care, have opportunities to training and mentoring programs.¹²⁴⁹ As Mr Watt stated:

One of the things we think is really important when looking at this area is partnerships. We as an organisation are really focused on partnering with other groups, other organisations and delivery of services. That is including our indigenous friends. We have two indigenous organisations that we are partners with: Narana Creations down in Geelong, and also a facility in Thornbury, Minanjaku, so we do outreach work with indigenous kids. The other organisation we are partnering with is a group called Melbourne Aboriginal Youth Support and Recreation, MAYSAR. They have a building and operation in Gertrude Street, Fitzroy. It is very important to partner with groups.¹²⁵⁰

Whitelion provides a range of outreach, employment, leadership and skills based programs for at-risk youth in addition to their mentoring programs. According to Mr Watt, these programs all complement each other. But the use of mentoring is particularly beneficial to troubled youth:

We have seen countless lives changed through mentoring. Just one quick little story: a young Aboriginal girl who has been locked up five times connects with her mentor and gets a job. That combination of a mentor and a job is very powerful and she has been working at the same company for two years and never been locked up again. Got a great mentor, got a great job and it has turned her life around. We have seen that time and time again with young people's lives.

The good thing about a mentor is it is long term. Once they connect they can have a mentor relationship for years. What we do is we establish the mentor, support them for up to two years and then we graduate them as friends. Of course, if the young person gets into trouble they can come back in and get support again. It is an ongoing commitment to the young person... Often, unfortunately, in our system you have to wait until [kids] are in gaol or they are just about dead before you can intervene, so some sort of more preventative thing — I mean, there is no doubt that mentoring works and it really does add a lot of value.¹²⁵¹

As with many of their programs, Whitelion's approach to mentoring is based on the utilisation of strong partnerships with other agencies: One of the specific aims of Whitelion's mentoring project has been matching up young at risk-boys and men with 'father figures', as many of their mentees have not had significant male role models or support figures in their lives:

One of the big things out there is a lack of men for our young people. It is a bit of a fatherless generation with the kids that we work with. We were going for example to try a program with the fire department in certain communities, because a lot of 'firies' work 12-hour shifts so they have a bit of time off.. .So male mentors in the lives of kids are really important.¹²⁵²

Whitelion believes mentoring is a useful intervention to address issues in the lives of young people at risk including those who may have drug-related problems. In their view the earlier the mentoring process begins the better, in some cases early intervention through mentoring programs may prevent problems arising or at least escalating for young people at

1248 For a discussion of Whitelion's Chatterbox outreach program, see Chapter 23.

1249 For a discussion of the effectiveness of mentoring programs for Aboriginal youth at risk, see Ware 2013.

1250 Mr Mark Watt, Chief Executive Officer, White Lion, Public Hearing, Melbourne, 24 March 2014.

1251 Mr Mark Watt, Chief Executive Officer, White Lion, Public Hearing, Melbourne, 24 March 2014.

1252 Mr Mark Watt, Chief Executive Officer, White Lion, Public Hearing, Melbourne, 24 March 2014.

risk. As such they suggest schools should be aware of and encourage mentoring programs in partnership with agencies such as Whitelion.¹²⁵³

YWCA Asista Mentoring Program

The Asista Mentoring Program run by the YWCA matches young women between 12 and 18 years of age with a volunteer female mentor who offers support, friendship and fun to the mentee along her path to independence. These women are in many cases involved with the child protection system and do not have strong family or community support. The program encourages personal development, new experiences and opportunities for young women and their mentors through fortnightly social and recreational activities.

Jan Berriman, Chief Executive Officer of YWCA Victoria, gave further details about the Asista program when she gave evidence to the Committee:

Asista mentors are often tertiary-educated white women between the ages of 25 and 35 who are working professionals identifying as being single or in a partnership but do not have children and live in metropolitan Melbourne. The Asista program and mentoring experience are unique to the participants, as no two relationships look the same. The matches of the mentors and the mentees is on a basis of shared interests and complementary strengths. The idea is for the mentors to become a confidante and a sounding board for these young women, someone to turn to, someone to have fun with and someone who may create opportunities for new experiences in areas of work, leisure, culture or education. In fact, most young women say to us that they are the only person that is not paid in their life.

Mentors make a minimum 12-month commitment but our experience shows that often relationships continue into their second, third and fourth year. Most relationships mature into adult friendships after the mentee has turned 18 and continue without any formal program support. However, if a mentee is up to 21 years of age and has not actually secured that stability in their life, we do continue to support the mentor and mentee relationship.¹²⁵⁴

Ms Berriman told the Committee that the young women with whom they work have been removed from their primary place of care due to sexual, physical, emotional, or psychological abuse or neglect and placed in kinship care, residential care or foster care settings: ‘The client’s trauma history more often affects their development on many levels, placing these young women at risk of achieving poor health, education and social outcomes’.¹²⁵⁵

With regard to drug abuse, Asista has had mentees with drug-related problems including methamphetamine use. However, ordinarily a mentee would be required to be sober or clean when entering into a mentoring arrangement:

At no point does YWCA encourage mentors and mentees to spend time together if the young person is drug or alcohol affected. However, we endorse a harm minimisation approach when working with young people. We encourage mentors to create an arena of non-judgment, use a strength based approach and, with gentle curiosity, explore the reasons and consequences of the decisions being made.¹²⁵⁶

In the context of drug use by young at-risk women, Ms Berriman told the Committee that there was much to be said for the idea of ‘peer mentors’, that is, matching someone with a drug-related problem with someone who had previously been through a similar stage in their lives:

I would say that people who have had a drug addiction are more than able to act as very good mentors or partners in any sort of relationship because they can empathise. They do understand. They understand exactly what that young person is going through. It does not mean to say everyone has

1253 Mr Mark Watt, Chief Executive Officer, White Lion, Public Hearing, Melbourne, 24 March 2014.

1254 Ms Jan Berriman, Chief Executive Officer, YMCA Victoria, Public Hearing, Melbourne, 24 March 2014.

1255 Ms Jan Berriman, Chief Executive Officer, YMCA Victoria, Public Hearing, Melbourne, 24 March 2014.

1256 Ms Jan Berriman, Chief Executive Officer, YMCA Victoria, Public Hearing, Melbourne, 24 March 2014.

to be a recovering addict to be a good mentor either. I think horses for courses, depending on the person you are involved with and depending on how strong and stable that person is. They have to go through police checks as well, so that can sometimes negate the mentor who might have had those sort of serious issues.¹²⁵⁷

Asista mentors are provided with training such as connecting and communicating with young people effectively, abuse and boundaries, a code of conduct, cultural awareness training, and issues affecting young people, including drug and alcohol issues, and setting and working towards life goals:

The training also covers extensive boundary-setting practices for mentors, and we encourage many of the boundaries as listed, which can be mentors not lending money to mentees, mentoring taking place in public spaces, never introducing mentees to friends and families or their social networks, not actually using social media contact with their mentees and not engaging in any of the primary level care and support. They are not the doctor. They are not their nurse or their rehab person.¹²⁵⁸

Ms Berriman told the Committee that mentoring is a successful preventive and intervention tool when working with young people at risk:

Whilst it is difficult to obtain formal and measurable outcomes, because quite often the mentee and the mentor relationship is an ongoing and quite fluid relationship, we do bear witness to participants making positive life choices and seeking counsel and guidance from their mentor on a regular basis.¹²⁵⁹

Moreover the Asista program is one of the few mentoring programs to work specifically with young women at risk. In doing so it addresses issues that are gender specific in ways that other more generalist programs do not.

Peaceful Warriors Mentoring Program — Anglicare Victoria

Anglicare Victoria's Peaceful Warriors programs mentor and guide socially disadvantaged and at-risk boys from adolescence to manhood. It is a mentoring program supporting disadvantaged boys aged 9 to 12 years exhibiting signs of potentially violent or other inappropriate behaviour. Peaceful Warriors supports boys living in out-of-home care, referred by local schools, or referred by their families — usually single mothers. There is one Warrior's program for around 10 boys each year.

The programs targets, in particular, boys who do not have a strong male role model within their family.

The programs support the vital connections between the boys and their families, schools and local communities along the challenging pathway to manhood. The Peaceful Warrior program is a preventative and proactive response to the ever dwindling opportunities for boys to develop relationships with positive, caring male role models. The program guards against the risk of them sliding into early school leaving, drug or alcohol dependence, violence and dangerous, risk-taking behaviours.¹²⁶⁰

The aims of the program include:

- To boost involvement of men in boy's lives and promote strong guiding friendships between boys and positive role-models.
- To challenge unhelpful attitudes, and abusive behaviours.

1257 Ms Jan Berriman, Chief Executive Officer, YMCA Victoria, Public Hearing, Melbourne, 24 March 2014.

Anthony Grimm from Whitelion also agreed with the use of ex users as mentors in appropriate circumstances. He told the Committee that: 'The fact that someone has used does not necessarily qualify them to work with someone who is using, but it certainly can be a benefit'. Mr Anthony Grimm, Co-ordinator, The Chatterbox Street Outreach Program, White Lion, Public Hearing, Melbourne, 24 March 2014.

1258 Ms Jan Berriman, Chief Executive Officer, YMCA Victoria, Public Hearing, Melbourne, 24 March 2014.

1259 Ms Jan Berriman, Chief Executive Officer, YMCA Victoria, Public Hearing, Melbourne, 24 March 2014.

1260 <http://www.anglicarevic.org.au/being-a-mentor>

- To address strong feelings and confusion about masculinity.
- To strengthen community partnerships.
- To link boys and men to local supports.
- To facilitate enduring mentor friendships.¹²⁶¹

Staff from Anglicare told the Committee they receive frequent requests from single mothers who are looking for someone to provide a positive male influence in their son's life. Boys are also often referred to the mentoring program by their school. Once referred, Anglicare matches the young person to a trained and accredited volunteer mentor.

Berry Street Mentoring Programs

The child welfare agency Berry Street provides a variety of mentoring programs 'that give young people the opportunity to build positive relationships with caring and supportive volunteer mentors from the community'. Their programs encourage young people to develop important life skills, increase their resilience, make connections with their community and set goals for the future. They cater for young people aged from 10 to 25 years.

Berry Street works with a range of partners in delivering mentoring programs, including schools and education training providers, local government and community agencies.¹²⁶² In particular, Berry Street has teamed up with Whitelion to provide the Leaving Care Mentoring Program (LCMP) to support some of the 400–500 young Victorians leaving State Care each year.

The LMCP aims to match young people leaving the out-of-home care system with a Mentor from within their own community prior to their move to independent living in order to reduce isolation and loneliness and assist them to connect with their community. In particular the program targets 15–18 year olds who are:

- Preparing to leave residential or home based care
- At risk of becoming homeless
- At risk of disconnecting from the wider community
- Vulnerable to 'dropping out' of education or training, or
- Pregnant/parenting teens who have limited or no formal support outside the care system ¹²⁶³

Mentoring within the LCMP aims to provide specific skills to prepare young people to transition from the out-of-home care system to independent living, including assisting young people with cooking, budgeting, tenancy and health matters and parenting skills where relevant. They will also support these young people to gain employment or enrol in education programs.¹²⁶⁴

The LMCP is an example of how community agencies can act in partnership, pooling skills and resources to address disadvantage and social deficits amongst some of Victoria's most vulnerable young people.

Big Brothers Big Sisters

Big Brothers Big Sisters is the longest-standing mentoring program in Australia and has been in operation in Victoria since 1982. Since then it has provided mentors to approximately 2500 vulnerable children and young people aged between 7 and 25 years. The Big Brothers Big Sisters program provides mentors to young people within metropolitan Melbourne and rural Victoria.

1261 <http://www.anglicarevic.org.au/being-a-mentor>

1262 Berry Street also provides training for Victorian schoolteachers who wish to become learning mentors as discussed above.

1263 <http://www.berrystreet.org.au/Assets/2478/1/LeavingCareforpotentialMentorsoct2013.pdf>

1264 <http://www.berrystreet.org.au/Assets/2478/1/LeavingCareforpotentialMentorsoct2013.pdf>

All of those provided with mentors in the Big Brothers Big Sisters programs have heightened needs due to social, emotional and educational disadvantage. They are characterised by:

- Having parents with psychiatric illness, intellectual disability or an addiction;
- Having exposure to family violence or child abuse;
- Living in low-income households and entrenched cycles of unemployment and poverty;
- Possessing poor socialisation skills, have difficulties making friends and have experiences of bullying;
- Experiencing family breakdown and/or residing in foster care or residential care placements;
- Being newly-arrived refugees from countries experiencing war, genocide and extreme levels of poverty;
- Experiencing learning difficulties at school or displaying behavioural concerns; and/or
- Possessing an intellectual disability.¹²⁶⁵

Programs such as Big Brothers/Big Sisters:

[c]an build resilience and a sense of self-worth in young people, helping them to stay at school, improve their relationships with families and their community which in turn can lead to long-term community benefits like an increase in school retention; school and community safety; and greater employment opportunities.¹²⁶⁶

Realising their potential

The state mentoring peak body, the Victorian Youth Mentoring Alliance, released the report *Realising their potential: a survey of young people in youth mentoring* in October 2011. The report was based on a survey of 153 young people aged 12 to 25 across a diverse range of 34 Victorian youth mentoring programs. Some of the findings were that the number of youth mentoring programs in Victoria has tripled since 2005; 65 percent of Australian youth mentoring programs are based in Victoria; and 47percent of Victorian programs operate in the Melbourne metropolitan area.¹²⁶⁷

The Report also found that

Of the young people who participated in the survey, the following percentage 'agreed' or 'strongly agreed' that because of their relationship with their mentor:

- 93% know where to go for help if they need it
- 90% have a more positive view of their future
- 87% feel more confident
- 81% go to school more often
- 79% have a clearer idea of what they want to do in the future
- 78% are less likely to use drugs or alcohol
- 75% know more about the education/ training/ work options that are available to them.¹²⁶⁸
(Committee's emphasis)

When considering the results it was found that:

- Females reported slightly better outcomes than their male peers
- Being mentored for a longer period of time often resulted in positive changes in behavioural and attitudinal areas

1265 <https://www.bigbrothersbigsisters.org.au/>

1266 <https://www.bigbrothersbigsisters.org.au/>

1267 See <http://www.youthmentoringvic.org.au/file/file/Research/VYMA%20Realising%20their%20Potential%20Report%20October%202011.pdf>.

1268 <http://www.youthmentoringvic.org.au/file/file/Research/VYMA%20Realising%20their%20Potential%20Report%20October%202011.pdf>

- Regular meetings with a mentor resulted in better outcomes in improved behaviour, *reduction in drug and alcohol use*, getting along better with family and being clear about education and training options
- School based [mentoring] programs resulted in improved school attendance, attitude and clarity regarding education and training options
- Community based programs assisted young people in being clearer about their work options and goals for the future
- A combination of one to one and group mentoring generally resulted in better outcomes for young people.¹²⁶⁹

Research into mentoring programs has identified a number of factors that are key to a successful program. These are:

- initial and on-going training for mentors;
- structured and varied activities for mentors and young people;
- developmentally sensitive goal setting with young people;
- clear expectations for the frequency of contact;
- the support and involvement of parents;
- structured support and supervision for the relationship (Stephenson, Giller & Brown 2007, p.181).

In short, mentoring works best when provided as part of a suite of programs providing positive pathways for young people, through education, employment or other opportunities.¹²⁷⁰

However as worthwhile as mentoring programs may be, they are not a panacea to address the problems associated with drug abuse. They should not be seen as a replacement for other services, but rather as an adjunct or additional support for vulnerable young people. The provision of such programs does not obviate the need for specialist youth services such as YSAS to provide additional support for young people with specific needs, particularly drug-related problems.

Recreation and leisure

Research suggests that sports, leisure and recreation programs can also play an important role in addressing the risk factors that may lead to drug use and antisocial behaviour. In particular leisure activities give young people an opportunity to enjoy increased social inclusion (Walker & Donaldson 2010; Bundick 2011; Hutchinson & Brooks 2011; Jackson et al. 2012). Conversely, boredom, as discussed in Chapter 13, may be one of the factors that can contribute to experimenting with crystal methamphetamine and/or other drugs (Morris et al. 2003; Caldwell & Smith 2006; Commonwealth of Australia 2008). This may particularly be the case in rural and Aboriginal communities (Mental Health in Rural and Remote Communities 2008; Ware 2013). Structured recreational pursuits as with mentoring can be one factor helping young people in particular to make meaningful connections to the broader community.

Leisure activities of themselves will not of course necessarily address the underlying problems contributing to drug use. Like mentoring programs, they cannot act as a substitute for other services particularly education and employment opportunities, that may promote resilience in young people and prevent them using drugs such as ice.¹²⁷¹ Nonetheless, they can serve as an important part of an overall strategy to address the potential or actual drug use of young people at risk.

1269 <http://www.youthmentoringvic.org.au/file/file/Research/VYMA%20Realising%20their%20Potential%20Report%20October%202011.pdf>

1270 Victorian Youth Mentoring Alliance at <http://www.youthmentoringvic.org.au/>

1271 See Chapter 13 for a discussion of the need to alleviate the boredom of young people as a measure to reduce drug use and antisocial behaviour.

Conclusion

Broad based prevention strategies such as public health and developmental models are essential in reducing drug-related harms or preventing the uptake of illicit drugs such as crystal methamphetamine. Prevention programs are particularly important for young people, especially those who are vulnerable or 'at risk'.

The importance of prevention cannot be overstated. It saves lives and is cost-effective (ADCA 2003; Allsop & Lee 2012). It has been estimated that 'for every dollar spent on drug use prevention, communities can save four to five dollars in costs for drug abuse treatment' (Pentz cited in ADCA 2003, p.1).

Prevention has been for far too long the 'poor relation' in the health sector generally and in addressing drug use in particular. Increasingly Australian researchers and research institutes are reviewing and evaluating protective models as the way forward in addressing harmful drug use (Ministerial Council on Drug Strategy, National Drug Strategy 2010-2015). Governments and communities at all levels also need to make a considerable commitment to investing in prevention over the long term in order to achieve lasting benefit.

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.

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.

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.

23. Education, Information and Support for Young People and Families

Introduction

One of the consistent findings of this Inquiry has been the lack of information available for individuals, families and communities about the drug crystal methamphetamine. Crystal methamphetamine has clearly been generating concern in the wider community, particularly with regard to issues such as personal and public safety. Evidence presented throughout this Inquiry has suggested that the families of methamphetamine users are bewildered by this drug and its effects.

These concerns have been particularly acute in rural and regional areas of Victoria. As a recent report by peak body Anex stated:

Community fear is amplified by media reports focusing on the negative impacts of ice use. The smaller the community, the greater the psychological impact (Anex 2014, p.12).

Anex also noted, however, that once people have been given factual, straightforward information on methamphetamine that ‘debunks the ice myths’ they feel more confident to address the ice-related problems facing their local communities (Anex 2014).

Education and information provision on methamphetamine and drugs can take many forms and may be disseminated in a variety of locations. School based drug education is one of the main ways in which young people receive information about drugs, although the efficacy of such methods and the appropriate timing of these interventions have been questioned. It should be noted from the outset that in the school education context, almost all program and curriculum content on drugs is generic based referring to licit and illicit drugs in non-specific ways and with a much greater emphasis on alcohol and tobacco.¹²⁷² There are few if any specific school programs on methamphetamine/ice, and this is reflected in the discussion in this chapter, particularly in the first half. Evidence also suggests that for younger students without any experience of drug use, general ‘life skills’ or health promotion education rather than specific information on the drug may be more suitable rather than specific reference to drugs. This may be particularly important given the evidence suggests very few young people use crystal methamphetamine, and for the small amount that do this usually takes place in the senior years of secondary school.¹²⁷³

Outreach and peer education approaches may, however, be more suitable for young people who are disengaged from the school system, are already using drugs or are in other

1272 See for example, the Drug Education in Victorian Schools (DEVS) program discussed later in this chapter. This school based approach to drug education concentrates on alcohol and tobacco and in later years, cannabis.

1273 Interestingly, the Victorian Department of Education drugs education program Get Wise noted that very few school students had used amphetamines (citing that 95% of students had never used them), generally use increased as students got older (2% of Year 7 students had used amphetamines versus 7% by Year 11 students) and generally using was male dominant. Moreover, these statistics did not differentiate between different forms of amphetamine, so the levels of crystal methamphetamine use specifically remain unknown. See, *Get Wise: working on illicit in school education: drug education resources for schools and their communities*, p.10, accessed at <http://www.education.vic.gov.au/Documents/school/teachers/health/getwise1to100.pdf>.

ways particularly at risk or vulnerable. Such approaches have been viewed as of benefit particularly when they utilise the internet and social media.

For specific groups within the community, drugs information may need to be specifically tailored to suit their circumstances. For people already using the drug, harm reduction information will be appropriate. For Aboriginal communities, education on methamphetamine will need to be culturally appropriate and tailored to Aboriginal needs.

A definite lack of knowledge

A submission to the Inquiry from the Northern Mallee Community Partnership has stated that: 'Education is the principal means of preventing drug abuse'.¹²⁷⁴ Certainly drug education is one of the principal forms of demand reduction and a key aspect of prevention approaches (Department of Health and Ageing 2011). Education and information strategies also have particular resonance for many people in the community. Many witnesses to the Inquiry have given evidence that in their opinion those who are using crystal methamphetamine, particularly young people, simply do not know what they are using and certainly do not understand either the physical or psychological short or long-term impact of it.¹²⁷⁵ This is true in the Australian context and also in other countries. For example, Dr Nick Thomson from Melbourne University, speaking about ice use in the South-East Asian context, told the Committee:

[w]hat we are missing is large-scale community based [harm reduction, education and prevention work]. This does not necessarily have to be costly nor particularly sophisticated. For example, in a narco [narcotics] ward in Asia, young people just had no idea what they were doing. Once we were actually able to get in front of them and say, 'Listen, this is what the drug does. The reason you're feeling not crash-hot on a Monday morning is because you haven't slept, you haven't eaten. You are fighting with your parents because you're on edge', they were actually able to start to understand what the drug was doing and make some more informed decisions.¹²⁷⁶

Similarly, Superintendent Paul O'Halloran told the Committee it was extremely concerning that young people seemed to know so little about the drug and how it worked:

A lot of it does come back to education. I do not think there is enough known about it, especially amongst the youth. They have seen it on TV, they have seen it glamorised with some shows. It is also glamorised with people in the community, sports people are using it. They do not see the actual bad effects that it causes against these sports people. They see that they go to rehab, they are out two weeks later and all is fine. The education has to be there. School children have to be made aware of the bad effects.¹²⁷⁷

This was certainly the views of some parents of young people who gave evidence to the Inquiry including young people who are currently using methamphetamine. The frustration felt by some of these parents was summed up by Kerryn and Stephen Johnston:

We come from a little town called Mount Beauty which is about an hour away from here, out the bush, and at the end of the school year, last year, year 12, there were all these kids leaving town to go to uni next year, and not one of them has the life experience to even look after themselves. They are not taught anything about it at school.

1274 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013.

1275 See for example, Mr Joey Chatfield, Aboriginal Community Liaison Officer, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

1276 Dr Nick Thomson, Research Fellow School of Population and Global Health and Field Director, Whole of Victorian Government Hotspots Project, University of Melbourne, Public Hearing, Melbourne, 24 March 2014.

1277 Superintendent Paul O'Halloran, Superintendent and Divisional Commander Eastern Region Division 4, Victoria Police, Public Hearing, Wodonga, 24 February 2014.

They do full-on sex education, and they know how to put a condom on a cucumber or whatever, but we really have to give them the strength and the knowledge to know if they are falling into a trap, how to know themselves whether they are strong enough. We need more education.¹²⁷⁸

These views about the ignorance of crystal methamphetamine were restated many times during the course of the Inquiry.¹²⁷⁹ However, as the rest of this chapter demonstrates, a variety of interventions are being developed and implemented to reduce the 'knowledge gap.'

Drug education for young people

One dilemma for drug educators and people working within the prevention and alcohol and other drugs (AOD) field is striking a balance between highlighting the potential dangers of drug use and not making it seem something exciting or fun. This may be particularly true of methamphetamine.¹²⁸⁰

Drug education in schools

Researchers in drug education agree that schools *can*, at least in theory, make useful contributions to drug prevention strategies through education and this has been reflected in a number of federal and state drug education programs.¹²⁸¹ Midford, McBride and Farrington argue that school based drug education is an attractive option for governments 'because it offers the potential to stop the next generation from experiencing drug problems' (1999, p.4). Given that schools are places of learning: 'there is a certain logical appeal to using school based drug education as a means of changing behaviour' (1999, p.4). Moreover:

Drinking and other drug taking usually starts during youth. Most young people go to school and are a 'captive audience'. Most schools are places of learning; *ipso facto*, use schools to educate young people about the pitfalls of using alcohol and other drugs and thus keep them from harm. Despite this seemingly inherent logic, drug education has not been greatly successful, which a number of researchers put down to the emphasis of abstinence as the only acceptable programme goal. If the state programme objective is non-use, then any use, no matter how little, constitutes a programme failure (Midford, Mc Bride & Munro 1998, p.319).

However, there are a number of factors that have to be taken into account in providing information about drugs to young people within the school sector. Some of the questions that should be considered include:

- ◆ How much information is needed?
- ◆ How relevant is the information?
- ◆ When should the information be timed or considered?
- ◆ How should it be delivered?
- ◆ Is the information to be given by imposition or is it generated through interactive sharing between teacher and student?

Some of these questions are addressed in the Commonwealth Government's *Principles for School Drug Education* a document adopted by all state education departments and still referred to as a pedagogical benchmark today.¹²⁸²

1278 Mr Stephen Johnston, Public Hearing, Wodonga, 24 February 2014. Ms Kerryn Johnston, Public Hearing, Wodonga, 24 February 2014.

1279 See discussion in Chapter 24.

1280 See comments of Ms Heather Pickard, Chief Executive Officer, Self Help Addiction Resource Centre, Public Hearing, Melbourne, 14 October 2013.

1281 See discussion later in this chapter.

1282 See <http://apo.org.au/research/principles-school-drug-education>.

Principles for School Drug Education (PSDE)

The PSDE document was first developed in 1994 by the Commonwealth for use in Australian schools drawing on expert academic and stakeholder expertise in the area. The document has been revised and substantially updated since then with the last revision being in 2005.

The revised principles, developed by the then Department of Education, Science and Training (DEST) as part of the National Drug Strategy, offer 12 key pointers to inform the development of effective drug education. They form a useful evidence-based guide for planning and undertaking effective school drug education.

The principles are embedded within a broader health promotion approach and are informed by and support evidence based practice that places importance on theory and research rather than ‘intuitive and ideologically driven decisions’ (Ministerial Council on Drug Strategy 2004, p.14).

The principles are outlined below in Table 23.1.

Table 23.1: Principles for School Drug Education

Comprehensive and evidence-based practice	
Principle 1: School practice based in evidence	Base drug education on sound theory and current research and use evaluation to inform decisions.
Principle 2: A whole school approach	Embed drug education within a comprehensive whole school approach to promoting health and wellbeing.
Principle 3: Clear educational outcomes	Establish drug education outcomes that are appropriate to the school context and contribute to the overall goal of minimising drug-related harm.
Positive school climate and relationships	
Principle 4: Safe and supportive environment	Promote a safe, supportive and inclusive school environment as part of seeking to prevent or reduce drug-related harm.
Principle 5: Positive and collaborative relationships	Promote collaborative relationships between students, staff, families and the broader community in the planning and implementation of school drug education.
Targeted to needs and context	
Principle 6: Culturally appropriate and targeted drug education	Provide culturally appropriate, targeted and responsive drug education that addresses local needs, values and priorities.
Principle 7: Recognition of risk and protective factors	Acknowledge that a range of risk and protective factors impact on health and education outcomes, and influence choices about drug use.
Principle 8: Consistent policy and practice	Use consistent policy and practice to inform and manage responses to drug-related incidents and risks.
Principle 9: Timely programs within a curriculum framework	Locate programs within a curriculum framework, thus providing timely, developmentally appropriate and ongoing drug education.
Principle 10: Programs delivered by teachers	Ensure that teachers are resourced and supported in their central role in delivering drug education programs.
Principle 11: Interactive strategies and skills development	Use student-centred, interactive strategies to develop students’ knowledge, skills, attitudes and values.
Principle 12: Credible and meaningful learning activities	Provide accurate information and meaningful learning activities that dispel myths about drug use and focus on real life contexts and challenges.

Source: Adapted from Commonwealth of Australia 2004, pp.12-14.

The Principles can be divided into four 'clusters': conceptual; relational, contextual and classroom levels.

Conceptual cluster

At the broader *conceptual* level, Principles 1–3 recommend a comprehensive and evidence-based approach incorporating school practice based in evidence, a whole school approach, and clearly identified educational outcomes.

This cluster of principles recognises that:

Seeking to prevent and reduce students' drug use through isolated programs that focus on drug issues only is not helpful. Comprehensive programs that place drug education within a broader health context and reinforce learning activities through a multifaceted approach are needed. The following have been identified as important considerations for a comprehensive approach by schools to the promotion of health and wellbeing:

- an approach that covers many aspects of health rather than a categorical or narrow focus;
- relevance and attention to reinforcement across schooling and beyond, where practicable;
- empowering students to participate in a range of teaching and learning;
- strategies with adequate time provided;
- integration of programs within a supportive school policy framework;
- maintenance of a healthy physical and social environment;
- well trained teachers;
- collaborative (and cooperative) involvement of teachers and students;
- involvement of health services; and
- adequate evaluation (Commonwealth of Australia 2004, p.18).

Relational Cluster

At the *relational* level, Principles 4–5 emphasise the importance of a positive climate and relationships with an emphasis on provision of a safe and supportive school environment, and positive and collaborative relationships:

The culture of a school is an important determinant of the health and wellbeing of students and staff. A sense of security, underpinned by care and respect, is central to a positive school climate. A sense of security involves feeling safe from physical threat as well as emotional harm and exclusion. A safe and supportive school environment for young people includes a climate in which there are trust, warmth and positive interest; clear messages of unacceptable behaviour; positive role models; learning opportunities; and access to social support.

Nurturing a healthy social environment within the school involves staff consistently promoting an inclusive environment in and beyond the classroom, modelling positive behaviour and setting clear and consistent boundaries for acceptable student behaviour.

Building a positive school environment requires attention to the culture, ethos, values, expectations and norms of the school community and to the role of these in influencing educational outcomes and health behaviours (Commonwealth of Australia 2004, p.23).

The involvement of parents, families and the wider community where appropriate in drug education programs can also be seen as beneficial. It is thought that such involvement will:

[i]ncrease the likelihood of their effectiveness and promote longer-lasting results (Evans and Bosworth 1997). Parents are a major influence on the drug-taking behaviour of their children through their modelling of behaviour as well as their attitudes and family relationships.

... Parents [may also] need drug education themselves to be effective in helping their children. Parent involvement helps increase communication and promotes positive attitudes towards healthy behaviour [and] parental involvement in drug education should be conceived as integral to the drug education process, rather than as separate and additional to it. As Ballard, Dawson and Kennedy (2002b) note, informing parents about drug education programs and involving them in collaborative decision-making on drug-related issues is now becoming recognised in Australian schools as an integral part of drug education (Commonwealth of Australia 2004, p.28).

Contextual Cluster

At a *contextual* level, Principles 6–8 challenge the school to take account of the local context and needs of the community. This encompasses an understanding of the risk and protective factors at play, and informs the development of culturally appropriate and targeted drug education. It also locates the importance of school policy and practice in sending consistent messages to the school community.

An understanding of the risk and protective factors impacting on patterns of youth drug use can assist schools to work more effectively at both prevention and intervention levels... Many problems share common risk and protective factors. Research is suggesting that effective intervention in one area is likely to lead to benefits in other problem areas.

When schools seek to enhance protective factors in young people's lives and enhance students' resilience, there are likely to be benefits in relation to drug-related issues *and also in other areas of their lives* (Commonwealth of Australia 2004, pp.33, 34. Author emphasis).¹²⁸³

Classroom Cluster

At the *classroom* level, Principles 9–12 focus on the importance of the classroom teacher in the provision of drug education. The Principles recommend that the classroom teacher uses interactive and inclusive strategies to promote knowledge and skills development. The program should be designed so as to deliver credible and meaningful learning activities as part of a broader curriculum framework addressing health and social development. Classroom drug education should also avoid 'using ideal expectations around drug use, rather than focusing realistically on what can be achieved' (Commonwealth of Australia 2004, p.22). As Midford (2000) notes, such expectations can be self-defeating and leads to the discrediting of drug education as a whole.

Similarly, school drug programs should be based on realistic goals; whilst desirable, it may be unrealistic to expect that there is no uptake of licit or illicit drugs amongst students. (Commonwealth of Australia 2004). Ultimately, classroom drug education should be placed within a broader health context:

- Drug education is best taught within a broader social, cultural or health curriculum rather than as a discrete subject. Isolated and *ad hoc* programs that lack progression and continuity are less effective.
- Drug education should be founded on a holistic view of health that encompasses attention to physical, social, mental, emotional, environmental and spiritual wellbeing.
- Drug education should not focus on drug issues in isolation, but investigate these choices in a way that is meaningful to students, addressing the lifestyle concerns and priorities in young people's lives.
- Drug education need not be compartmentalised by drug type, although consideration does need to be given to providing targeted programs for particular drugs, especially with older or at-risk students (Commonwealth of Australia 2004, p.39).

Importantly this cluster of principles stresses that effective pedagogy requires that drug education is based on *interactive* learning strategies:

¹²⁸³ See also discussion on risk and protective factors in Chapters 13 and 22. For a discussion of 'social influence' programs that seek to prevent drug use through enhancing personal development, see Midford 2009.

Research has consistently identified interactive strategies as a critical component of effective programs. Interactivity involves students having the opportunity to be involved in the exchange of ideas and experiences as well as to practice new skills and receive feedback.

Interactive strategies work best within a climate of respect. Teachers need to acknowledge and affirm diversity and actively discourage processes that stigmatise or marginalise groups or individuals. Inclusive methods that ensure all students are actively engaged are critical to effectiveness... (Commonwealth of Australia 2004, p.45).

Similarly, in this regard Cahill states that 'interactive learning tasks provide opportunities for students to enhance their knowledge and skills and to predict, problem-solve and "rehearse" for a range of challenges they may encounter in relation to drug use' (2005, p.14).

LEAD — *Leading Education about Drugs*

The Principles for School Drug Education are complemented by another series of 'guiding principles' outlined in a document on drug education called LEAD (Leading Education about Drugs). This was produced by the Australian Youth Research Centre at the University of Melbourne (Commonwealth of Australia 2005) and is still viewed as a valuable resource to be read alongside the PDSE. The key messages to come out of this document are:

- Use an evidence based approach
- Knowledge is not enough
- Provide accurate information
- Watch you don't glamourise or normalise risky behaviours
- Strategies have to match the person and the circumstances
- Interactive strategies work best
- Tailor the program to suit the needs and interests of the target audience (Department of Education, Science and Training 2005, pp.1-2).

Participatory approaches

Both LEAD and the PSDE strongly advocate using youth participation approaches in drug education and the implementation of health and wellbeing educational programs. Both youth participation and peer education approaches, discussed below, share an approach that takes the input of young people seriously. The assumptions behind youth participation models are that:

- Active participation enhances learning and positive development;
- Effective learning occurs when young people are recognised as active partners in the process;
- Young people should be viewed as a resource rather than simply as recipients of the education experience;
- Students can do important and valuable work and that they have skills, expertise and knowledge and a valuable perspective to contribute to their community; and
- Schools are in a unique position to provide the community with a valuable model of working productively with young people (Department of Education, Science and Training 2005, p.5).

These principles accord with a growing body of evidence that suggests 'Prevention programs that *engage* young people have the best chance of achieving and maintaining benefit in their own right' (Midford 2009, p.1694). Lee is also firmly of the view that students themselves may have valuable contributions to make — that drug education is a two-way process:

Too often knowledge is offered as if to fill the empty vessel, the learner. Yet with drugs, as with most other topics of concern, young people may possess a great deal of knowledge and experience, often more than the teacher...Education is about people, and drug education needs to consider people and their ability to

cope in a drug-oriented society and not just to see drugs in terms of ‘problems’. Schools offer a marvellous opportunity to consider the areas of knowledge, attitudes and skills and self-esteem, for it is there that young people can learn, share, discuss, practise, refine and adapt these attributes (Lee 1989, p.332).

Josephine Baxter from Drug Free Australia has suggested that a taskforce of adolescents could be established to initiate a discussion on what will influence their generation in relation to drug use including methamphetamine. In her view you start developing education initiatives by involving adolescents.¹²⁸⁴

School drug education — What constitutes effective practice?

The Victorian academic Helen Cahill published research in 2005 on what constitutes effective school drug education. This research is still viewed as establishing the benchmark for evidenced based approaches to classroom drug education. The paper argued that overall classroom drug education programs should not only exemplify good pedagogy but also good health promotion practice.

Cahill believes that good drug education programs do not use scare tactics nor rely on survivors or-ex users to tell their stories.¹²⁸⁵ Nor should they act on the assumption that risky drug or alcohol use is a normal or inevitable part of youth culture:

If the educator frames the entire conversation about drugs inside of the assumption that students will or do use them, this assumption can become a hidden agenda, sending the message that it is the norm to use or use in a risky way. Young people can conclude that there is something ‘wrong’ with them if they don’t follow this pattern (Cahill 2005, p.3).

Similarly, Cahill argues that educators can easily make the assumption that it is *knowledge* that children need to keep them safe around drugs. *‘If they just knew more about drugs — then they would make rational choices not to use them’*:

But whilst young people do need to be informed, it has been demonstrated that knowledge alone is not enough to influence behaviour, and information-only approaches to drug education have not demonstrated reductions in harmful behaviours.

An effective program asks students to *apply* their knowledge about drugs to specific contexts. In applied approaches, as well as considering risk in association with the drug type, amount, and the frequency of use, the students are asked to consider contextual risks associated with when, where and with whom the use will take place, the reason for use or the desired effect of the drug (Cahill 2005, p.3).

Cahill contends that a greater focus should be placed on locating drug education within integrative school health education programs that promote life skills, resilience, strengthen protective factors and lessen risk factors.¹²⁸⁶ They should also promote belonging, participation, coping skills, learning and wellbeing (Cahill 2005).¹²⁸⁷ Such an approach should also be encompassed in formal school policies on student safety and wellbeing and encourage robust teacher training and development on student welfare including drug-related issues.^{1288 1289}

1284 Demand Reduction Workshop convened by Josephine Baxter, Drug Free Australia. Rangatira Methamphetamine Forum, 6 June, Melbourne.

1285 Both these issues are covered below.

1286 See discussion in Chapter 22.

1287 In Europe, where traditionally drug education programs in schools have not been prevalent, there has been a shifting focus to the promotion of drug policies based on enhancing protective school climates and promoting personal and social skills training amongst students ‘and a move away from activities such as basic information provision where the evidence for effectiveness is weak’. See European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2013, pp. 48ff.).

1288 In the Victorian context, see discussion in Chapter 25.

1289 These are approaches that have been recognised on an international level by the World Health Organization. The WHO *Framework for Health Promoting Schools* recommends that schools should be health-promoting places that put a premium on creating an environment that is optimal for the health and wellbeing of students, teachers, parents and the school community (WHO 1994).

Stuart Fenton, an ex-user of ice, told the Committee that in his view as an ex-teacher himself, such approaches were invaluable:

We have such a massive focus on academia in schools. [But] In the schools I worked at there was never any focus on emotions or life skills or any of that sort of stuff. There was occasionally a sort of lip service attempt to do that sort of stuff, but if there was some way to be able to integrate learning about the self, about what our emotions are for, what our needs are, how to communicate, boundaries — all that sort of stuff — maybe that would be a way to prevent this from happening quite as much as it has been happening.

At the moment what we are mainly focused on is down-the-river stuff, with the harm minimisation and the pulling the people out of the water and trying to fix them up. Even then we do not even have adequate resources to do that, or not in Victoria.¹²⁹⁰

More recent reviews of school drug education have made similar findings to Cahill (Midford & Munro 2006; Allsop 2012). Whilst acknowledging that much of the literature on drug education in schools focuses on legal drugs such as alcohol or tobacco, Allsop states that:

The more effective [school] programs do not rely on passive information exchange or a singular focus on skills related to preventing drug use (eg drug refusal skills) but are based on more elemental personal self-management and social skills and on ensuring school connectedness through social and academic competence. They are usually well resourced and ongoing rather than short term and connected to other initiatives across the school and in the broader community, rather than delivered in isolation. This last point is critical — if drug use is influenced by availability, environmental and individual risk factors outside the influence of the education system, it is unlikely that a few hours of drug education will be a sufficient antidote. Of course school based approaches will have limited relevance for those who are at higher risk of harm, such as children who are disconnected from the school system (eg frequent truants, those who have been suspended or expelled), unless they include a strong focus on school engagement and reengagement and attending to the range of other risk factors (Allsop 2012, p.177).

Cahill says that overall effective drug education programs are supported by an integrated school-wide approach to generating pro-social attitudes:

Added value is obtained if community and parental standards and expectations reinforce the positive health promotion messages delivered by the school and if there is integrity of message between the classroom program and the school policy and practices. The drug education program should be housed within a broader health and social education curriculum, be attuned to the cultural and developmental needs of the students, and conducted within an atmosphere of high expectation and support (Cahill 2005, p.14).

The following table gives a list of 'Dos and Don'ts' for communicating with school students on drug use based on the types of best practice evidence outlined in the previous discussion.

Table 23.2 Simple Dos and Don'ts when providing information about drug use

DO	DON'T
<ul style="list-style-type: none"> • Ask what young people know about drugs. • Listen to what they have to say. • Provide information that they see as credible and that matches their experience. • Acknowledge the good things about drugs. • Acknowledge the things young people can do to keep themselves safe. • Focus on the positive things they do. 	<ul style="list-style-type: none"> • Don't generalise about all drugs (eg that they are all dangerous — this is not consistent with young people's experience and you just damage your credibility). • Don't exaggerate the risks or show extremes in an attempt to 'scare' them. • Don't use language or terminology that you don't understand or that isn't your 'natural' language. • Don't pretend you know more than you do.

Source: Commonwealth of Australia 2006, p.73.

¹²⁹⁰ Mr Stuart Fenton, Drug and Alcohol Counsellor, Public Hearing, Ballarat, 18 November 2013.

The need for culturally appropriate approaches

Another hallmark of an effective drug education program is that where appropriate it is tailored to the specific social and cultural needs of its targeted recipient. Drug education experts have argued in this regard that it is particularly important that information provision and educational messages with regard to drugs such as ice be responsive to cultural and language particularities of the target group. In the context of young people from diverse backgrounds, including those at school, it has been said that:

Some cultural groups and those who are socially disadvantaged have proportionately high experience with drugs. Targeted interventions are needed to address those young people who are at a higher risk of drug use problems. It is critical that assumptions or stereotyping about drug use among particular cultural groups do not form the basis of drug education decision-making. Schools for example need to work with local communities and access local prevalence data to determine drug education needs and strategies. Schools that work collaboratively with local agencies, community and cultural representatives, families and students are more likely to provide responsive and targeted drug education programs, policies and practices (Commonwealth of Australia 2004, p.31).

Dusenbury and Falco (1995) identify cultural sensitivity as a critical component of effective drug education programs, noting that although social skills training appears to be successful across different target groups, there is a need to provide culturally and ethnically responsive programs. Most of the research on issues of heterogeneity and school drug education, however, is from the United States, the research in Australia on culturally targeted school drug education being very limited.

Sanci et al. (2002, p 4) report that there are few intervention programs targeting young people from different social and cultural backgrounds at different stages of their drug use. This is despite the growing recognition that interventions and evaluations of effectiveness need to be tailored to different target groups.

Hawks et al. (2002) recommend that drug education programs be made culturally appropriate through the use of strategies such as undertaking formative research with students prior to the program's development and implementation, and ensuring teachers have the skills to adapt such programs to their students' cultural backgrounds and issues of relevance (Commonwealth of Australia 2004, p.32).¹²⁹¹

Culturally appropriate education and information materials are particularly important in the context of Aboriginal communities (Australian National Council on Drugs (ANCD) 2011). As Cristofer Beal from Tanderra AOD Services told the Committee:

Every community is different and it is unlikely that a one-size-fits-all approach will be effective. There needs to be recognition of those hard-to-reach rural and remote areas through targeted funding and resourcing; consideration of culture, again through effective and meaningful consultation.¹²⁹²

School drug education – community views

A number of witnesses have also told the Committee that school drug education that adheres to pedagogical principles outlined above can be worthwhile. For example, advertising executive Dion Appel told the Committee that in some circumstances a structured environment such as a school could work better in getting drug education messages across than a mainstream mass media or non-targeted campaign:

1291 For further comment on the importance of culturally appropriate education and information provision particularly in the context of Aboriginal communities, see Chapter 12.

See also Ms Lynne Macdougall, Manager, Alcohol, Tobacco and Other Drugs, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014; Mr Rudolph Kirby, Chief Executive Officer, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013.

1292 Mr Christofer Beal, Coordinator, Tanderra AOD Services, Bairnsdale, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

In an education environment, people are willing to learn, so you can be a bit more factual in that environment. You could take them on a bit more of a journey, and you could show them from trial right through to addiction what each of those stages looks like. You do not have the luxury of doing something like that when you are communicating [in a marketing campaign] because there are too many messages, but when you are in the education system I think a proper syllabus could be created that talks about and educates what the drug is, what the effects of the drug are, the situations that you are most likely to be encountered with it and how you should approach that particular situation if you do come into contact with it.¹²⁹³

Geoff Munro from the Australian Drug Foundation (ADF) stated in this regard:

Our view is that young people in schools deserve to be well informed about alcohol and tobacco — legal drugs in particular — and to understand the dangers of using illicit drugs, but that should be done within the standard health curriculum by the students' teacher and not be made dramatic, because that does call attention to it. The fact is that young people in Victoria and Australia are at greatest risk of harm from alcohol, of all the drugs, and then tobacco and to a lesser degree illicit drugs. We are concerned that it does appear that the resources Victoria had for school education hit a highpoint in the early 2000s, following the Turning the Tide program. It seems to have been withdrawn. There is less support, in a personnel sense, for schools to conduct drug education.¹²⁹⁴

Peter Wearne from Youth Support + Advocacy Service (YSAS) also supported a comprehensive classroom program on drugs. He told the Committee:

The first thing is, tell the truth about the drug. I think we need a comprehensive education program within the school system that talks about the effects of drugs, the long-term harms, the immediate harms, the dangers, without exaggeration.¹²⁹⁵

Drugs Educator Professor Richard Midford told the Committee, however, that caution was required in including illicit drugs in the school curriculum:

What I would say with illicit drugs is that you have got to be very careful with what you tackle or how you tackle them, because if it is not on the radar for young people, you do not want to give them very prescriptive harm reduction strategies, like, 'If you use heroin, make sure you clean your needle', or that sort of thing because you may actually then give them the confidence to do things which they would not necessarily do. With illicit drugs, in our drug education program we generally went for generic safety strategies about how you keep yourself safe in situations where illicit drugs are being offered — things like blood safety, not taking up things you do not know anything about, staying with friends and that sort of thing.¹²⁹⁶

Professor Midford has also previously commented that drug programs that focus on simply sending strong anti-drug messages may make the community feel good 'but any program that does not change behaviour beneficially is a waste of resources and ultimately a failure of responsibility towards young people' (Midford 2009, p.1690). He argued that prevention programs whether based in school or outside the classroom need to acknowledge why drug use may be pleasurable and attractive for some people (2009).

Some witnesses have expressed the view that the quality of drug education can vary between schools and between different teachers at schools. For example, Mr Richard Michell from Youth Projects indicated that he had concerns about the quality of drug education in schools.

1293 Mr Dion Appel, CEO, Lifelounge Agency, Public Hearing, Melbourne, 16 June 2014.

1294 Mr Geoff Munro, National Policy Manager, Australian Drug Foundation, Public Hearing, Melbourne, 14 October 2013.

1295 Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

1296 Professor Richard Midford, Professor of Health in Education, School of Education, Charles Darwin University, Public Hearing, Melbourne, 3 February 2014.

It seems to vary between different schools because it depends on how they take up their drug education plan and who is actually running the drug education plan. So maybe there is more room for drug and alcohol agencies and drug and alcohol education agencies to be involved in the implementation of drug education in schools.¹²⁹⁷

Other people who spoke to the Committee argued that a classroom teacher needs to be complemented with the employment of a dedicated drug and alcohol instructor who could teach the staff and the teachers about drug use and work in tandem.¹²⁹⁸ This was thought particularly important as school teachers are not experts on drug education and with already onerous workloads neither should they be expected to be.¹²⁹⁹ Conversely, however, the Health Promoting Schools Framework developed by the Commonwealth recognises that:

Whilst in most cases school staff members are not specialist drugs counsellors, they often develop an ongoing relationship with students that may be the most significant relationship with an adult outside the family environment. As such they may play a vital role in intervening early with students to prevent or reduce the uptake of drug use (Commonwealth of Australia 2006, p.1).

Challenges in providing drug education in schools

There are a variety of challenges in providing drug education in a classroom environment. These include knowing *when* to teach young people about drugs and their effects and the level at which such instruction should be pitched. Whether to employ an outside 'expert' in conjunction with the teacher to talk about drugs is also contentious.¹³⁰⁰ This may be particularly controversial where the 'expert' is an ex-user. Finally, instruction on drugs and their effects must be culturally appropriate to the background of the student.

Timing and intensity of School Drug Education

There has been much debate as to when young people are ready to receive education about drugs and their effects and at what stage of their learning the content of such information should be intensified.

The Principles for School Drug Education state in this regard:

Drug education should be provided before problematic behavioural patterns become established and more resistant to change. Program commencement dates should be adjusted to meet the needs of particular target groups...Hawks et al. (2002) identify the timing of interventions as a critical consideration for school drug education programs. They note that there are three important times for interventions that are most likely to impact on behaviour. First is what is called the 'inoculation phase before drug use begins. Second is 'early relevancy' when students are experiencing early initial exposure. Providing programs at this time is when information and skills are likely to have the most meaning. Third, recent research is indicating that there is another important phase known as 'later relevancy' when prevalence of use increases and the context for use changes; for example when young people drink and drive. This WHO report on what works in the area of prevention recommends that school-based programs address these phases, guided by local prevalence data for the school community. Midford, Snow and Lenton (2001) note that the general consensus in the literature is

1297 Mr Richard Michell, Manager, Youth Outreach, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

1298 The Drugs Education in Victorian Schools (DEVS) is a Victorian drugs education program discussed later in this chapter. When DEVS was piloted, a train the trainer model was used whereby professional alcohol and drug training was provided to the teachers who then taught the program itself. In particular teachers were trained to be able to identify students with drug problems or potential drug problems and then make the appropriate referrals.

See also on this point the views of Professor Richard Midford, Professor of Health in Education, School of Education, Charles Darwin University, Public Hearing, Melbourne, 3 February 2014 and Professor Steve Allsop, Professor, and Director, National Drug Research Institute, Curtin University, Public Hearing (via teleconference), Canberra, 11 February 2014.

1299 See for example Mr Peter Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013.

1300 An external expert *brought into* the school in this context is different from an alcohol and drugs specialist employed by the school as discussed in the previous section.

that the optimal time for initiating youth drug interventions is during late primary/early teens when experimentation starts. Onset can vary in different populations and with different drugs (Spooner, Hall and Lynskey 2001). Hence the timing of programs needs to take into consideration appropriate prevalence data and be responsive to the particular target groups and drugs (Commonwealth of Australia 2004, pp.40-41).

From a pedagogical perspective, Cahill argues that:

The research indicates that drug education should take place before young people are routinely exposed to making choices about drug use. In addition, further education should be provided when young people are engaging with the decisions in their social contexts.

As with any education program, the focus and tasks should be developmentally appropriate. The best time to begin the education program seems to be late primary or early secondary school so as prevention work can occur before experimentation occurs. Age appropriate booster sessions are also needed in the middle to later years in secondary school, or around the time when adolescents are making drug-use decisions in their social contexts (Cahill 2005, p.9).

Similarly, a landmark analysis of the evidence base on drug prevention and drug education, *'The Prevention of Substance Use, Risk and Harm in Australia: A Review of the Evidence'*, also suggested drug education programs may be less effective when they are initiated too early. They also recommended that drug education be targeted at the late primary and early secondary years.

The consensus is that the optimal time for introducing youth preventive programs is late primary school or early secondary school, when experimentation often begins. This may also help to capture higher-risk individuals who may leave school early. Junior programs should be generic as the most effective programs for reducing cannabis use at this stage are also effective in reducing tobacco and alcohol use (Loxley et al. 2004, p.120).

Life skills rather than drug specific education in the earlier years

Rather than specific drug education in early primary school, Cahill suggests the 'development of social competence' should be a priority for younger children:

A broad prevention approach to drug education could include a focus on enhancing resilience or attributes associated with resilience including social competence, problem-solving, autonomy and a sense of purpose and optimism. A social skills curriculum in the early and middle years of primary school may be the most appropriate foundation to support a later investment in a drug education curriculum (Cahill 2005, p.10).

When children reach upper primary or lower secondary school they then may be ready for more specific content on drugs and their effects. However, to be successful such education needs to be prolonged and sustained and accompanied with continual emphasis on the development of life skills and resilience training:

A review of the literature also identifies that the intensity of the intervention may also be important in its success. It appears that most of the successful programs are intensive and long-term (including booster sessions)... This has implications for school delivery. Competing pressures in a crowded curriculum may mean that teachers only dedicate a few lessons to drug education and thus the efficacy of the program may be jeopardised (Cahill 2005, p.10).

Community views on timing the message

Witnesses to the Inquiry had mixed views as to how early (or late) drug education messages should be targeted at young people. Overall, the consensus seemed to be that factual non-sensationalised information on illicit drugs could be targeted at late primary and early secondary school students. As Cristofer Beal explained:

We need quality information and whether that quality information is there is another thing. How it is delivered is a different story, but it has to be targeted, it has to be appropriate, it has to be done at an early stage. It is pointless educating people at 35 about the impacts of alcohol and drugs. We need to get in there early. We need to be teaching our children about it in such a way — sex education is often spoken about, teaching young children about sex. There are two schools of thought. Do you tell them about it when they are nine years old before they are active or do you tell them when they are 13 years old when they are that much closer to being involved with it?... These kids are not staying in school past year 9, so getting them at year 10 is not going to do any good. We need to get them when they are there, when they are in school, when they are young and you can actually get some information into them.¹³⁰¹

Professor Richard Midford told the Committee that in terms of the *Drug Education in Victorian Schools* program:

In terms of when to start drug education, we started in year 8. We focused very much on alcohol, and then we went into illicit drugs in year 9. We started at year 8 with alcohol because that is when use tends to rise, and with cannabis anyway it tends to rise a bit later on, so we tended to deal with it a bit later in the program.¹³⁰²

Certainly Don Currie from Gateway Community Health in Wodonga thought that drug education needed to be provided ‘way before the train has left the station’:

It is providing this education to children before they even get to high school so that they are aware of the dangers that are out there. It is also making sure that we are providing the education without creating hysteria.¹³⁰³

Dion Appel thought the timing of school drug education was complex but on balance believed the later years of primary school was probably best:¹³⁰⁴

I think it has to be upper primary; I do not think you can wait until secondary school to start educating. I would think that grade 4 or grade 5 is not too young. They [children] are pretty mature these days, especially with the access to technology and what they are exposed to.¹³⁰⁵

Fiona Harley from Mallee Family Care wondered whether drug education might not even be pitched at an earlier age, in the early years of primary school:

If I think about smoking as an example, over the years there has been a lot of focus on very early education — by ‘very early’ I mean preschool and kindergarten and primary school children — around how bad smoking is. As a consequence of that, lots of kids are going home and saying to mum and dad, ‘Smoking’s going to kill you’. In their minds smoking is really bad and something their parents should not be doing and they should not be doing because in fact it could kill you. It has been in their psyche from a very early age, and I know adults who give up smoking because of that ...

I wonder whether we should not be looking at education around drug use in the same way — that it is not okay and that they learn from the time they are really little that it is not okay to do that. We teach kids that it is not okay to punch people or to be violent or to rob houses or to do those sorts of things, and that is taught from a very early age, so I think this may be something that perhaps we need to be looking at... Younger children are little sponges, and if you get it in their psyche that it is not okay to do something, then in fact — not for all, but for many — that will stay with them through life.¹³⁰⁶

1301 Mr Christofer Beal, Coordinator, Tanderra AOD Services, Bairnsdale, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

1302 Professor Richard Midford, Professor of Health in Education, School of Education, Charles Darwin University, Public Hearing, Melbourne, 3 February 2014.

1303 Mr Donald Currie, Team Manager Alcohol & Other Drugs, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014.

1304 This view was also expressed by John Thompson, General Manager with Mitchell’s Advertising, speaking as a parent rather than a drug expert. Mr John Thompson, General Manager, Mitchell & Partners, Public Hearing, Melbourne, 24 March 2014.

1305 Mr Dion Appel, CEO, Lifelounge Agency, Public Hearing, Melbourne, 16 June 2014.

1306 Ms Fiona Harley, Deputy Executive Director, Mallee Family Care, Public Hearing, Mildura, 5 December 2013.

Drug education can't be a 'one off' part of the curriculum

Criticisms have been raised that drug education is seldom sustained across primary and secondary school. For example, witnesses from Junction Support Services, a youth support agency, believed that drug education needed to be staggered during the secondary school years. To limit school drug education to one particular time in the six years of secondary school was insufficient. In their view, drugs education in Year 7 and again in Year 10 would be a good start with the messages becoming more sophisticated, detailed and frank on specific drugs such as methamphetamine in the later years of school.¹³⁰⁷ Several other witnesses thought drug education also needed to be ongoing rather than just reactive and 'one off'.¹³⁰⁸ As Professor Steve Allsop stated in this regard:

Drug education is not something that you can teach for one hour and then drug education is done. The most effective approach [to] drug education is [that it is] being taught within a health context, within a health curriculum and [that it is] intense and continues over a period of time. We need to recognise that drug education needs to be delivered throughout a young person's career, but we need to match it to the challenges they might face, the learning challenges. In the early stages of a young person's career it might be simply providing information, but as they begin to face developmental and learning challenges and challenges in the real world it's about matching that so providing intervention before behaviours are well established.¹³⁰⁹

This was something that Laurence Alvis from Uniting Care ReGen definitely agreed with:

With drug education, what we have found all the way through is that a single session around drug and alcohol just does not work. It goes in one ear and out the other. It has to be integrated into the syllabus, and as a real issue that is brought up all the time because it is something that is coming up all the time.¹³¹⁰

The use of 'experts' in getting the message across

The use of external people with experience of drug issues has also been an issue some schools have engaged with. The employment of outside experts might take two forms. First, in the school context expert educators and health workers may be employed to do train the trainer programs with teachers and education staff. Second, experts in the field may be engaged to come into the schools and do 'hands on' sessions with students. This is seen as being more generally appropriate at secondary school level. For example, Paul Dillon a drug education expert who gave evidence to the Committee frequently visits government and independent schools around Australia addressing young people on alcohol and illicit drugs. Paul also provides tailored drug education programs and presentations to students, teachers, education support staff and parents through his company, Drug and Alcohol Research and Training (DARTA).¹³¹¹

The employment of ex-users of drugs can also be used in schools, at least in the final years of education.¹³¹² Certainly it has been remarked by some observers that AOD staff with knowledge and even personal experience of methamphetamine use or at least 'general life

1307 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Public Hearing, Wodonga, 24 February 2014; Mr David Reid, Public Hearing, Wodonga, 24 February 2014.

1308 See for example, Ms Suzie Mansell, Manager, Community Partnerships, Greater Bendigo City Council, Public Hearing, Bendigo, 25 October 2013.

1309 Drug Education: An Effective undertaking for schools — An Interview with Professor Steve Allsop. www.education.vic.gov.au/Documents/about/.../sallsoptranscript.docx.

1310 Mr Laurence Alvis, Chief Executive Officer, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013.

1311 See <http://darta.net.au/>.

1312 Most often, however, ex-users are employed in peer education programs *outside* of the school environment particularly with young people who are at risk and/or disengaged from formal education. This may particularly be the case where the user is of the same age as the audience and has moved in similar environments. Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013. See also the discussion in Chapter 13.

Another area where ex-users have been employed is in mentoring programs for people at risk of drug abuse and other destructive behaviours. See discussion in Chapter 22.

experience and understanding of drug use and drug users' is important' (Kenny et al. 2011, p.5).

Rob McGlashan from the Northern Mallee Partnership suggested the use of *informed* and properly educated people with experiential knowledge of methamphetamine use may be a powerful tool for disseminating credible information messages on the drug both within schools and in the general community. This could be either an ex-user or a family member with first-hand experience of dealing with the problems associated with methamphetamine:

There is nothing more powerful than a real-life example. We are working with some people now who are coming on board with us. Their stories are so much stronger than ours. It is incredibly powerful when they talk about their own life experiences, their family hardship, their financial hardship and so forth. The textbook presentations are okay, but they only go a certain way.¹³¹³

Mr McGlashan believed that in the schools context, a trained, properly informed frontline 'expert' could be instructive: 'I believe the kids will take that a bit more seriously than the arts teacher'.¹³¹⁴

John Thompson from Mitchells Advertising thought that whilst people with real life experience or individual exposure to the drug could be useful, he would 'avoid at all costs' having celebrities endorsing a particular campaign as these type of approaches tend to lack credibility.¹³¹⁵ And Claire Yeatman from Zena Women's Services also believed that the use of 'real life experience' could be instructive likening it to some of the ex-prisoners who talk to young people about family violence:

I have found from personal experience getting prisoners that have done their time for the crimes they have committed that come in to talk to young people about their own experiences is the way to go. That is what we did in the UK when I was a drug and alcohol counsellor working with prisoners. I worked with 600 prisoners in two years around their drug choice and their mental health issues. By getting them to come out and speak to young people in schools that is where you engage because they have been at the same level as young people and they can evidence their experience by saying, 'I did five years in gaol. I did this crime because I was on this drug. Look at me. Look where I am today'. It is personal experience sometimes that is the way to go engaging young people, especially ones that are used to it from their parents, from their peers. It is a good way to go.¹³¹⁶

David Reid an ex-user of crystal methamphetamine also told the Committee that the employment of recovering users of drugs like methamphetamine such as himself could be valuable in deterring young people from drug use:

I reckon the best way is at school before they get on it. Send somebody out there that has done it, because if you send somebody out there that does not know about it and has not experienced it, they do not really know what they are talking about. If you send somebody out there that has done it and has been there, you can stand up and say, 'Hey, look, I've lost this, this has happened,' a lot more people will relate to it.¹³¹⁷

Criticisms with regard to employing ex-users

The engagement of ex-users is an intervention model that is not without its critics. Although Victorian schools operate within an autonomous environment and are not *prohibited* from engaging the services of ex-drug users:

1313 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

1314 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

1315 Mr John Thompson, General Manager, Mitchell & Partners, Public Hearing, Melbourne, 24 March 2014.

1316 Ms Claire Yeatman, Support Service Manager, Zena Women's Services, Public Hearing, Geelong, 28 October 2013.

1317 Mr David Reid, Public Hearing, Wodonga, 24 February 2014.

[e]vidence suggests this is not an effective mechanism by which to promote pro-social and positive behaviours or minimise drug-related harm and as such the Department [of Education and Early Childhood Development] would not endorse this activity in schools.¹³¹⁸

Education academics question the use of ex-drug users to speak to students about their experiences. Cahill for example argued:

[These tactics] can inadvertently *glamorise* risky behaviours. The ‘survivor’ or ex-addict can gain a heroic status in the telling of their story. Thus scare tactics may make certain behaviours more attractive or compelling, especially to those with something to prove, those with an adventurous streak, or to those who are driven to cause themselves harm (Cahill 2005, p.2).

Shane Varcoe, Executive Director of the Dalgarno Institute (Coalition of Alcohol and Drug Education) also believes there are serious problems with having ex-addicts speak in school. In particular he was concerned that some young people may look at these people and see that they had used drugs but were now ‘OK’.¹³¹⁹

Finally, Francis Broeckman of Brophy Family and Youth Services in Warrnambool also believed that the use of ‘experts’ such as ex-users needs to be addressed very carefully. *Where* the user speaks is also important. A presentation by an ex-user may be appropriate in the setting of a youth drug rehabilitation facility but not in a school. According to Mr Broeckman, in the school environment a combination of the school teacher whom the students may trust and a person with professional AOD knowledge may be the appropriate way of delivering ‘expert’ drug information:

Some people who have come through it — and they need to be professionally assessed to ensure that they are not inadvertently saying how wonderful it was, and how great they are in terms of having got through it, because that might be giving the messaging, ‘You can have a crack at it but you’ve got to be strong to get out the other end’, Those people need to be carefully screened to ensure that they are giving the right messages.¹³²⁰

The importance of the classroom teacher

Whilst outside ‘experts’ may be useful in complementing drug education in schools, they should not supplant the role of a well-trained teacher, according to some witnesses.

Professor Richard Midford, for example, was opposed to the use of outside ‘experts’ or role models as the sole instrument for delivering drug education.¹³²¹ This is in his view primarily, at least in the school context, the teacher’s role:

I have a very strong view on that. The literature suggests that it should be the teachers. That does not preclude the teacher, in doing drug education, getting somebody in as part of the program....

It is much better to have a teacher on the basis that the teacher knows the kids. If anything comes up and the teacher is somebody the students trust, they will follow that up with the teacher. The teacher is somebody who will follow those kids through and is available, whereas somebody from outside is a one-off hit. They may be really good at doing their presentation, but that follow-up and continuity is simply not there.¹³²²

Professor Steve Allsop has also made similar comments:

1318 Information provided to the Law Reform, Drugs and Crime Prevention Committee by Mr Darren Brown, Chief of Staff, Office of the Hon Martin Dixon MP, Minister for Education, 11 July 2014.

1319 Mr Shane Varcoe, Executive Director of the Dalgarno Institute (Coalition of Alcohol and Drug Education. Observations at Panel Group Summary of the Rangatira High Level Summit on Methamphetamine, June 6, Melbourne.

1320 Mr Francis Broeckman, Chief Executive Officer, Brophy Family and Youth Services, Public Hearing, Warrnambool, 3 March 2014.

1321 Midford, Snow and Lenton (2001) also note that external and peer leaders are unlikely to have the organisational and management skills to instruct in drug education programs without at least the assistance of teachers.

1322 Professor Richard Midford, Professor of Health in Education, School of Education, Charles Darwin University, Public Hearing, Melbourne, 3 February 2014.

The first thing that stands out for me is, in relation to drug education is who's the most important person to deliver drug education and for me the most important person, the most skilled person is actually, within the school system that is,...are teachers. Teachers are trained to work with young people, to educate young people, to teach young people. And whilst in the past a lot of people have turned to external expertise... In fact the evidence tells us the best people to deliver education are school teachers. We need to equip school teachers with the skills where they are needed, with information where that's needed and with resources to back up their role. If we bring in external expertise it should be for specific things, for example we might bring in the police for information about the law, but essentially the best people to deliver drug education are teachers.¹³²³

Francis Broeckman told the Committee that it was necessary to be careful when engaging ex-users in relating their experiences with drug use. At the same time he recognised that teachers were not always sufficiently knowledgeable or confident in instructing students in this area. A possible compromise, in his view, could be AOD experts presenting in tandem with the teacher.¹³²⁴

Parents and carers can also help

Research has shown that young people usually rely on the values and attitudes of parents and caregivers when making important life decisions:

It does help for parents to talk to their children about alcohol and other drugs, and parents can have a positive influence on their children by communicating with them about these issues (Commonwealth of Australia 2006, p.115).

Drug educators have therefore argued that it is not only important that family members, particularly parents, get information on drugs for their own benefit, but also to enable them to assist and support their children about drug use. This may be particularly the case for young people who are still at school, whether or not they have commenced using drugs:

It is essential to involve parents or caregivers in the management of drug use issues, and school policies and guidelines provide support in working with parents. There are a number of scenarios relating to working with parents or caregivers:

- involving them in the prevention of alcohol and other drug-related problems
- raising the issue of alcohol and other drug use issues and incidents with them
- responding to their concerns about their child's drug use
- responding to the concerns of students in relation to the alcohol or other drug use of their parents or caregivers (Commonwealth of Australia 2006, p.115).

Parents, like school staff, health professionals and community members, can assist in the prevention of alcohol and other drug use and related problems among students by:

- being positive role models
- being consistent
- providing credible information
- listening and allowing for open communication
- developing positive relationships with them — teaching responsibility (Commonwealth of Australia 2006, p.115).

Commonwealth Government approaches to drug education

1323 Professor Steve Allsop, Professor, and Director, National Drug Research Institute, Curtin University, Public Hearing (via teleconference), Canberra, 11 February 2014.

1324 Mr Francis Broeckman, Chief Executive Officer, Brophy Family and Youth Services, Public Hearing, Warrnambool, 3 March 2014.

At the Commonwealth level, the Australian Government provides national leadership 'in setting national policy priorities for school education and investing in actions to secure nationally agreed policy priorities'.¹³²⁵ This may include the provision of national guidelines and national frameworks for various aspects of school education including drugs. The Principles for School Drug Education discussed above are one such example. State governments on the other hand have responsibility for the delivery of specific school education programs including those pertaining to school drug education.

The (former) National School Drug Education Strategy and its successors

The key Commonwealth strategic framework for school drug education was The National School Drug Education Strategy (NSDES). This strategy developed an overarching framework to promote a nationally consistent approach to school drug education. The Strategy was informed by research and evidence-based practice and supported the development of resources and implementation of a range of initiatives to assist schools and the broader school community to deliver effective drug education. In the 2012-13 Budget the NSDES and the Values Education and Values Drugs programs were merged into one program to form the Students Resilience and Wellbeing Program (SRWP).¹³²⁶

The SRWP aims to improve student wellbeing by:

- Helping students develop capabilities which promote health and wellbeing and lead to success in life
- Ensuring the school and home learning environments are supported
- Strengthening engagement with parents and the wider community.¹³²⁷

The SRWP is complemented by the National Safe Schools Framework (NSSF), which aims to ensure that all Australian schools are 'safe, supportive and respectful teaching and learning communities that promote student wellbeing'. The Framework supports the Safe Schools Hub a 'one stop shop' information service that provides the tools and knowledge that will enable all members of the school community to:

- nurture student responsibility and resilience
- build a positive school culture
- foster respectful relationships
- support students who are impacted by anti-social behaviour, including bullying and cyber-bullying.¹³²⁸

The Safe Schools Hub project is funded by the Australian Government, working in partnership with state and territory governments, the non-government school sectors and Education Services Australia.

The National Education Curriculum

The Australian Curriculum, Assessment and Reporting Authority (the Authority) develops the national or Australian curriculum. The national curriculum is designed to provide a national standard for student achievement founded on building essential knowledge, understanding, skills and capabilities.¹³²⁹ The Council of federal, state and territory education ministers is responsible for endorsing the Australian Curriculum, with state and territory education authorities being responsible for its implementation.¹³³⁰

1325 <https://education.gov.au/school-education>.

1326 <http://education.gov.au/>.

1327 <http://education.gov.au/student-resilience-and-wellbeing>. See also discussion in Chapter 22.

1328 <http://education.gov.au/safe-schools-hub-0>.

1329 The Australian Curriculum, Assessment and Reporting Authority, *The Australian Curriculum*, accessed at <http://www.australiancurriculum.edu.au/>.

1330 The Australian Curriculum, Assessment and Reporting Authority, *The Australian Curriculum*, accessed at <http://www.australiancurriculum.edu.au/>.

In the context of this Inquiry, the national curriculum incorporates drug education material as part of the health and physical education component. The material developed by the Authority is tailored to different age groups. For example, in the material for years three and four health and physical education, teachers discuss strategies aimed at helping students to be healthy, safe and active in different scenarios including ‘identifying and practising appropriate responses to unsafe situations in relation to drugs and drug use’.¹³³¹ Other modules deal with ‘investigating reasons why young people choose to use or not use drugs, and proposing strategies to make informed choices’,¹³³² ‘scripting and rehearsing how to refuse drugs they may be offered, such as medication, tobacco product or alcohol’,¹³³³ ‘investigating the impact of performance-enhancing drugs on individuals and sporting codes’,¹³³⁴ and ‘analysing how societal norms, stereotypes and expectations influence the way young people think about their bodies, food, physical activity, sexual health, drugs and/or risk-taking behaviours’.¹³³⁵

Policy approaches to school drug education in Victoria

The policy model for drug education in Victoria is based on ‘a whole school approach that utilises research and evidence-based practice, effective pedagogy and encourages a positive school climate and strong partnerships’.¹³³⁶

Victorian Drug education focuses on educating students about the risks associated with drug use and promoting healthier alternative behaviours. Drug education in Victorian schools includes an emphasis on:

- developing students’ life skills and protective behaviours
- promoting the range of relationships in which students can engage
- ensuring that students are connected to their schooling
- external influences such as, media, family and peers.¹³³⁷

Overall, the Australian National Curriculum for Victoria and the Commonwealth Principles for School Drug Education provide the framework for delivering drug education in Victoria. The Victorian Health Education Approaches Policy in the School Policy and Advisory Guide (SPAG) stipulates that schools should deliver drug education consistent with the Principles for School Drug Education, which is referenced as best practice approaches in whole-school drug education strategies in this Policy.¹³³⁸

It should be noted that the former overarching strategic and policy document, the *Victorian amphetamine-type stimulant (ATS) and related drugs strategy 2009-2012* placed a key emphasis on prevention and early intervention.¹³³⁹ A key element of this priority area was targeting young people through school-based education on drugs. This strategic framework, however,

1331 See the Australian Curriculum, Assessment and Reporting Authority, subject material codes ACPPS035, ACPPS073.

1332 See the Australian Curriculum, Assessment and Reporting Authority, subject material code ACPPS073, accessed at <http://www.australiancurriculum.edu.au/Search?q=drugs>.

1333 See the Australian Curriculum, Assessment and Reporting Authority, subject material code ACPPS054, accessed at <http://www.australiancurriculum.edu.au/Search?q=drugs>.

1334 See the Australian Curriculum, Assessment and Reporting Authority, subject material code ACPMP107, accessed at <http://www.australiancurriculum.edu.au/Search?q=drugs>.

1335 See the Australian Curriculum, Assessment and Reporting Authority, subject material code ACPPS089, accessed at <http://www.australiancurriculum.edu.au/Search?q=drugs>

1336 Information provided to the Law Reform, Drugs and Crime Prevention Committee by Darren Brown | Chief of Staff | Office of the Hon Martin Dixon MP, Minister for Education|. 11 July 2014.

1337 Information provided to the Law Reform, Drugs and Crime Prevention Committee by Darren Brown | Chief of Staff | Office of the Hon Martin Dixon MP, Minister for Education|. 11 July 2014.

1338 See <http://www.education.vic.gov.au/school/principals/spag/curriculum/Pages/health.aspx>.

1339 Victorian Government, *Victorian amphetamine-type stimulant (ATS) and related drugs strategy 2009-2012*, pg. 5.

has now lapsed and it is unclear as to what extent schools based drug education will form part of any new strategic alcohol and drugs framework for Victoria.¹³⁴⁰

Current Victorian drug education programs for schools

Although there are few school education programs specifically addressing crystal methamphetamine in Victoria, there are a number of programs that teachers can use to address alcohol and drug use as part of a broader health promotion and life skills curriculum (discussed below). Schools can use these programs as part of the 10 hours of drug education per year level, per year they are required to deliver in accordance with the SPAG.¹³⁴¹

In devising these programs the Department of Education and Early Childhood Development (DEECD) partnered with a range of experts to support the development and delivery of health and wellbeing messages and to develop the materials as indicated in correspondence to the Committee from the DEECD:

DEECD liaises regularly with other Departments, including Department of Health and Department of Human Services, as well as organisations such as headspace, KidsMatter, MindMatters, Turning Point and YSAS (Youth Support and Advocacy Service).

The Get Ready Drug Education program was informed by a number of resources produced by experts from organisations such as The Youth Substance Abuse Service, The Centre for Adolescent Health, and the Centre for Youth Drug Studies, as part of the National School Drug Education Strategy and state-based initiatives in Victoria and other states and territories.

In terms of program delivery, under Victorian curriculum policy schools operate within an autonomous environment and may choose to deliver different drug education programs in different models according to the age of the student or any particular need.¹³⁴² Thus, for example, some materials may be particularly suitable for and culturally appropriate to the needs of Aboriginal youth or culturally and linguistically diverse (CALD) students.

The following section outlines some of the major drug education programs currently being used in Victorian schools. These programs generally are based on the types of approaches espoused in the PSDE and other examples of best evidence drug education pedagogy.

Drug Education in Victorian Schools

The Drug Education in Victorian Schools (DEVS) Study (DEVS study) investigated the effectiveness of a pilot, comprehensive, evidence-based, harm reduction focused school education program for junior secondary students. The education program once implemented in Victoria became known as the Get READY Program (discussed below). The DEVS study assessed the program over a three-year period, and addressed issues around the use of alcohol, tobacco, cannabis and other illicit drugs.¹³⁴³

At the end of the study, the researchers made a number of conclusions. In assessing the trial by reference to use of the program, it was concluded that the program was ineffective.¹³⁴⁴

1340 Under the Victorian ATS Strategy a variety of communication material was published to help encourage discussion about drugs between parents and young people. These included general drugs material such as *Talking Facts together*, *Parent involvement in drug education*, *Drug information for parents* and specific material such as *What parents should know about Ice*. The latter document provided an overview of crystal methamphetamine, its effects and risks, strategies for talking about drugs with children.

1341 <http://www.education.vic.gov.au/school/principals/spag/curriculum/Pages/health.aspx>

1342 Information provided to the Law Reform, Drugs and Crime Prevention Committee by Mr Darren Brown, Chief of Staff, Office of the Hon Martin Dixon MP, Minister for Education, 11 July 2014.

1343 Midford R, Cahill H, Foxcroft D, Lester L, Venning L, Ramsden R & Pose M 2012, *Drug education in Victorian schools (DEVS): the study protocol for a harm reduction focused school drug education trial*, BMC Public Health, 2012, 12:112.

1344 Midford R, Cahill H, Foxcroft D, Lester L, Venning L, Ramsden R & Pose M, *Drug Education in Victorian Schools (DEVS) — Findings from comprehensive school drug education pilot research project*, PowerPoint Presentation, date unknown, accessed at http://www.dao.health.wa.gov.au/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntityId=272&PortalId=0&TabId=211.

However, the researchers found that in terms of reducing risk and harm, the ‘program produced meaningful change’ making it a ‘worthwhile result for a mass program’.¹³⁴⁵

Professor Richard Midford one of the architects of DEVS, explained the program when he gave evidence to the Committee. He emphasised, however, that the content of the program was only marginally related to illicit drugs such as methamphetamine:

Drug Education in Victorian Schools was a study that started off as a pilot with three schools. We then got an ARC linkage grant and extended the trial to 21 schools across Victoria. It was a program that targeted all drugs, both licit and illicit, so we targeted alcohol, tobacco, cannabis and other illicit drugs. We found that in terms of alcohol and tobacco we did not reduce uptake — we did not stop people from using — but we found that we reduced consumption. We reduced harmful or risky consumption — that is, consumption of five or more standard drinks per occasion — and we reduced associated harm. The same was the case with smoking. We did not reduce uptake, but we reduced the amount that people smoked, and we reduced the harms associated with smoking.

What I would say in regard to illicit drugs apart from cannabis is that we virtually recorded no responses in terms of illicit drug use, and what responses we did record tended to be around ecstasy use.¹³⁴⁶

Professor Midford told the Committee that a major difference between DEVS and other drug education programs is that whilst abstinence approaches could be incorporated into the teaching; they were not the only focus unlike some American models:

Drug education is quite controversial in that most of the research comes out of America; about 75 percent of published research is American. They tend to have as their goals abstinence or delayed onset, and their programs in terms of those objectives have not been very successful, so drug education does not have a good reputation. What we tend to do in Australia, and not just in the DEVS program but generally — programs in Australia tend to focus on reducing harm and then measure outcomes in terms of reduced harm rather than reduced use.

The DEVS program in Victoria found that drug education has been useful in reducing harm. Harm can be measured in a number of ways and should not exclude abstinence. Abstinence is a legitimate harm reduction strategy, but in some cases it is not going to be appropriate; people may have already started to use, and to try to say, ‘Don’t take up use’, or, ‘Don’t use’, is not going to be particularly effective as a drug education strategy.¹³⁴⁷

Get Wise

Get Wise was an educational resource produced for use in schools which was produced as part of the Drug Education Support for Schools (DESS) project.¹³⁴⁸ It built on an earlier program, *Get Real*, which provides teachers and principals with information and examples of drug education and drug-related student welfare using a ‘policy, curriculum and welfare perspective’.¹³⁴⁹ A key difference between the two programs is that *Get Real* focuses on licit drugs whereas *Get Wise* extends the curriculum and approaches to illicit drugs.¹³⁵⁰

1345 Midford R, Cahill H, Foxcroft D, Lester L, Venning L, Ramsden R & Pose M, *Drug Education in Victorian Schools (DEVS) — Findings from comprehensive school drug education pilot research project*, PowerPoint Presentation, date unknown, accessed at http://www.dao.health.wa.gov.au/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=272&PortalId=0&TabId=211.

1346 Professor Richard Midford, Professor of Health in Education, School of Education, Charles Darwin University, Public Hearing, Melbourne, 3 February 2014.

1347 Professor Richard Midford, Professor of Health in Education, School of Education, Charles Darwin University, Public Hearing, Melbourne, 3 February 2014.

1348 *Get Wise: working on illicit in school education: drug education resources for schools and their communities*, pg. 1, accessed at <http://www.education.vic.gov.au/Documents/school/teachers/health/getwise1to100.pdf>.

1349 *Get Wise: working on illicit in school education: drug education resources for schools and their communities*, pg. 1, accessed at <http://www.education.vic.gov.au/Documents/school/teachers/health/getwise1to100.pdf>.

1350 *Get Wise: working on illicit in school education: drug education resources for schools and their communities*, pg. 1, accessed at <http://www.education.vic.gov.au/Documents/school/teachers/health/getwise1to100.pdf>.

The illicit drug focus in *Get Wise* is framed by reference to drugs which are illegal to cultivate, manufacture, sell or possess, as well as drugs which are not legally available to the general population or have conditions applied to their use (for example, by prescription).¹³⁵¹ *Get Wise* consists of six booklets which are set out below:

- ◆ *The Principal's Guide* — which provides guidance to principals on drug education curriculum, student welfare and dealing with drug-related incidences, including structures for monitoring and supporting students who are at risk;
- ◆ *The Student Welfare Action Manual* — which provides student welfare staff with strategies and advice to 'enhance student welfare through drug education with a focus on illicit drugs';
- ◆ *Communication with Parents* — a booklet for schools on how to work with parents on drug education;
- ◆ *The Primary Classroom Activities* — aimed at guiding teachers on the development of their classroom approach and teaching of illicit drugs in upper primary levels;
- ◆ *The Secondary Classroom Activities* — as above but aimed at secondary school students; and
- ◆ *The A to Z of Illicit Drugs* — an up-to-date directory of information on illicit drugs.

In terms of the education approach to illicit drugs, *Get Wise* informs its readers that curricula that use prohibition approaches, only provide information, focus solely on long-term consequences or try to scare students, among others, are ineffective.¹³⁵² Instead, *Get Wise* suggests that successful drug programs are those that 'combine knowledge, social and life skills and values clarification'.¹³⁵³ Further, in its discussion of curriculum leadership, *Get Wise* explains that the harm minimisation approach is the preferred approach and is appropriate for all students.¹³⁵⁴

Get READY

The *Get READY* program was developed by the Victorian DEECD for Years 7 to 9. It is 'designed to assist teachers to provide evidence-based approaches to help students explore positive ways to address drug-related issues'.¹³⁵⁵ It received the 'Excellence in Prevention and Community Education Award' at the 2012 National Drug and Alcohol Excellence awards. This suite of learning and teaching activities was released in 2013 and is available online to all Victorian schools:

The resources are designed to support teachers to deliver 10 hours per year of evidence-based drug education, through which students explore positive ways to address drug-related issues. Information around the effects of illicit drugs including cannabis, amphetamines (speed and ice), ecstasy and cocaine, as well as licit drugs including tobacco, alcohol and painkillers are included in the resources for Years 8 and 9 students. The Year 7 materials focus on alcohol and tobacco.¹³⁵⁶

1351 *Get Wise: working on illicit drugs in school education: drug education resources for schools and their communities*, pg. 2, accessed at <http://www.education.vic.gov.au/Documents/school/teachers/health/getwise1to100.pdf>.

1352 *Get Wise: working on illicit drugs in school education: drug education resources for schools and their communities*, pg. 19, accessed at <http://www.education.vic.gov.au/Documents/school/teachers/health/getwise1to100.pdf>.

1353 *Get Wise: working on illicit drugs in school education: drug education resources for schools and their communities*, pg. 19, accessed at <http://www.education.vic.gov.au/Documents/school/teachers/health/getwise1to100.pdf>.

1354 *Get Wise: working on illicit drugs in school education: drug education resources for schools and their communities*, pg. 20, accessed at <http://www.education.vic.gov.au/Documents/school/teachers/health/getwise1to100.pdf>.

1355 Department of Education and Early Childhood Development, *Get READY (Research Based Education Addressing Drugs and Youth) — Year 7 Teacher Manual*, Victorian Government, January 2013, pg. 3, accessed at <https://fuse.education.vic.gov.au/content/0cfb16dc-104a-4792-a4df-f2a87da6d0aa/getreadyyear7teachermanual.PDF>.

1356 Information provided to the Law Reform, Drugs and Crime Prevention Committee by Darren Brown | Chief of Staff | Office of the Hon Martin Dixon MP, Minister for Education|. 11 July 2014.

A number of electronic resources (teacher's manuals and student workbooks among others) form part of the program which is aimed at providing 'secondary school students with essential learning about drug education and healthy relationships'.¹³⁵⁷ Each teacher manual provides 'contextual advice for teachers on the use of the material with students'. The DEECD recommends that 'the 10 lessons for each year level be delivered sequentially, as research supports this as the most effective delivery method'.¹³⁵⁸

An evidence-based, drug and alcohol education program, *Get READY* supports curriculum materials for Years 8-9 developed from an Australian Research Council (ARC) project (the *Drug Education in Victorian Schools Trial 2010–2012*) and is underpinned by the Australian Curriculum in Victoria.¹³⁵⁹ Prior to it being implemented, the program had been trialled in 21 schools, involving 1750 students.¹³⁶⁰

Other materials

In addition to the programs mentioned earlier, the DEECD also produces a number of other drug education resources. *Talking Tactics Together* is a primary school focused interactive family drug education program, which includes resources to help the school community plan and run events on drug-related issues.¹³⁶¹ *Creating Conversations* is a secondary school based program that aims to 'facilitate discussion sessions between parents and children about drug-related issues'.¹³⁶² Through its website, the DEECD also provides drug education guides, documents and tools and links to parent support organisations which provide parent drug education facilitators.¹³⁶³ Examples include *Resilience Education and Drug Information (REDI)*, *Parent Partnerships*, school case studies, and drug information for parents.¹³⁶⁴ The DEECD also provides teachers and schools with guidelines aimed at dealing with drug and substance abuse including drug prevention guides for student welfare coordinators.¹³⁶⁵

Despite the programs and policies that have been established at state government level, some evidence to the Inquiry suggests that the delivery of school based drug education is not as robust as it could be. A submission from Northern Mallee Community Partnership for instance stated:

Education in schools has to be the number one key priority. While we are informed by DEECD 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

1357 Department of Education and Early Childhood Development, *Get READY (Research Based Education Addressing Drugs and youth) — Year 7 Teacher Manual*, Victorian Government, January 2013, pg. 6, accessed at <https://fuse.education.vic.gov.au/content/0c16dc-104a-4792-a4df-f2a87da6d0aa/getreadyyear7teachermanual.PDF>.

1358 Department of Education and Early Childhood Development, *Drug Education — Learning and teaching*, accessed at <http://www.education.vic.gov.au/school/teachers/health/pages/drugedulearn.aspx>.

1359 Department of Education and Early Childhood Development, *Get READY (Research Based Education Addressing Drugs and youth) — Year 7 Teacher Manual*, Victorian Government, January 2013, accessed at <https://fuse.education.vic.gov.au/content/0c16dc-104a-4792-a4df-f2a87da6d0aa/getreadyyear7teachermanual.PDF>.

1360 Department of Education and Early Childhood Development, *Get READY (Research Based Education Addressing Drugs and youth) — Year 7 Teacher Manual*, Victorian Government, January 2013, accessed at <https://fuse.education.vic.gov.au/content/0c16dc-104a-4792-a4df-f2a87da6d0aa/getreadyyear7teachermanual.PDF>.

1361 Department of Education and Early Childhood Development, *Drug Education — Engaging Parents*, accessed at <http://www.education.vic.gov.au/school/teachers/health/pages/drugeducation.aspx>.

1362 Department of Education and Early Childhood Development, *Drug Education — Engaging Parents*, accessed at <http://www.education.vic.gov.au/school/teachers/health/pages/drugeducation.aspx>.

1363 See Department of Education and Early Childhood Development, *Drug Education*, accessible at <http://www.education.vic.gov.au/school/teachers/health/Pages/drugedures.aspx> and <http://www.education.vic.gov.au/school/teachers/health/Pages/drugeduengage.aspx>.

1364 See Department of Education and Early Childhood Development, *Drug Education — Engaging Parents*, accessed at <http://www.education.vic.gov.au/school/teachers/health/pages/drugeducation.aspx>.

1365 Department of Education and Early Childhood Development, *Drug Education — Learning and teaching*, accessed at <http://www.education.vic.gov.au/school/teachers/health/pages/drugedulearn.aspx>.

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.¹³⁶⁶

Approaches in providing information, education and support to young people outside the school system

There will be young people in need of information and advice on drugs such as crystal methamphetamine who will not be engaged in the formal school sector. Tailored strategies need to be developed to address young people in the community who are at risk of potential crystal methamphetamine use or who may even have commenced to consume the drug. For such young people peer education and outreach programs have been commended as particularly useful and non-threatening interventions. The use of online and social media mechanisms may also be of value, allowing young people to access factual information on crystal methamphetamine and its effects in non-judgemental ways. However, the use of the internet and social media can be a two-edged sword. Not only may people access information about the dangers of the drug on the internet they may also use it to find out how to take it and even where to access it.

Tailored approaches for different audiences outside the school system

A recent development in health policy and public health interventions has been to target specific groups for various levels of intervention depending on whether they fall into what have been classified as *universal*, *selective*, or *indicated* populations. The Australian National Council on Drugs (ANCD) describes these discrete groups as follows:

Universal: target entire populations (e.g school students) with messages to prevent, or at least delay, use.

Selective: target at risk youth who are not yet using to prevent or delay use.

Indicated: target those who are already using to prevent abuse, and target those who are abusing substances to prevent progression to further harms (ANCD 2001, p.55).

Many witnesses have given evidence to the Committee endorsing the use of tailored approaches for different groups of young people.¹³⁶⁷ John Ryan, Executive officer of the Penington Institute told the Committee:

The approach in terms of an education campaign and programs is to very much target and segment the audience. It has to be culturally appropriate so that it is not one size fits all. We have seen from overseas that 'Just say no' education campaigns do not work, so we have to have an element of primary prevention but also a nuanced campaign for early intervention for people who are using but are yet to have slipped into serious use or addiction to ice, and then we have to have other programs for people who are using ice problematically and are at risk of transitioning to injecting, for example, and of transitioning to serious addiction to try to pull back that trajectory. The other very important audience is family members who are concerned about ice use in their communities and in particular in their families. My sense is that the best campaigning would be nuanced across all the different cultural groups and also across different ranges of people who are impacted by ice.¹³⁶⁸

Drugs educator Paul Dillon was of a similar view. He told the Committee that targeted campaigns aimed at risk groups were a far better alternative to mass media general campaigns¹³⁶⁹ as far as methamphetamine was concerned:

1366 Mr Rob McClashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013.

In this regard see also the comments of Ms Michelle Withers, Integrated Services Coordinator, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

1367 See also evidence of Mr John Thompson, General Manager, Mitchell & Partners, Public Hearing, Melbourne, 24 March 2014.

1368 Mr John Ryan, CEO, Penington Institute, Public Hearing, Melbourne, 4 July 2014.

1369 See discussion below.

I think the only way that you can really deal with this effectively is by targeted campaigns. I think a broadbased universal campaign is probably a waste — I say ‘waste’, but there are limited funds. I think you have to target and target very specifically the at-risk groups. Realistically I think this is not a drug that is used by most young people, so in a school setting I think you target your education much more at where it is going to do most good. Realistically, for most young people it is alcohol, alcohol, alcohol. In terms of methamphetamine I think it does need to be targeted to at-risk groups, whoever they are. From the data that I have seen from Victoria, it would appear that it is predominantly in regional and rural areas. It would appear that most probably a targeted regional campaign is appropriate as well.

I certainly would not suggest — as I think it would be a bit of a waste, and I do not know quite what you would do — a school-based campaign around methamphetamine... The story about bugs and everything under your skin may work really well on often young people who have no intention of using the drug. But if Victoria — particularly regional Victoria — has such a great problem with amphetamine, as is being said, I think it has got to look at a campaign that is going to have credibility with those people, with that target group. I do not know. Whatever that message is, it has got to be a message that is based on good evidence and is not just completely trying to scare, shock and horrify. It should say, ‘This is what can happen’.¹³⁷⁰

Similarly, a witness from Junction Support Services told the Committee:

A few years ago there were a lot of ads around ice use and violence towards hospital staff, and being aggressive and that kind of thing. I spoke to some of my young parents about that and they said it did not really relate to their experience of using ice at all because they said that seems to be something, like violence, that you are kind of predisposed to, or it is in your personality. Whereas they said they had never violently assaulted anybody, and it was really the opposite, that they got a good feeling when they used and it was a positive thing. That kind of messaging is not really the same for everybody. I am not sure if that advertising against it was necessarily effective for a full range of people.¹³⁷¹

Some groups of young people may particularly benefit from targeted approaches especially if they are an at-risk group of user or potential user. For example, as Chapter 14 discussed, ‘tradies’ and apprentices are one group who may be particularly vulnerable to experimenting with ice. Magistrate Clive Alsop believed that one strategy that could effectively address this issue is to have targeted drug education in trade and technical schools with ongoing ‘boosters’ whilst the apprentice is ‘on the job’.¹³⁷² Education and information provision strategies may also need to be tailored to take into account gender differences, with strategies devised to cater for the particular needs of female users (Brecht et al. 2004).

A problem with some generic approaches to drug education is that they do not differentiate between *different* groups of young people or adolescents. Therefore it is essential that tailored strategies be developed to provide information on methamphetamine and its effects for people already using the drug (Health Education Board of Scotland (HEBS) 2002).

Information provision for users

Lee et al. have stated that methamphetamine users are ‘relatively naïve about the risks and harms associated with methamphetamine use’ (Lee et al. 2007, p.29) The difficulty in providing messages on the dangers of crystal methamphetamine to young people who are already using is that it is a case of telling someone something is bad when it in fact, at least in the early stages, can make you feel so good. As youth worker Les Twentyman told the Committee:

1370 Mr Paul Dillon, Director and Founder, Drug and Alcohol Research and Training Australia, Public Hearing, Melbourne, 3 February 2014.

1371 Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services, Public Hearing, Wodonga, 24 February 2014.

1372 Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates Court, Public Hearing, Traralgon, 28 January 2014.

Just saying, 'Don't take ice, blah, blah, blah', does not cut it, because the thing is it does make them feel really good. That is the hard part about it. I used to say to young people doing heroin, 'What are you doing taking that crap?', and they would say, 'That's the problem, Les, it's so good'.¹³⁷³

Given this reluctance to hear that methamphetamine use is invariably problematic, Lee et al. believe it is essential to give users advice about the potential harms of methamphetamine that is careful, non-judgmental, factual and non-sensationalised (2007). Such an approach is particularly important for young people who are already engaging in methamphetamine use.

The YSAS argues similarly that education and information provided to young crystal methamphetamine users must avoid moralistic and judgmental approaches to drug use in general and recognise the reality of the substance use from the user's point of view.¹³⁷⁴ Peer education approaches may be particularly useful in this regard.

Peer education and outreach approaches¹³⁷⁵

With respect to delivering harm reduction messages and information on methamphetamine generally, drug experts agree on the use of social networks and peer led interventions (Carlson et al 2004; Falck et al 2004 in McKetin et al 2012). Drugs researcher Professor Richard Midford stated that education and prevention programs and messages that 'engage' young people have the best chance of achieving and maintaining benefit — peer education programs are part of such an engagement process (Midford 2009). Mike Sabin, one of the key contributors to of New Zealand's Methamphetamine Action Plan, told the Committee that peer education programs certainly have their place:

In my view one of the most effective tools you can have in education is having it led by the very generation you want to influence. You have to get alongside those people and understand the messages they resonate with and the media they resonate with.¹³⁷⁶

Information about drug use, both accurate and inaccurate is derived from many sources, including from peers, and as noted by Moore, this may be more influential than 'official' sources.

[i]nformation from a personal source rather than a booklet, or other printed material or some other 'official' source is more likely to be understood and assimilated. For these reasons most knowledge about using drugs is almost exclusively derived from other drug users (Moore 1992, p.87).

Drug researchers have also generally agreed that in some contexts; for example amongst disengaged or homeless youth, peers in leadership roles in a program may support the program's credibility and promote positive student norms. In particular, peer education is based on the view that '[y]oung people can explore controversial issues with others of a similar age and background' (DEST 2004, p.49).

Youth marketing expert Dion Appel also underscored the importance of peer approaches and peer networks when he gave evidence to the Committee. In the context of young people, peers are more likely to listen to their friends than they are a parent, schoolteacher or other 'authority figure':

The younger you are, the more you look to your peer network to define who you are as an individual. That is a very challenging position to be in as well, because if your peers do not think you are cool or you are doing the right thing, you can be easily cast out of your social network, and for a young person that is almost more scary than trialling something or doing the right or the wrong thing.¹³⁷⁷

1373 Mr Les Twentyman, OAM, 20th Man Fund, Public Hearing, Melbourne, 9 December 2013.

1374 Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS, Submission, 21 October 2013.

1375 Peer education has been defined as: Members providing education and information to other members of the same group in both formal and informal ways. This model of education is based on social learning and health behaviour theories and is designed to impart information, skills and knowledge to others (peers). Peer education also recognises the influence that peer pressure and behaviours of a peer group have on the decisions an individual makes (ANCD 2011, p.x).

1376 Mr Mike Sabin MP, Member for Northland, New Zealand Parliament, Public Hearing, Melbourne, 5 June 2014.

1377 Mr Dion Appel, CEO, Lifelounge Agency, Public Hearing, Melbourne, 16 June 2014.

Peer education interventions may be particularly valuable for young people who are disengaged from the school system, homeless and/or at greater risk.¹³⁷⁸ In such cases evidence has shown peer education can have a positive influence on ‘knowledge and to a lesser extent attitudes, skills and behaviours’ with regard to drug use (McDonald 2003; Allsop 2012, p.186).

Peer education and methamphetamine use

There is only limited information on the benefit of peer education with regard to methamphetamine use specifically (Allsop 2012). Most reviews of peer education have related to opioid use (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2010). Nonetheless, Allsop argues there is ‘reason to argue that outcomes demonstrated with other illegal drugs could be replicated with people affected by ATS use’ (Allsop 2012, p.186). An earlier survey of methamphetamine users in Adelaide found that users identified peer support and education as an important avenue for accessing information and timely assistance (Vincent et al. 1999 in Lee et al. 2007). Potential options for facilitating peer support and education identified included:

- A collaborative approach with local user groups;
- Providing an environment to support peer groups to meet and exchange information;
- Creating peer positions within an organisation (Lee et al. 2007, p.55).

Peer education has also been identified as particularly important for some Aboriginal communities:

Many [informants] suggested that peer education is a powerful tool for providing [culturally appropriate] information...However, it could be difficult to actually recruit Aboriginal peers, as they may not want to be publicly identified...improvement could be made around the use of peers; in particular ensuring peer educators receive adequate training for their role and have access to up to date information (ANCD 2011, p.79).

Peer education initiatives in Victoria — the work of Harm Reduction Victoria (HRV)

Peer education initiatives have generally been supported and recommended by AOD workers in Victoria.¹³⁷⁹ They are seen as one of the most influential education mediums because for the most part those who deliver the message are *credible* to users or potential users particularly when they come from the same background or environment.¹³⁸⁰ The use of peer education in the drug field can give young people opportunity to have their voices heard.¹³⁸¹ Jenny Kelsall from HRV told the Committee that when it comes to illicit drug use:

[w]e believe that people who use drugs, past and present, are the true experts, so we strongly endorse the principle of ‘nothing about us without us’; we think it is essential that people who use drugs have a voice in the debate about drugs.

Our work is informed by our links to extensive and diverse drug user networks — this is not a homogenous community — and by our specialised knowledge of the culture and context surrounding

1378 See Mr Francis Broeckman, Chief Executive Officer, Brophy Family and Youth Services, Public Hearing, Warrnambool, 3 March 2014.

1379 See for example evidence of Ms Claire Ryan, Alcohol & Other Drug Services Team Leader, Ballarat Community Health, Submission, 12 November 2013.

Other witnesses who strongly commended the use of peer education programs included: Dr David Jacka, Addiction Medicine Specialist, Monash Health, South-East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014; Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013; Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol and Drug Association, Public Hearing, Melbourne, 14 October 2013; Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014; Mr Bill Wilson, Youth Outreach, Alcohol, Tobacco and Other Drugs Team, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014.

1380 Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

1381 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.

drug use. Our expertise in peer education and health promotion for people who use drugs is well established. What makes our education unique, I think, is that it is based on lived experience of drug use. That is what gives it its edge.¹³⁸²

Ms Kelsall explained the operation of HRV's peer education programs to the Committee:

Our peer education programs are very grounded and simply based in common sense. They stress sleep, food, things like dental hygiene, safer sex, safer drug use and listening to your mates. If a friend is telling you that you need a break, it is probably good advice. It is pretty basic stuff, but that is our intention — to get to meth users early in the piece with the sort of information and education which will keep them alive and well and help prevent and protect them from some of the more severe adverse effects. We want to get to meth users long before they ever encounter the pointy end of the spectrum.

These are some of the reasons that peer education is so effective. It is not rocket science; we all do it every day. We share information with our friends and associates. When it comes to illicit drug use, those friends become an even more essential source or conduit of information. Who else do you ask? Your mother? Your teacher? I do not think so. The important thing is to take the hysteria out of the equation. It does not help, but it does make it harder for people to ask questions and to ask for help if and when they need it. We firmly believe that we need peer education programs if we are serious about educating young people about the potential hazards of this drug. There is fortunately a wealth of evidence now to support the effectiveness of peer education, although there are still critics who point to the lack of rigorous evaluation.¹³⁸³

One of the peer education programs overseen by HRV in the illicit drug area is *Dancewize*, formerly known as RaveSafe. This is a peer education program that has come out of the dance party or rave scene, It involves young trained people called Key Peer Educators going to dance parties, festivals and nightclubs to disseminate educational information aimed at reducing drug and alcohol-related harm:

Our Key Peer Educators [KPEs] attend up to 15 events per year: hosting a chill-out space; discussing safer drug use with peers and disseminating health resources.

The DanceWize goal is to provide our peers with accurate, credible information through face-to-face discussion or through the provision of resources (which always include information about the harms associated with illicit and licit drug use).

Our KPEs are recruited from the dance party, festival and nightclub communities and are trained by experts in the field to equip them with the knowledge and skills they need to answer questions or to refer peers to other services where appropriate.

The DanceWize chill-out space is not a first-aid facility. We use this area to engage our peers and to look after patrons who might be a little confused or freaking out. DanceWize KPEs use their experience and knowledge to talk them through their moments of confusion. Anyone needing medical attention is referred to First Aid.¹³⁸⁴

Harm Reduction Victoria also runs peer education programs pertaining to overdose prevention and pharmacotherapy for people who are already injecting methamphetamine.

Finally, one of HRV's key methods of communication about prevention and harm reduction with regard to methamphetamine and other drugs is its magazine *Whack*. Ms Kelsall told the Committee that this very popular publication addresses drug education in a frank, realistic, yet informative way:

Our magazine, *Whack!* is one of our primary methods of communication, and it retains a loyal readership who eagerly await each new edition. We currently distribute about 4000 copies per addition. *Whack!* is now available online, and it will be interesting to see how that impacts on the number of hard

1382 Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013.

1383 Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013.

1384 <http://hrvic.org.au/dancewize/>

copies we need to print in future. We are very proud of the magazine; it showcases the extraordinary talent that exists amongst our members and followers. Increasingly our website provides us a site of engagement and a way of reaching into diverse groups and subgroups of people who use drugs, and of course we are active on Facebook and Twitter.¹³⁸⁵

Other forms of drug outreach education and support programs

Peer education messages on drugs can also be used in conjunction with proactive outreach programs designed to assist people at risk or people otherwise disengaged from mainstream services. Allsop has argued that assertive outreach programs are important in the context of methamphetamine use because of the few links users may have with mainstream AOD services (2012).¹³⁸⁶ This is particularly important in the context of young people.

The Chatterbox Outreach Project

One example of an effective outreach project brought to the attention of the Committee is the Chatterbox Street Outreach Program run by the Whitelion youth service and Open Family. The operation of this outreach program was explained to the Committee by Anthony Grimm:

The Chatterbox Street Outreach Program is essentially an assertive outreach program, an after-hours outreach program. We have a modified bus that goes out, currently, three nights a week, although as of April we are going to be going out four nights, with a view to extending that to five nights a week by May. It is staffed by myself and another outreach worker and by a core group of dedicated volunteers. The object of the program is to go out after hours and actively seek young people who are at risk.¹³⁸⁷

Chatterbox volunteers visit designated hotspots where groups of young people congregate particularly in central Melbourne and St Kilda including street sex-working areas.¹³⁸⁸

The Chatterbox program has been in operation for over 12 years. According to Mr Grimm it is a trusted service with a good name amongst young people. In appropriate circumstances, Chatterbox volunteers, many of whom may be the same age as the young person, may be able to dispense factual non-judgemental advice on drugs and their effects and/or link them to drug and alcohol services.¹³⁸⁹ Importantly the service engages young people who may have formerly used the bus, to act as informal peer interveners:

What we try and do is encourage the young people to get on board the bus. They engage with the volunteers. ...for a lot of these young people all the adults that have been in their lives have been paid to be in their lives, whether they be schoolteachers, psychologists, social workers, corrections officers, so when they get on board the bus, a lot of the time they say, 'Look, you're only doing this because you're paid to do it. You only care because it's your job,' and that is where the power of the volunteers comes in. They say, 'Look, actually, no, I'm not being paid to do this'.¹³⁹⁰

Other examples of drug support and outreach projects

During the Inquiry the Committee was told of other examples of outreach programs designed to address drug use by young people. They included mobile outreach drug workers who put young people in touch with early intervention programs;¹³⁹¹ youth and

1385 Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013.

1386 See also Iguchi 2012 for a discussion of outreach programs in the context of methamphetamine use and how if delivered correctly they can encourage or promote entry into treatment programs.

1387 Mr Anthony Grimm, Co-ordinator The Chatterbox Street Outreach Program, Whitelion, Public Hearing, Melbourne, 24 March 2014.

1388 Mr Anthony Grimm, Co-ordinator The Chatterbox Street Outreach Program, Whitelion, Public Hearing, Melbourne, 24 March 2014.

1389 Mr Anthony Grimm, Co-ordinator The Chatterbox Street Outreach Program, Whitelion, Public Hearing, Melbourne, 24 March 2014.

1390 Mr Anthony Grimm, Co-ordinator The Chatterbox Street Outreach Program, Whitelion, Public Hearing, Melbourne, 24 March 2014. See also <http://www.openfamily.com.au/what-we-do/mobile-youth-outreach/chatterbox-melbourne.html>.

1391 Mr James Dale, Acquired Brain Injury and Alcohol and Other Drug Clinical Consultant, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

family outreach workers who may go to a person's home to address their drug use,¹³⁹² a 'Streetsurfer' outreach bus,¹³⁹³ Aboriginal outreach workers,¹³⁹⁴ and outreach education for pregnant women with alcohol and drug dependencies.¹³⁹⁵

Youth worker Les Twentyman testified to how important outreach services and programs were in contacting and assisting young people who may otherwise be unreachable with regard to their drug use and problems in their lives more generally. He told the Committee that outreach workers were particularly important for those young people who had become disengaged from the school system:

I think outreach youth workers should be in every school, primary and secondary. That way they can pick up kids at risk of falling out of school into truancy. Our research shows that kids that have a fractured education are the most at risk of getting into or accessing drugs and alcohol at a far earlier age than those who are in the school system. That is what I would have, because we are getting kids who are hardly ever at school and no-one is doing anything about it because they do not have the resources to be going and finding them.¹³⁹⁶

Similarly, Melanie Raymond from Youth Projects told the Committee that outreach such as their Foot Patrol program was so important for at-risk youth as it was often the first time that a drug user would receive any type of information about the drugs they were using and the effects it might have on their bodies:

Foot patrol is street-based drug safety workers who work in a harm reduction health promotion model and also provide a unique point of engagement and referral. At the very hard-core end are people who are sleeping rough and who are homeless, with drug and alcohol issues but usually also a mental health issue and a variety of other significant problems in their lives, and they [Foot patrol workers] are often the first place and the first point of connection that a drug user will have.¹³⁹⁷

Online and social media approaches

Many writers on the social and cultural aspects of drug use amongst young people in particular have commented that policy and practice must be cognisant of and responsive to new developments in the patterns of methamphetamine use.

One such development is increasing engagement with online drug-related discussion groups, which presents new risks for drug use [how to access or make drugs for example] as well as new opportunities for [information provision] and harm reduction (Dwyer et al. 2012, p.67).

Such sites provide information about methamphetamine but more importantly provide a forum:

[f]or present and former users to share their stories and approaches to dealing with amphetamine group substances. Although unimproved these peer education approaches could increase awareness about the risks of amphetamine group substances. Funding for rigorous assessments of the effectiveness of social marketing and internet based [peer] intervention programs are needed (Colfax et al. 2010, p.7).

Such approaches can be particularly important given that some young people at risk are unlikely to spend time reading pamphlets or information sheets.

1392 Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Public Hearing, Shepparton, 25 February 2014.

1393 Mr Daniel Moyle, General Manager of Client Services, Barwon Youth, Public Hearing, Geelong, 28 October 2013.

1394 See for example, Mr Daryl Sloan, Indigenous Advocate, Regional Information and Advocacy Council, Public Hearing, Shepparton, 25 February 2014.

See also Mr Tim Church, Aboriginal Drugs and Alcohol Worker, Albury-Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014.

1395 Dr Ellen Bowman, Paediatrician, Royal Women's Hospital Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

1396 Mr Les Twentyman, OAM, 20th Man Fund, Public Hearing, Melbourne, 9 December 2013.

1397 Ms Melanie Raymond, Chairperson, Youth Projects, Public Hearing, Melbourne, 3 February 2014; Mr Richard Michell, Manager, Youth Outreach, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

The National Drug Strategy (2010–2015) recognises the power of the internet and social media approaches in influencing messages that young people in particular are susceptible to. However, in the field of drug education it states the internet poses both challenges and opportunities.

Certainly the risks associated with the use of online websites and search engines and social media sites such as Facebook or Twitter for accessing information on methamphetamine are considerable. As Armstrong and Guthrie have commented:

A purely anthropological visit to user based websites reveals a staggering display of chemical expertise and in depth discussion of the merits of various side chain additions to the basic amphetamine molecule (2012, p.150) ¹³⁹⁸

According to Bill Wilson of Gateway Community Health in Wodonga, Facebook causes 'huge problems' in terms of providing individuals information on how to access and use drugs.¹³⁹⁹ Zach Mason from Junction Support Services agreed. He told the Committee:

Facebook is rife. Social media is the only way to contact clients now or the only way clients contact each other, and it is free. Messaging and phone calls cost money. It is largely done over Facebook, and it would be done in codes or whatnot. On the internet you can easily find recipes on how to make meth on YouTube. There are three-minute recipes which is pretty scary. Clients have reported that you can make an ounce of methamphetamine from seven packets of pseudoephedrine. They are researching this stuff on the internet.¹⁴⁰⁰

It is not, however, only young people who may access social media to find out information about ice. Online forums and media such as Facebook can be used by community agencies to provide virtual community information forums. This has been one approach taken by Project Ice in Mildura:

Last week we launched a Facebook page from one of our younger staff members who knows how to do that. As of yesterday afternoon at about 3.30 p.m., she brought the stats up and there were 89,576 people who had read the Project Ice Facebook page, with 2000-odd likes,... there is also on the Facebook page a link to local and national support agencies and services. Within that time we have already had 2000 people follow that link, which I think is phenomenal.¹⁴⁰¹

The internet can also be used as a train the trainer facility or for ongoing drug education for health and AOD workers, particularly in rural regions. For example, the Royal Women's Hospital Alcohol and Drug Service provide online information for health and AOD workers on how to address the needs of pregnant women who have substance abuse disorders.¹⁴⁰²

Certainly evidence given to the Inquiry stressed both the positive and negative aspects of the internet and social media in either disseminating useful drug information about methamphetamine or conversely acting as a forum for ascertaining how to access or use the drug.¹⁴⁰³

1398 For a discussion of online forums where some methamphetamine users may access their drug-related information, see Dwyer et al 2012.

For an example of a comprehensive drug forum website that provides information on illicit drugs, addiction and self-help; see *Drugs Forum*. This not for profit website in addition to providing basic information on drugs including methamphetamine also has a blog and reader's forum for readers to exchange news and information.

See www.drugs-forum.com/showwiki.php.

1399 Mr Bill Wilson, Youth Outreach, Alcohol, Tobacco and Other Drugs Team, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014.

1400 Mr Zach Mason, Youth Worker, Junction Support Services, Public Hearing, Wodonga, 24 February 2014.

1401 Ms Michelle Withers, Integrated Services Coordinator, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

1402 Dr Ellen Bowman, Paediatrician, Royal Women's Hospital Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

See also Chapter 25 for a discussion of workforce development and training in the context of methamphetamine use.

1403 See for example: Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013; Mr Geoff Munro, National Policy Manager, Australian Drug Foundation, Public Hearing, Melbourne, 14 October 2013; Ms Samantha Hunter, Chief Executive Officer, Crime Stoppers Victoria, Public Hearing, Melbourne, 9 December 2013; Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Public Hearing, Shepparton, 25 February 2014; Ms Marg Bell, Senior Manager, Adolescent Specialist Support Programs, Shepparton, Berry Street, Public Hearing, Shepparton, 25 February 2014; Associate Professor Peter Miller, Principal Research Fellow, School of Psychology, Deakin University, Public Hearing, Ballarat, 18 November 2013; Mr Christofer Beal, Coordinator, Tanderra AOD Services, Bairnsdale, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

The use of information technology as an information tool – A proposal for a ‘digital strategy’ to address drug use

It is clear from the above discussion that the evolution of new technologies over the last two decades, including the internet and mobile phones, has had an enormous influence on the ways in which people communicate, give and retrieve information. As a recent Report from the Pennington Institute (the Institute) has commented:

People using drugs have also embraced these technologies, and they are used in order to purchase, sell and find out information about drugs. The internet is increasingly being utilised as a knowledge and transaction medium. The proliferation of smart phones means people who use drugs have portable means of accessing knowledge, and a communication tool to facilitate purchasing and use of drugs. Family members and other community members affected by drug use are similarly engaged online. Added to this is the rapid growth and proliferation of use of social media channels like Twitter, Snapchat and Facebook enhancing the speed of word of mouth communication between those using drugs (2014, p.9).

Notwithstanding these advances in communication technology, the Pennington Institute has also claimed that the AOD sector and especially harm reduction bodies have been slow to fully embrace their potential:

This means that the sector is not using technology to effectively communicate health promotion messages or to access and engage with clients. Further, current models of Needle and Syringe Programs [NSP] are predicated on conventional drug markets, and are not orientated to new markets of drug use and sources of drug information — such as those found online (2014, p.10).

As such the Institute has proposed a new digital strategy to be applied for NSPs and harm reduction workers:

A digital strategy would harness a number of untapped opportunities using technology as a tool to better engage, understand the needs of, inform and advise people who use drugs on safety and health protection. This includes the potential use of technology for health promotion, client engagement, referral adherence, and as a means to access harm reduction materials.

Smart phone technology also has potential application as a professional tool for service workers to provide easy access to technical knowledge on drug use issues where there are currently gaps in technical knowledge (2014, p.10).

The Institute also believes that such an intervention would be of assistance in providing information for people outside the workforce on methamphetamine and other drugs.¹⁴⁰⁴

A digital campaign could also provide fact-based information to the proliferation of parenting and other relevant advice websites and the potential of a bigger blogger campaign. Through these channels, information will be provided to enable fact-based discussions with community members about drug-use issues. For example, this could include alerting parents to methamphetamine-related behaviour issues allowing early identification of problems and therefore more timely responses (2014, p.10).

The Committee awaits with interest the development of such a strategy by the Pennington Institute.

Education and support for families

I kind of suffered in silence because I did not know who to go to. I did not know who I could trust to go to. Because it was so big to deal with, I didn’t know where to start. Now I am just starting to understand and learn that there are agencies out there that can support me’.¹⁴⁰⁵

1404 See also discussion below with regard to information provision for families.

1405 Ms Darlene Sanders, Indigenous Engagement Officer, Mallee Family Care, Public Hearing, Mildura, 5 December 2013.

These words reveal the anguish of an Aboriginal woman in Mildura who was initially at a loss as to how to handle her son's emerging problems with crystal methamphetamine use. Fortunately, the woman worked for Mallee Family Care, a health and welfare agency that could assist her with support and referrals. Other family members may not be so fortunate.

As with any form of problematic licit or illicit drug, crystal methamphetamine is taking a heavy toll on the families of the users. In a submission to the Inquiry the Self Help Addiction Resource Centre (SHARC) told the Committee that their community family support groups are reporting a pronounced increase in the number of family members seeking support due to a family member using crystal methamphetamine (an increase of 24%):

It should be noted that problematic use of any drug, not just ice, by a family member negatively impacts on [other] family members. The families who come to us are struggling with a range of issues including worry, stress, anxiety, grief, loss of trust, financial loss, isolation etc. With ice however, there is an increased reported incidence of violence and property damage. The extreme mood changes of the users are difficult to handle and communications break down as they 'just go off'.¹⁴⁰⁶

Cheryl Sobczyk from Bendigo Community Health also spoke of families' need for assistance:

Many of our intake calls — people wanting to get information about drug and alcohol services — are actually from family members. Even though we can offer them individual counselling or refer them to family support services, it does not go far enough to address how they cope day to day with a using member of their family... They just do not know what to say to her or how to encourage her into treatment... And I do not think education or knowledge of even the workers or their ability to work with families who are struggling with the problems their loved ones have [is sufficient] — I think that is a particular gap we currently have.¹⁴⁰⁷

The Committee received evidence from a number of family members who spoke of their experience with loved ones who had crystal 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 including Ms Sanders quoted above spoke of the helplessness felt when they couldn't access help or information on the drug and its effects. As another 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.¹⁴⁰⁸

John Ryan from Anex told the Committee that education and information provision for families was crucial:

We need to have family members actually skilled up about these issues. How do they identify meth use within their family? Because of the secrecy a lot of people will deny it even to their closest family members. How do we actually skill up family members about those issues? How do we skill up family members to manage a person's meth use? How do we say to parents, even though they are desperate, as some of them absolutely are, 'Don't support your child's meth consumption. No matter how desperate they are, don't purchase drugs for them'? Because sometimes that happens; parents will actually support their child's drug addiction in order to try to reduce the more negative consequences. I think skilling families up to deal with those very complex problems is very important.¹⁴⁰⁹

1406 Ms Heather Pickard, Chief Executive Officer, Self Help Addiction Resource Centre Inc. (SHARC), Submission, 13 October 2013. See also Chapter 7 for a discussion of the types of pressures facing the families of methamphetamine users.

1407 Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013.

1408 Ms Kerry Johnston, Public Hearing, Wodonga, 24 February 2014.

1409 Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

Programs for families

SHARC, through its Family Drug Support Groups, is one organisation that *does* assist family members to cope with their family member's drug use through information provision, peer support and networking with people who are facing similar challenges. In a submission to the Inquiry they stated that the help and support that families need is much the same as when other drugs are involved. They need:

- to know they are not alone;
- encouragement and support to look after themselves, including diffusing from their own trauma;
- acceptance of what they can and cannot control;
- learning helpful responses such as boundary setting.
- understanding the negative emotions they are experiencing; and
- knowledge of the treatment system and how and where to get help for themselves and the family member.¹⁴¹⁰

Heather Pickard from SHARC outlined the program and emphasised the importance of education for families when she gave evidence to the Committee:

Education is really critical for families to understand the impact of the drug, and drugs do have different impacts... We run six-week courses, and a lot of those are just the same as they would be in any school when you are giving basic drug information. We will talk about what the drug does and its impact... We have a siblings program as well. Then there are the ongoing family support groups. We also provide family therapy, and we have a 24-hour helpline run by 68 people who have a lived experience. So our 24-hour helpline is run by families who have a lived experience of, they call it, recovery from the impacts of drug addiction. So it is not specifically ice, but that 24-hour helpline is families with lived experience... Family members call, and we train them as volunteers at a certain point in their journey with us. Then they help others. So we have 68 trained volunteers who run that helpline.^{1411 1412}

Family Drug Support is another program to support the families and friends of people with alcohol and other drug-related problems. Like SHARC, Family Drug Support operates a national 24-hour Drug Support Phone line where people can seek advice, assistance and referral information pertaining to their family member's drug use. There are also online forums where members can share information and a variety of local support group meetings that family members can attend.¹⁴¹³

A number of health, AOD and welfare agencies that provide general assistance to clients also told the Committee that whilst it was not the main remit of their agency, they increasingly had to provide assistance, information and support to the families of people who had been using methamphetamine.¹⁴¹⁴

Limitations of family support

Some AOD agencies have told the Committee that due to their ignorance of crystal methamphetamine and its effects, families can have a misconceived idea of what can be done to support their children or siblings, particularly in the area of treatment and rehabilitation. For example Christine May from YSAS in Gippsland told the Committee:

1410 Ms Heather Pickard, Chief Executive Officer, Self Help Addiction Resource Centre Inc. (SHARC), Submission, 13 October 2013.

1411 Ms Heather Pickard, Chief Executive Officer, Self Help Addiction Resource Centre, Public Hearing, Melbourne, 14 October 2013. SHARC also convenes public information forums on ice. See Chapter 24.

1412 For further discussion on the importance of education and information provision for family members see, Ms Donna Ribton-Turner, Director, Clinical Services, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013; Mr Terry Robinson, Co-ordinator, Barwon Youth, Public Hearing, Geelong, 28 October 2013; Ms Melissa Lonsdale, Team Leader, Drug Treatment Services, Sunraysia Community Health Services, Public Hearing, Mildura, 5 December 2013.

1413 See <http://www.fds.org.au/about>.

1414 See for example, Ms Bev McIlroy, Manager, Glenelg Southern Grampians Drug Treatment Service (QUAMBY), Public Hearing, Warrnambool, 3 March 2014.

The families that we are coming in contact with now 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'. So we have a lot of education with those parents to assist them to understand that we do not have the wand that makes them feel better.¹⁴¹⁵

For Aboriginal people, conventional information provision may not always be appropriate. Daryl Sloan from the Regional Information and Advocacy Council told the Committee in such circumstances assertive outreach approaches could be more suitable:

[a]s an assertive outreach worker going onto the riverbanks and other places...I actually push more into those areas where the supports are lacking. My role is really about engaging with the community, with the people sitting down at the table, with the mums and dads who have got a son or a daughter with a raging ice addiction, and trying to talk to them about that. They are trying to engage their son with me or their daughter with me, but if that person is over 18, they need to approach me themselves, it is also an educational perspective around the parents, that the abuse that they are putting up with — the domestic violence, the thefts, the robberies and the assaults — is actually a criminal offence, and walking them through that thinking process, that enlightening process that they may have to actually consider taking out an apprehended violence order against their child, whom they love, and then trying to link them into support services, which are stretched far too thin on the ground.¹⁴¹⁶

Conclusion

The evidence as to the effectiveness of education programs with regard to drug use and its effects is equivocal. This is the case whether they are school programs, community interventions or, as the next chapter discusses, mass media campaigns. There is insufficient evidence that education and information provision programs will be sufficient without any other interventions or supports in modifying people's behaviour, and particularly whether they will prevent the uptake of drug use by young people.

Nonetheless, some approaches that focus on boosting resilience, reducing risk factors and developing protective factors and promoting life skills in a health promotion context have shown promise. Approaches for both young people and adults that go beyond simply 'just say no' messages or the promotion of abstinence only have also found favour. This is particularly the case when they use well designed interactive methods that *engage* people and are tailored specifically for individual groups with different needs (Stockwell et al. 2005; Allsop 2012).

The issues discussed throughout this chapter and the debates pertaining to drug education are clearly ones that need to be taken into account in developing an effective and comprehensive drug education strategy. Education and information on drugs such as methamphetamine is not something that needs to be provided just to individuals or even family groups. It is essential that a whole of community education approach to ice use is developed and implemented. The need for the wider community to be engaged in such a process is therefore the topic of the following chapter.

1415 Ms Christine May, Manager Latrobe Valley, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

1416 Mr Daryl Sloan, Indigenous Advocate, Regional Information and Advocacy Council, Public Hearing, Shepparton, 25 February 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.

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.

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.

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.*

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.

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.

24. Methamphetamine Awareness Campaigns and Community Education Strategies

Introduction

The use of crystal methamphetamine can have repercussions that spread far beyond the individual involved or even his or her family. Community based approaches in addressing public health issues generally and drug abuse in particular are therefore essential. Such approaches are particularly important for providing information and education on drug use issues and often take the form of interactive public forums and targeted campaigns.

Whilst community based approaches undertaken for the 'long haul' can be expensive to develop and maintain and may not produce positive results in the short term, the available evidence suggests they can be effective measures to address crystal methamphetamine-related harms in local communities when those communities are fully involved in their development and implementation. This may be particularly true of communities in rural and regional areas of the state.

To achieve such involvement a range of strategies may be required. The Committee is aware that community awareness and engagement strategies are being employed in Victoria, including community forums and other community mobilisation approaches. Community awareness on ice may also be raised through the use of mass media public education campaigns. Such strategies, however, have traditionally had mixed results as to their effectiveness, particularly when they utilise 'scare' or 'shock' tactics.

Community awareness and engagement

One of the main concerns expressed throughout this Inquiry was that people lack knowledge and are unsure about what action to take with regard to the ice problem in Victoria. This has been apparent for both family members and community stakeholders in both rural and metropolitan locations.

A submission from the Commissioners for Children and Young People stated:

The anecdotal evidence we have received from speaking to parents, carers and service providers is that more needs to be done to ensure that information is widely known and easily accessible and to ensure that services can be found quickly and easily. We have spoken to carers desperate for information about how to support someone within their families who is using ice and been told that services are not readily available... In his recent visits to Koori communities in regional centres, the Commissioner for Aboriginal Children and Young People has heard from families and professionals about the impact of ice on their communities.

We understand that there is strong interest in and attendance at regional forums where ice use is to be discussed. Such forums indicate that more effort needs to be made to develop resources and services which are particularly targeted at the most vulnerable members of the community, including those who have low levels of literacy, limited access to the internet and/or those for whom English is not their first language.¹⁴¹⁷

¹⁴¹⁷ 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.

As the Commissioners indicated, this need for information on crystal methamphetamine and its affects and consequences has been particularly acute in Aboriginal communities. Primary Care Connect stated in its submission that the Koori Court in Shepparton has requested further information and training in order to be able to respond to the situation:

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 the Ice 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.¹⁴¹⁸

One of the key recommendations that Anex made to the Committee concerned the need for ongoing awareness campaigns concerning methamphetamine to 'be developed, delivered and evaluated' for a variety of audiences.¹⁴¹⁹ Yet it has been Anex itself, in conjunction with the Victorian Department of Justice, that has taken the running on the development and delivery of a number of methamphetamine awareness forums across the state. Reflecting on the size of public attendance at these forums, John Ryan of the Penington Institute¹⁴²⁰ told the Committee in this regard:

Gone are the days when the community was in denial that drug use affects people from all walks of life. I think that is a shift that has happened over the last 15 years in terms of community understanding about drug use. Gone are the days when they thought there was a magic wand that could prevent all drug use problems. I think that has been challenged by the reality that people are experiencing through their social networks and in their local communities. People really do want help in these issues. They particularly want information. There is a general sentiment that there is a dearth of information around drug use.¹⁴²¹

Community forums

One proactive intervention to address methamphetamine use at a community level has been a series of community forums for the general public and professional stakeholder workshops run by the Department of Justice Regional Services Network in association with Anex. Recognising that concern about ice was particularly high in rural and regional centres these forums have been held in most regional centres of Victoria throughout 2013 and 2014:

The rationale for the forums was outlined in correspondence to the Committee:

During 2013, the Department of Justice's (DOJ) Regional Directors became increasingly aware of the prevalence of ice in the communities that they work with, in particular the availability, use and impact of ice and addiction issues. The community concerns brought to regional directors' attention presented an opportunity for regional leadership. Regional Directors and regional staff come face to face with the impact of ice use through clients of Community Corrections and Sheriff Operations.

Additionally, the impact of ice use on users and their families was reported and discussed with Victoria Police locally, via relationships and networks in the Koori community and the Regional Aboriginal Justice Advisory Committees, as well as Crime Prevention Reference Groups.¹⁴²²

Given the rise in anxiety about the crystal methamphetamine issue, John Ryan, Chief Executive Officer from The Penington Institute, believed the time was right to hold these events:

1418 Mr Hamish Fletcher, Chief Executive Officer, Primary Care Connect, Submission, 18 October 2013.

1419 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013. Yet it has been Anex itself, in conjunction with the Victorian Department of Justice that has taken the running on the development and delivery of a number of methamphetamine awareness forums across the state.

1420 The Penington Institute now oversees Anex's programs.

1421 Mr John Ryan, CEO, Penington Institute, Public Hearing, Melbourne, 4 July 2014.

1422 Correspondence from Greg Whelan, Secretary, Department of Justice to the Law Reform Drugs and Crime Prevention Committee, 17 April 2014.

Community forums and stakeholder workshops can help develop community connections, provide access to accurate information, and start a process to address community perceptions of drug-related issues. They are particularly useful for obtaining feedback from local people about drug and alcohol issues specific to the local area (Anex 2014, p.6).

Some of the reasons the DOJ believed the forums were necessary included:

- responding to direct community concerns raised with the department about the impact of ice use
- a reported lack of available and accurate information regarding the drug and treatment options
- to bring the community into direct contact with local agencies who provide drug and alcohol and supportive services to ice users and their families
- to provide the community with an opportunity to voice their concerns, discuss a community-wide problem, identify gaps in existing services and encourage potential collective responses
- to proactively respond to an emerging issue that the justice system, through police, corrections officers, family violence and emergency service workers had identified because justice [Department] were seeing some of the early impacts of ice before local treatment agencies
- the department's contact with offenders and prisoners indicated there was/is an increasing issue around the use of ice and the harm it is causing with the community
- [an] opportunity to bring together government agencies, service providers, community members and business to discuss how ice is impacting the local community and develop an action plan
- increased media coverage and discussion in the community about the harmful impacts of ice, its availability and limited treatment options.¹⁴²³

The forums were divided into general community forums open to the public and stakeholder workshops. Attendees at the public forums included parents, emergency service workers, teachers, nurses, community service organisations, local businesses, state and local government, among others.

Stakeholder groups were targeted at professionals. Invitees included local representatives from:

- community organisations/service providers (non-government agencies)
- local government
- state government departments/agencies, such as Victoria Police, departments of health, human services, education and early childhood development, premier and cabinet (regional)
- Koori organisations
- Local health services including psychiatric services
- Schools
- Entertainment venue associations and industry groups known to be affected by ice
- Local chambers of commerce
- Sporting groups/clubs
- Local businesses.¹⁴²⁴

The forums program has not yet been formally evaluated. Part of Anex's responsibility under the arrangement however was to write up the discussions from each forum/workshop. These will then be used by the department and local communities as the basis for developing a local ice action plan. Feedback has already been collated from some individual regional

¹⁴²³ Correspondence from Greg Whelan, Secretary, Department of Justice to the Law Reform Drugs and Crime Prevention Committee, 17 April 2014.

¹⁴²⁴ Correspondence from Greg Whelan, Secretary, Department of Justice to the Law Reform Drugs and Crime Prevention Committee, 17 April 2014.

workshops/forums. For example, a report prepared for the DOJ by Anex on a stakeholder workshop in the Grampians Region found it was highly valuable at both community and stakeholder levels. In particular, professional stakeholders and the general public stated that these forums raised awareness of the drug, how it works, what its affects are and how ice-related problems could be addressed.¹⁴²⁵

With regard to education and information provision specifically, the feedback from the Grampians region indicated that: 'Reliable information and strong communication are vital for generating awareness and achieving collaborative local approaches to methamphetamine use' (Anex 2014, p.15). In particular, stakeholder participants recommended approaches should:

- Strengthen AOD [alcohol and other drugs] and ice-specific education programs targeted at primary and secondary school and tertiary students.
- Continue to produce and distribute easy-access information.
- Use social and mainstream media to get proactive educational messages out about ice, its impacts and the services available.
- Hold more public/community forums to discuss information, issues and concerns about ice.
- Share knowledge more widely among service providers and within the community.
- Communicate awareness of the issues and concerns about ice to workers in local service providers.
- Implement health promotion campaigns to make using ice socially unacceptable, like for smoking.
- Encourage and support greater sharing of information, statistics and resources. For e.g. create a central information point such as a 'hub' website ('methpedia') that is easy to navigate and provides easy access to accurate information about ice and what services are available (Anex 2014, p.15).

These forums held throughout the state from all accounts attracted 'exceptional attendance', with average attendance at the community forums ranging between 50 and 230 people and attendance at the stakeholder workshops ranging between 25 and 50 people.¹⁴²⁶ The Traralgon 'Breaking the Ice' forum for instance was a 'packed house' despite the 'freezing temperatures and pouring rain'. According to witnesses who attended it was indicative of the concern felt by the local people in the Gippsland area as to crystal methamphetamine and its effects.¹⁴²⁷ The community forums encouraged lively 'grass roots' question and answer sessions, which allowed local people to elicit information on the issues that were of most concern to them after having first heard the basic information from stakeholders on the group panels such as police, local government workers and Anex representatives.¹⁴²⁸ This was a reflection of the need and desire for 'local communities to be involved'.

Other forms of community mobilisation

In addition to the forums developed and delivered by Anex, a variety of local awareness sessions and project groups have been initiated around the state in both Aboriginal and non-Aboriginal communities to disseminate information on and assistance with crystal methamphetamine.

1425 Interestingly, it was raised in the workshop report that this Parliamentary Inquiry had been another valuable way of raising awareness on ice particularly for stakeholder groups.

1426 Correspondence from Greg Whelan, Secretary, Department of Justice to the Law Reform Drugs and Crime Prevention Committee, 17 April 2014.

1427 See comments of Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates Court, Public Hearing, Traralgon, 28 January 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; and Superintendent Malcolm (Jock) Menzel, Divisional Commander, Eastern Region Division 5 — Morwell, Victoria Police, Public Hearing, Traralgon, 28 January 2014.

1428 Ms Dianne Barker, Acting Senior Manager, ICMS and Residential Care, St Luke's Anglicare, Bendigo, Public Hearing, Bendigo, 25 October 2013.

Project Ice — Community Action in Mildura

One of the most prominent community initiatives to be established in rural and regional Victoria is Project Ice.¹⁴²⁹ Project Ice utilises local service providers, business and local media to address growing concerns about ice in Mildura and the surrounding communities. Michelle Withers from Northern Mallee Community Partnership, the project's organiser, told the Committee that within the Mildura community little was known about crystal methamphetamine and its effects prior to the formation of the project:

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...¹⁴³⁰

Rob McGlashan, Executive Officer of the Partnership added

It is very much a preventive model. That is our main area; our biggest weapon that we have got at our disposal is education to the community. It is a proactive response. It is organised, and it aims to try to reduce the demands and the supply in our region. It is important that we educate the community, and most important that we allow families and friends to have that difficult conversation with their loved ones and so forth that this is an issue locally and we need to start talking about it to address it.

Out of that comes information from the community, which is leading to enforcement agencies on the issue. We want to try and promote local access to drug and alcohol services, and also to advocate for further services down the track.¹⁴³¹

Project Ice's proactive campaign uses a variety of interventions to 'get the message across'. These include television and radio advertisements, flyers and information pamphlets, stationary and mobile billboards. Project Ice has ensured that all these forms of information provision include referral information to relevant support and treatment agencies.

In addition, Project Ice organisers have responded to the growing demand for information by training local professionals to deliver information at interactive community forums:

A number of community information sessions are being run locally, and we have had about 29 so far run through invitation and monthly events. When you look at it on the ground, we had three community forums initially that were run by Anex out of Melbourne. We realised that demand was outgrowing our budget, so we decided to train local professionals to be able to go and deliver information sessions on this particular issue. As mentioned, there have been 29 to date that registered about 630 people.¹⁴³²

The Greater Geelong Collective Community Effort on Substance Abuse

Geelong is another area of Victoria in which there have been particular concerns about methamphetamine use and the impact it is having. This has resulted in the formation of a local community action group — the Greater Geelong Collective Community Effort

1429 Project Ice in Mildura and other rural community mobilisation initiatives such as the efforts of WDAT in the Wimmera are discussed in further detail in Chapter 11.

1430 Ms Michelle Withers, Integrated Services Coordinator, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

1431 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

1432 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

on Substance Abuse (GGCCESA). A submission from GGCCESA outlined how the local community mobilised 'from discussion to action' on ice-related problems by forming this community group:

Several recent issues and discussions have catalysed the Geelong Community to move from discussion to action. The first of these was the recent release of the ambulance attendance figures for "ICE" where the metropolitan area increased by approximately 100%, rural areas by 200% and the Geelong Region by more than 300%. The second was a meeting involving approximately 40 practitioners in fields affected by this issue where there was a general recognition that much discussion had occurred but none of this had resulted in action. After this meeting, several government departments for the Barwon South West Region, led by Victoria Police, decided to investigate ways in which direct action could be taken. This group decided to run what is now known as "collective Community Effort", a well recognised means of bringing a community together to create meaningful outcomes. This led to the establishment of the GGCCESA and a steering group being formed to ensure that meaningful actions and outcomes were achieved for this issue.¹⁴³³

The GGCCESA group is focusing its efforts particularly on addressing methamphetamine use in sport and its effects on employers and families.¹⁴³⁴ The group will discuss how initiatives and programs can be established to address ice use in Geelong culminating in a 'Day of Action for Geelong' on the 14th November 2014, where community members will be invited to a launch of the proposed programs. A substantial amount of community and philanthropic funding has been raised to develop these programs and a marketing company has been employed to organise and oversee the project.

GGCCESA sees their project as an excellent example of direct community mobilisation to address crystal methamphetamine:

It might well present a model that can be used in other geographical areas of the state. A great deal of community effort has gone in to this initiative which now involves 5 local governments, 7 state government departments or statutory authorities and more than 30 community groups and businesses. It is now truly a joined up community effort for this issue that is effecting the Geelong Community more than most and I urge the Inquiry to note this attempt, by a community, to take innovative action.¹⁴³⁵

Community mobilisation in Aboriginal communities

There is clearly a strong level of interest and desire for information on crystal methamphetamine by Aboriginal communities. This was highlighted by Gilbert Freeman, a counsellor with Ngala Willumbong Aboriginal Cooperative, when he told the Committee about the advertising of a forum on ice to be run by the Aboriginal Health Service and the outcome:

There was this simple email sent and it took about a week to go around, saying that there would be a community meeting regarding ice at bars in Northcote. I went along to it and they could not fit everyone in. There were over 300 family members there. That was not on the radio or television. That was just an email that started to go the rounds.¹⁴³⁶

1433 Daryl Clifton, Superintendent of Police Geelong on behalf of Greater Geelong Combined Community Effort on Substance Abuse (GGCCESA) Inc., Submission, 30 June 2014.

1434 To this end a group of selected experts will come together for a 2 day forum on the 14th and 15th of August 2014 to determine projects that can be undertaken to lessen the impact of ICE. The 3 groups will have approximately 20 experts in each cohort and they will be led by:

- Sport — Geelong Leisure Networks.
- Families — Barwon Adolescent Task Force.
- Employers — The Geelong Chamber of Commerce.

See Daryl Clifton, Superintendent of Police Geelong, on behalf of Greater Geelong Combined Community Effort on Substance Abuse (GGCCESA) Inc., Submission, 30 June 2014.

1435 Daryl Clifton, Superintendent of Police Geelong on behalf of Greater Geelong Combined Community Effort on Substance Abuse (GGCCESA) Inc., Submission, 30 June 2014.

1436 Mr Gilbert Freeman, Counsellor, Ngwala Willumbong Co-operative Ltd, Public Hearing, Melbourne, 24 March 2014.

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) also ran three forums with other Aboriginal health and community organisations.¹⁴³⁷ Participants were a mixture of service providers and Aboriginal community members and audience size varied from over 100 to 15. Participants were asked to fill in evaluations with one question asking ‘what would you like more information about’. Participants’ responses were grouped into themes (presented in Table 24.1). A submission to the Inquiry from VACCHO stated that:

In particular, health staff requested professional development in methamphetamine treatment and families wanted support to deal with methamphetamine dependent family members and their behaviours. Rather than promoting ICE forums VACCHO now recommends more targeted solution based workshops. There are also concerns that ‘ICE Forums’ create moral panic and marginalise ICE users further potentially deterring them from help seeking behaviour.¹⁴³⁸

Table 24.1: Ice forum participant responses to the question, ‘What would you like more information about?’

Prevention	Participants thought early intervention for young at risk clients, providing self-care, and holistic programs for young people were important interventions.
Treatment	Participants wanted clarity on what harm reduction and treatment options should be implemented for clients. More places in detox and rehabilitation were needed.
Family support	Participants asked for better support and advice about how they can make a difference with supporting loved ones.
Service access	Making sure mainstream services were culturally safe and running support programs for drug users and their families.
Sharing information	Participants wanted to know more about helpful strategies that work with Ice users and sharing of best practice models. Participants also wanted more information about what Ice users need for their journey to improved health.

Source: Dr Karen Adams, Researcher, Victorian Aboriginal Community Controlled Health Organisation, Submission, 18 October 2013.

Community action for families

Family drug support groups have also convened their own community forums on methamphetamine use. For example, the Self Help Addiction Resource Centre (SHARC) has facilitated community forums that focus on information provision, awareness raising and support for families of users:

[i]nvolving local police, and community health organisations and which have been extremely well received and supported by the community. They have been attended by many family members desperate for help and information. Local family peer support groups are being established in these communities as a result of these forums. We had well over 200 at each forum.¹⁴³⁹

Clearly one of the valuable outcomes of such forums has been the establishment of ongoing family support groups at the conclusion of each forum, something advertised in the flyers publicising the forums.¹⁴⁴⁰

These are but a few of the smaller and localised examples of community mobilisation on methamphetamine awareness that have been developed in the period 2013–2014 as concern about ice continues to grow.

1437 See also discussion in Chapter 12.

1438 Dr Karen Adams, Researcher, Victorian Aboriginal Community Controlled Health Organisation (VACCHO), Submission, 18 October 2013.

1439 Ms Heather Pickard, Chief Executive Officer, Self Help Addiction Resource Centre Inc. (SHARC), Submission, 13 October 2013.

1440 See Appendix 13 for an example of such a flyer.

Rangatira Summit

Another stakeholder forum which recently gathered a number of experts in the field to discuss the use of methamphetamine in Victoria was the self-styled High Level Summit on Methamphetamine organised by the Rangatira Management Consultancy.¹⁴⁴¹ This was held on the 5-6 June 2014 in Melbourne. The overarching theme of this summit was ‘How do we begin to tackle the problem of Methamphetamine in Victoria? Developing an Action Plan for Initiatives and Solutions’. Information sharing focused on the three pillars of drug strategy relevant to Methamphetamine: namely, Demand Reduction, Treatment and Supply Reduction.¹⁴⁴² Whilst the forum focused on many aspects of the methamphetamine problem, a submission to this Inquiry from Rangatira has stated that demand reduction, particularly education and awareness-raising on methamphetamine, was probably the most important aspect in addressing methamphetamine abuse in Victoria.¹⁴⁴³ In particular it was thought aggressive and tailored marketing campaigns aimed at various sections of the Victorian community were required as part of an ongoing strategy to combat methamphetamine use. Such sections of the community included young people generally, incarcerated youth, families, ethnic groups and educators.¹⁴⁴⁴

The Rangatira Summit was a useful exercise in information sharing and workshopping possible solutions to address the methamphetamine problem in Victoria. Although stakeholders’ opinions on the nature of the problem and how to address it were often divided, for example between those who strongly supported harm reduction initiatives and those who opposed them, the forum was viewed as another important step in raising community awareness on what all participants agreed was a serious issue. Mike Sabin, a New Zealand Parliamentarian, former police officer with experience of drugs issues and a contributor to New Zealand’s Methamphetamine Action Plan told the Committee that forums such as these were the first part of a step towards change:

The process is one of, I guess, holding up a mirror and understanding: ‘Have we got a problem? And if we’ve got a problem, are we actually addressing it successfully, and if not, what should we be doing?’. I think what you are doing by virtue of this process is actually the first steps of building an action plan. It has really been a case of trying to separate the wheat from the chaff in terms of what is just simply describing the problem versus [planning towards] an intervention or a strategy change than can be given effect to.¹⁴⁴⁵

Mass media campaigns

Research studies have shown that mass media campaigns are widely used to expose large populations to a variety of health-related messages through media such as television, radio, newspapers, billboards and increasingly social media (Wakefield, Lokin & Hornik 2010; Durkin, Brennan & Wakefield 2012). Television advertisements in particular are likely to have greater recall amongst targeted populations than other media and reach a wider

1441 Rangatira Consultancy is ‘A recently founded business which evolved from an apparent need to effect strategies for change against the rapidly-increasing problem of Methamphetamine use and abuse in Australia’. Ms Erica Lambert, Founding Partner, Rangatira Management Consultancy, Submission, 15 June 2014.

1442 Interestingly, Rangatira does not refer to ‘harm reduction’, one of the usual aspects traditionally part of Australia’s strategic drugs policy, replacing it with the more neutral term ‘treatment’.

1443 Ms Erica Lambert, Founding Partner, Rangatira Management Consultancy, Submission, 15 June 2014.

1444 To take the general youth category for example, some of the demand reduction initiatives suggested at the forum included:

- Television advertising campaign during prime time segments for Youth
- Publications conveying messages in a language relative to the Youth market
- Presentations to Youth groups targeting schools
- Promotional services at major Youth events, e.g. Good Life Festival
- Production of live theatre/play for Youth market
- Production of Methamphetamine documentary targeted at Youth.

Ms Erica Lambert, Founding Partner, Rangatira Management Consultancy, Submission, 15 June 2014.

1445 Mr Mike Sabin MP, Member for Northland, New Zealand Parliament, Public Hearing, Melbourne, 5 June 2014.

audience. Although it could be speculated that amongst cohorts of young people, social media has become increasingly more relevant to delivering health-related messages than television (Durkin, Brennan & Wakefield 2012).

The effectiveness of such, usually passive, exposure is variable. Most research in this area is American and in many instances not transferable to the Australian context (Wakefield, Lokin & Hornik 2010). However, in general terms mass media can produce positive changes to health-related behaviours when there is 'a concurrent availability of required services and products, availability of community based programs and policies that support behaviour change' (Wakefield, Lokin & Hornik 2010, p.1261). In addition it is essential to have longer, sustained and better funded campaigns (Wakefield, Lokin & Hornik 2010).

A review of the literature on mass media campaigns in the drug field by Allsop suggests that they are likely to be more effective when:

They are well resourced and enduring: target a clearly defined audience; have a basis in advanced marketing strategies that effectively target, communicate with and have relevance for and credibility with the desired audience; and provide a credible message to which the audience is frequently exposed. Mass media campaigns [should] be best conceived as one component of a multifaceted approach. For example, a mass media campaign on alcohol impaired driving might be valuable when it is combined with highly visible roadside breath testing. It is a challenge however to find such comprehensive approaches in the illicit drug domain, let alone in relation to amphetamine type stimulant use (Allsop 2012, p.175).

However, mass media campaigns can be counterproductive according to Allsop when:

[m]essages do not sit well with an individual's own experience (for example implying that ecstasy use will often lead to death when in fact such occurrences are rare) may not be credible with the target audience, and have the potential to undermine confidence in other messages or strategies (Allsop 2012, p.175).

Finally, Allsop argues that mass media campaigns that strongly highlight the adverse impact of drug use may contribute to the stigmatisation and marginalisation of drug users 'reducing the possibility that they will seek or be offered assistance' (Allsop 2012, p.175).

One issue raised in the literature is whether mass media campaigns can be tailored to demographic sub groups (for example, age, gender, education levels and ethnicity). Much of the research in this area has been done in the context of anti-smoking campaigns, but it would seem that in general terms tailored or 'sub campaigns' that stem from the main or parent campaign may be effective in getting messages across to specific audiences. However:

Given finite resources, targeting messages may result in lower rates of exposure. The extent of targeting and segmentation therefore needs to be weighed carefully against the importance of maximising campaign exposure (Durkin, Brennan & Wakefield 2012, p.133).

The extent to which such considerations apply to methamphetamine is largely unknown.

How appropriate are media campaigns in relation to drug abuse — views from the field?

In addition to academic research, the Committee received evidence from experts in the fields of advertising, marketing and public health promotion who had experience of media campaigns addressing health-related issues. John Thompson, General Manager of Mitchells Advertising, spoke to what makes an effective mass media campaign. In his view one of the key components is consistency, that is, a prolonged message over a period of time.

He cites the Transport Accident Commission campaigns as a good example of this:

The key message out of TAC's example is coordinated strategy, clear delineation of the organisations that are responsible for those activities, having measurable objectives that are set and funding the operation.¹⁴⁴⁶

Mr Thompson contrasted this with the federal government's 2007 methamphetamine campaign:¹⁴⁴⁷

You have asked me to comment on the 2007 federal government campaign. I think the first problem exists in the question, in that there is a seven-year gap between activity. That is the biggest issue that I can see in that. If you look at the example we have given in the TAC—road safety in Victoria, I should say—consistent over 40 years, constantly making changes, constantly making investments and delivering a result. The effect of the 2007 campaign will be long forgotten now, because it has not been followed up.¹⁴⁴⁸

Mr Thompson also stated that for any public education campaign on any subject matter to have a positive effect it must be grounded in research such as programs like Sun Smart, TAC, Quit or Worksafe.¹⁴⁴⁹ These types of campaigns can also have a significant effect on agenda setting and policy change. As Professor Melanie Wakefield, an expert in marketing and health promotion, told the Committee:

[They] alert people to the fact that this is an issue that deserves public attention. It shapes their views about it. It also shapes the views of policymakers. It puts it as an agenda, as a public issue, and it leads ultimately to policy discussion and ultimately to policy change¹⁴⁵⁰

In the context of methamphetamine however, Professor Wakefield was doubtful whether a mass media campaign, particularly aimed at general populations would be overly effective. In fact it could possibly be counterproductive in encouraging impressionable (young people) to experiment with the drug:

I think there are times when mass messaging is not the right thing to do, and I think methamphetamine use is an example of that. The reason is because, on a population basis, methamphetamine use is relatively uncommon. I realise it is a higher frequency in some population subgroups and it has terrible consequences for some individuals, but on a mass population basis it is extremely low-prevalence behaviour.

It is pretty hard to run an intervention at a population level and expect to see a decline in substance use when it is already, at a population level, very low. That is quite unlikely. You are unlikely to be able to demonstrate any benefit of a mass reach campaign. You have to balance up—painting an issue as a problem for young people who have probably never heard of it and would never take up use of the substance anyway.

The risk of running a mass reach media campaign is that you are informing people this stuff is out there, you are drawing attention to the issue, you are making it a discussion item, when in fact it probably was not in many children's eyes before. You can have boomerang effects, which I think is risky. I think this is a behaviour for which you should narrowcast, not broadcast. You could have education approaches for high-risk groups. You certainly would have at least an adequate school based program, which might be more kind of resilience training for kids in general, which would deal with a number of different drugs.¹⁴⁵¹

1446 Mr John Thompson, General Manager, Mitchell & Partners, Public Hearing, Melbourne, 24 March 2014.

1447 This campaign is discussed below.

1448 Mr John Thompson, General Manager, Mitchell & Partners, Public Hearing, Melbourne, 24 March 2014.

1449 Mr John Thompson, General Manager, Mitchell & Partners, Public Hearing, Melbourne, 24 March 2014.

1450 Prof. Melanie Wakefield, Centre for Behavioural Research in Cancer, Cancer Council Victoria, Public Hearing, Melbourne, 31 March 2014.

1451 Prof. Melanie Wakefield, Centre for Behavioural Research in Cancer, Cancer Council Victoria, Public Hearing, Melbourne, 31 March 2014.

Mass media campaigns directed to non-users of methamphetamine

Witnesses from the alcohol and other drugs (AOD) and health sectors who gave evidence did not generally approve of mainstream campaigns directed towards non-using members of the community. For example, a submission from the Western Region Health Centre stated:

It is important to note that any social marketing campaign which is designed to engage users and reduce harm and risk-taking behaviours should be aimed at the user and not the general community. Peer engagement has been shown to have a greater impact on reducing harm and risk taking than expensive media campaigns. Campaigns aimed at *prospective* users should be regarded with suspicion as they ignore the vital understanding of the context people are in at the time they make the decision to use a substance for the first time.¹⁴⁵²

Similarly, a submission from the Yarra Drug and Health Forum stated that:

The committee should avoid recommending ‘TAC’ style advertising to warn about the ‘dangers’ of ‘ice’. These mass-media strategies are mostly ineffective and in many cases counter-productive.¹⁴⁵³

On the other hand bodies such as the Pharmacy Guild of Australia believes that such public information campaigns are important and necessary. The Guild notes, however, that they need to be accompanied by other health promotion interventions, such as harm reduction initiatives and the ability to refer actual and potential users for further advice and treatment where necessary:

Overall, the Guild strongly believes that frameworks established to address supply reduction strategies will require targeted public information campaigns, information sharing and social marketing which engage the health sector and community. It is essential for community pharmacy to be involved in the development of such campaigns, as it is the most commonly utilised health service provider in Australia with a track-record in effective health promotion and public health awareness activities.¹⁴⁵⁴

Finally, Mike Sabin told the Committee in terms of social marketing it was necessary to set up a ‘roadblock campaign’ for the messaging about methamphetamine to succeed in deterring the uptake of the drug:

One thing to consider in terms of a social marketing strategy is what I have seen in some places, which is called a roadblock campaign, where basically on a given day for a given hour across every media spectrum there is one message delivered. Town halls will run it and set up big screens, it will be on the television and it will be on the radio — it will be live cast everywhere. It is a roadblock across every medium that is well advertised and well promoted and basically provides that in-depth scientific knowledge and understanding so that en masse you can educate your population to understand that this is what it is about.

Then you have captured them, and you can actually roll through your other messages. It sounds like a pretty unusual thing to do, but it is actually perfectly achievable with modern technologies. At some point you have to capture a critical mass of people through a prevention mechanism, but it is really important what that message looks like. You cannot just scare people off the stuff.¹⁴⁵⁵

‘Scare or shock’ tactics in campaigns

Much of the research literature, at least as it pertains to the use of shock tactics in both school and community drug education, is equivocal about its effectiveness (see, for example, Erceg-Hurn 2008; Orwin, Caddell & Chu 2006; Block et al. 2002). In the school

1452 Ms Lyn Morgain, Chief Executive Officer, Western Regional Health Centre, Submission, 22 October 2013.

1453 Mr Greg Denham, Executive Officer, Yarra Drug and Health Forum (YDHF), Submission, 3 October 2013.

1454 Mr Allan Crosthwaite, Director and Mr Stan Goma, Manager — Professional Services, The Pharmacy Guild of Australia — Victoria, Submission, 10 December 2013.

1455 Mr Mike Sabin MP, Member for Northland, New Zealand Parliament, Public Hearing, Melbourne, 5 June 2014.

context the Principles for School Drug Education state ‘Programs that provide biased or inaccurate information and use “scare tactics” as a deterrent are bound to fail. Focusing on fear may glamorise or enhance the status of risky drug use behaviours’ (Commonwealth of Australia 2004, p.48).

Cahill expands on this principle, viewing the use of scare tactics in drug education as being based on an incorrect assumption:

Intuitive approaches have led in the past to the use of scare tactics in drug education. Scare tactics are based on the assumption that *if we could just show how risky it is — they wouldn’t do it*. Students, parents and teachers are often convinced that confronting young people with the most severe harms will deter them from using drugs. However, programs that rely on scare tactics have not shown reduction in the incidence of harmful drug use (Tobler et al 1997). There may be a number of reasons why this is so. These include a tendency to believe in one’s own invulnerability — *this is not going to happen to me*, and a poor fit between the young person’s observation or experience of drug use and the consequences shown in the scare tactics program — *this is not what I have seen happening to others*. Many students have observed parents, peers or community members using drugs such as cigarettes, alcohol and cannabis without appearing to come to harm (Cahill 2005, p.2).

Similarly, evidence to the Committee from AOD, health and youth workers have also advised caution in the employing of such messages in the community context.

A submission from North Yarra Community Health for example stated that ‘a question mark exists around the effectiveness’ of mass media campaigns particularly when directed at young people.’¹⁴⁵⁶ Ambulance Victoria told the Committee methamphetamine campaigns, particularly when directed at young people, need to be ‘contemporary, honest and factual’.¹⁴⁵⁷

Jenny Kelsall from Harm Reduction Victoria was not impressed with the federal government campaign of 2007 ‘Don’t let ice destroy you’,¹⁴⁵⁸ nor with subsequent ‘scare campaigns’ involving crystal methamphetamine. She told the Committee:

Sadly we keep on with these scare campaigns, although there is little evidence that they work. As researchers pointed out who spoke to thousands of teenagers after these ads were shown, they actually had an adverse effect. Almost half of the thousands of young people interviewed believed that ice was not dangerous; it [the campaign] certainly had not had the desired effect. These sorts of scare tactics simply do not hit the mark, because they do not gel with the reality of ice use for anyone who has tried it, so all of the information gets discarded — the baby gets thrown out with the bathwater.

Scare tactic campaigns have worked with smoking, they have produced positive outcomes, but with illicit drugs it just does not seem to hit the mark. The young people we work with who are experimenting with these drugs are quite distinctive in their desire to be well informed about their drug use. They are very IT literate and are very well informed about all the sites available. Some of them are extraordinarily well informed about the various drugs on offer. ... It is almost insulting to present these images to some of these young people who have a knowledge base and who have their own experience.¹⁴⁵⁹

Geoff Munro from the Australian Drug Foundation also thought shock campaigns aimed at methamphetamine *users* but not necessarily the uninitiated could backfire:

I think we recall that the Grim Reaper [HIV/AIDS] campaign led a lot of what were called the ‘worried well’ to seek help — people who were not at particular risk. We know that shock campaigns often do not work, because they do not actually reach the people who are at greatest risk of the particular behaviour. For example, people who tend to use illicit drugs watch less TV, probably, than most other people. They are hard to survey through household surveys because they are either homeless or less

1456 Ms Vera Boston, Chief Executive Officer, North Yarra Community Health, Submission, 21 October 2013.

1457 Mr Allan Eade, Intensive Care Paramedic, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013.

1458 See discussion below.

1459 Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013.

likely to be at home when surveyors call. That is why those sorts of — perhaps we could call them ‘underground’ or ‘peer-led’ — communication techniques are more successful. They are people who are often not part of the mainstream. The shock tactics have been known to attract people to risky behaviour partly because it is risky...people who are using illicit drugs to cope with their difficult life circumstances are not turned off by knowing that the activity may be risky, because they are responding to that personal need or that social need. They are coping with homelessness or trauma or an abusive relationship. The shock tactic does not remove that incentive or that reason for use. That is why we do not advocate for shock tactics.¹⁴⁶⁰

Dion Appel, Chief Executive Officer of youth marketing company Lifelounge, told the Committee that the evidence to support the effectiveness of campaigns based on shock and scare tactics was equivocal, particularly with regard to young people:

[b]eing in the youth market I can say generally that young people tend to find themselves quite invincible and they believe that ‘this won’t happen to me’. I am making specific reference to scare tactics here. What we find is that if young people are being spoken down to and they are being told, ‘Don’t do this, don’t do that, look at the effects of this’, and really rattling the cage around shock tactics and scare tactics, they will rebel against that just because of the nature of the conversation.¹⁴⁶¹

Therefore these scare tactic campaigns only tend to increase anxiety among the broader community, including parents, and they are the ones who feel the brunt of these particular campaigns. Then you are dealing with a segment, in parents, that feel compelled to tell their kids, and so the kids are being told through scare tactics in mass media campaigns and then their parents, ‘Don’t, don’t! No, no!’¹⁴⁶²

Mr Appel’s view is that shock tactics can work as long as they are not pushed to the point where they are neither credible nor resonate with the target audience’s experience of the subject. In this respect shock tactics such as those in the Montana Meth project discussed below may be more beneficial for an audience that has never used the drug rather than one that has already tried it. According to Mr Appel, messages should be targeted to different segments of the market. For example, a preventive campaign possibly utilising scare tactics for a mainstream audience that has never used the drug and a specific campaign for those who are already using concentrating on harm minimisation type messages.

Ultimately, however, any campaign that addresses methamphetamine use, particularly for young people, needs to understand its target audience including what might be the possible attractiveness of the drug or its ‘positive’ aspects for that audience:

‘Scare’ campaigns need to be coupled with comprehensive programs and long-term commitment

Mr Appel’s preferred approach would be that if shock tactics are to be used they are linked to a sustained and continuous program of education, information provision and support rather than a one-off campaign:

I am also very aware of the campaign that took place in 2007, the federal campaign, and I suppose the tactics that were used there were very hard hitting ... But again in terms of disconnect, ‘Is this something that could happen to me?’, I do not think it would have resonated with everybody. I am not necessarily sure it would have stopped [ice use] and clearly it has not, because the issue has become a much bigger one since 2007. What it did do was increase the awareness that there is this drug on the market and this drug on the market is pretty extreme, with the bugs under the arms and the scratching and all those sorts of things. I think it was one way of bringing a campaign like that into the market, but I think the challenge that has taken place since 2007 is that there has not been any continuity.

1460 Mr Geoff Munro, National Policy Manager, Australian Drug Foundation, Public Hearing, Melbourne, 14 October 2013.

1461 Mr Appel also believed that whilst shock tactic campaigns may not resonate personally with a young person, he or she might be more apprehensive if they thought friends were ‘at risk’.

1462 Mr Dion Appel, CEO, Lifelounge Agency, Public Hearing, Melbourne, 16 June 2014.

There was one campaign and then there has kind of been nothing really consistently in the market since then. If you look at the TAC, at tobacco advertising to a certain extent and certainly at drinking responsibly and things like that, there has been consistent messaging in the market year on year, which I think helps raise awareness, which is the first hurdle, and then changes behaviour, which is the second hurdle. — I think a program is required as opposed to just a campaign, so a long-term commitment.¹⁴⁶³

In this regard, Mr Appel saw strengths in the Montana Meth campaign in that it *had* evolved from an information campaign to a long-term project that was about more than just scare tactics:

So it [Montana Meth] did evolve once the scare tactics came out, and they could see how effective or ineffective it was being. It did not get more shocking in its tactics. It actually got less shocking in its tactics,

It has now positioned itself as a project as opposed to a campaign. A campaign feels a bit more one-off, and a project feels ongoing. A project is something you can add to and build on, and it can actually become something quite ownable. People can feel like they contribute to a project. 'This is not a one-off — here today, gone tomorrow — campaign; this is an ongoing issue that we need to be able to tackle'. Therefore there is some continuity with regard to that particular campaign or project.¹⁴⁶⁴

Similarly, Michelle Withers from the Project Ice campaign in Mildura told the Committee that a shock tactics aspect of a public campaign could only work in conjunction with a wide range of other forms of information, support and service delivery:

[w]e had looked at some of those Grim Reaper scare tactic campaigns but our expert advice was not to start in those scary, shock tactics. It can be built into the campaign, but you cannot start there.

So while initially we immediately thought of jumping to that sort of shock 'get the message out there' approach, our expert advice said not to do that. So it is something that we are certainly looking at building into the campaign, depending on the lifespan of the project. But given the advice, no, we have not as yet.¹⁴⁶⁵

In this regard Gino Vumbaca from the ANCD told the Committee that to be successful a methamphetamine campaign would need to be launched in conjunction with a raft of other demand, harm and supply reduction strategies similar to those used for tobacco:

As I said, the lesson we learn from tobacco is that the campaign is part of a broader package. They had smoking in public places. If we go back 20 or 30 years, when I worked in St Vincent's hospital in Sydney, people used to smoke in the workplace, even in hospitals. I remember sitting there and people used to smoke at their desk and things like that.

Even on planes you used to be able to smoke. If you think back 20 or 30 years ago and how pervasive smoking was, it was not the graphic advertisements and the like that changed that. That was part of it, but there were also legislative reforms put in place which restricted access or restricted where you could smoke. A public education campaign about the dangers of smoking was inherent in that. Cost was also a factor — tax rises caused people to make economic decisions to stop smoking. All of those things together led to this quite dramatic decrease in the smoking rates in Australia.¹⁴⁶⁶

The use of scare tactics in education campaigns on crystal methamphetamine was also discussed in a group panel discussion at a conference on methamphetamine organised by the Rangatira Management Consultancy. Views on their utilisation were very mixed. For example, Mike Sabin argued that it was important young people understood the consequence of crystal

1463 Mr Dion Appel, CEO, Lifelounge Agency, Public Hearing, Melbourne, 16 June 2014.

1464 Mr Dion Appel, CEO, Lifelounge Agency, Public Hearing, Melbourne, 16 June 2014.

1465 Ms Michelle Withers, Integrated Services Coordinator, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

1466 Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

methamphetamine use ‘locked up, dead or sober’ and that ‘raw reality’ campaigns could be useful. Similarly, Josephine Baxter from Drug Free Australia argued that the success of campaigns around tobacco advertising showed that scare type campaigns could be successful. On the other hand, Drug Court Magistrate, Tony Parsons believed that scare campaigns were not balanced given that some people *could* use crystal methamphetamine with no measurable detriment. As such, ‘smash, crash, scare the hell approaches’ would not work as they would not ‘speak to the reality of young people’s reality’.¹⁴⁶⁷

Finally, Mike Sabin whilst not opposed by any means to the use of hard hitting education campaigns stated that ultimately such campaigns had to be based on science;

The challenge with some of the education is that youngsters will always be ignorant because they do not have life experience, and they will always be curious. Ignorance and curiosity are really dangerous when you have a drug like ice, which is quite available. Also — how can I put this? — they have pretty good bullshit meters, for want of a better phrase. They can work stuff out when someone is try to pull the wool.

My belief is that what you need to be able to say is, ‘Understand how this works. Understand the science of your brain, and understand why it is no different to his, hers or yours for that matter’. Then understand what this drug actually does to interact with that brain and why it does. It is education that comes not from a judgmental standpoint or a ‘just say no’ standpoint; it comes from a ‘just understand the science’ standpoint.

For modern youngsters it needs to be something empowering that gives them the ability to understand that drug use causes loss of control and loss of freedom of choice and that if people use, there are consequences and it all gets ugly. They need to understand why they are no different. It needs to be in that mechanism. There needs to be a place for the sort of stop-and-think messages — absolutely — as long as they are interwoven with stuff that is very much about understanding the inevitabilities of the science in this.¹⁴⁶⁸

Examples of mass media campaigns as they apply to crystal methamphetamine

This section outlines three specific campaigns that have addressed crystal methamphetamine use, including the famous or perhaps infamous Montana Meth Project.

National Drug Strategy Campaigns — 2001–2010

A number of Commonwealth Government campaigns have focused on reducing the use of drugs, including methamphetamine, through education aimed at students, other young people and their parents. National Drugs Campaigns (NDC) developed by the Commonwealth’s Department of Health and Ageing that have had an education component were undertaken from 2001 to the latest campaign developed in 2010-2012.

Each campaign has had different foci. Beginning in 2001, the NDC was ‘designed to encourage a discussion about drugs between parents and children, supported by materials to support parents to prevent drug use among children and teenagers’.¹⁴⁶⁹ In the 2005 campaign, the key message was the effects of illicit drugs, with a focus on the impact of using marijuana, speed and ecstasy and an age group focus of eight to 17 year-olds.¹⁴⁷⁰ A recurring theme was

1467 Mr Peter Wearne, from the Youth Support + Advocacy Service affirmed Magistrate Tony Parsons’ view on scare campaigns. Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

1468 Mr Mike Sabin MP, Member for Northland, New Zealand Parliament, Public Hearing, Melbourne, 5 June 2014.

1469 Australian Government, Past phases of the National Drugs Campaign, Department of Health and Ageing, accessed at [http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/\\$file/Past%20phases%20of%20the%20campaign.pdf](http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/$file/Past%20phases%20of%20the%20campaign.pdf)

1470 Australian Government, Past phases of the National Drugs Campaign, Department of Health and Ageing, accessed at [http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/\\$file/Past%20phases%20of%20the%20campaign.pdf](http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/$file/Past%20phases%20of%20the%20campaign.pdf)

conversing about drugs within families. The 2007 NDC was the first to focus in ice, and also recognised the importance of educators in supporting and helping young people.¹⁴⁷¹ Interestingly, this campaign also sought to contribute to a reduction in the proportion of young Australians using illicit drugs.¹⁴⁷² The 2009 NDC extended the earlier campaigns by targeting an older audience (15 to 25 year-olds), with an ongoing focus on ice and the importance of educators and parents.¹⁴⁷³ The 2010 campaign targeted a larger cohort of users or at-risk age groups, including 18–25 year-old users of illicit drugs such as methamphetamine, teenagers aged 15–17 and parents of 15–25 year-olds, among others.¹⁴⁷⁴ Its aim was, similarly, to reduce usage rates by raising awareness and encouraging people not to use illicit drugs.

The most recent campaign, 2010–2012, followed the earlier campaigns with a focus on ecstasy. All of the NDC campaigns used advertising including television commercials, with some employing shock advertising similar to those used in the Montana Meth project, discussed below. Indeed, the television commercials in 2007 drew criticism due to their graphic nature (for example a young woman picking at her skin). In explaining the use of such advertising, John Herron, the chairman of the Australian National Council on Drugs, noted that they were intended to ‘scare people off trying [these drugs] in the first place’.¹⁴⁷⁵ That sentiment was also supported by the then Minister for Ageing Christopher Pyne, who stated that ‘the tough-on-drugs campaigns have worked, it’s just that ice has suddenly emerged in a way that the government wants to nip in the bud if it can’.¹⁴⁷⁶

The Federal Government Ice Campaign — ‘Don’t let ice destroy you’

As mentioned above, one of the NDS campaigns – ‘Don’t let ice destroy you’ – was a hard hitting campaign relying on a variety of messages aimed at young people and their families warning them of the negative physical and social consequences of methamphetamine use. The advertisements that were part of the campaign were screened or displayed in a variety of media including television, newspapers, social media such as YouTube and in poster form on billboards and in bus shelters. The content of the advertising was very similar to the American Montana Meth campaign with its reliance on ‘before and after shots’ of people who had used the drug. The impact of this very negative depiction of crystal methamphetamine use is hard to gauge, given the difficulty of evaluating mass media campaigns generally. However, an independent evaluation of this campaign found that the impact of this particular message was that young people stated they would be less likely to try this particular drug and viewed it as a harmful substance.

‘Ice — It’s a Dirty Drug’ Campaign — Victoria 2007

The Victorian Department of Human Services (DHS) launched the *Ice: It’s a dirty drug* campaign in 2007.¹⁴⁷⁷ The campaign was targeted at 15–25 year olds, and centred on the consequences

1471 Australian Government, *Past phases of the National Drugs Campaign*, Department of Health and Ageing, accessed at [http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/\\$file/Past%20phases%20of%20the%20campaign.pdf](http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/$file/Past%20phases%20of%20the%20campaign.pdf)

1472 Australian Government, *Past phases of the National Drugs Campaign*, Department of Health and Ageing, accessed at [http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/\\$file/Past%20phases%20of%20the%20campaign.pdf](http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/$file/Past%20phases%20of%20the%20campaign.pdf)

1473 Australian Government, *Past phases of the National Drugs Campaign*, Department of Health and Ageing, accessed at [http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/\\$file/Past%20phases%20of%20the%20campaign.pdf](http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/$file/Past%20phases%20of%20the%20campaign.pdf)

1474 Australian Government, *Past phases of the National Drugs Campaign*, Department of Health and Ageing, accessed at [http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/\\$file/Past%20phases%20of%20the%20campaign.pdf](http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/content/campaign/$file/Past%20phases%20of%20the%20campaign.pdf)

1475 Australian Broadcasting Corporation (ABC), *Govt defends graphic new ‘ice’ TV ads*, 16 August 2007, accessed at <http://www.abc.net.au/news/2007-08-16/govt-defends-graphic-new-ice-tv-ads/642086>

1476 The Age, *PM takes credit for drop in drug deaths*, August 16, 2007, accessed at <http://www.theage.com.au/news/NATIONAL/New-ads-to-warn-against-ice-use/2007/08/16/1186857631498.html>

1477 State Government of Victoria, *Ice campaign shows reality of a dirty drug*, Department of Human Services, Press Release, 4 November 2007.

of crystal methamphetamine use. Founded on a fear-based approach, the campaign's key focus was that crystal methamphetamine was 'the most potent and dangerous form of amphetamine' that could have long-term, highly damaging mental and health consequences.

The campaign was targeted at events and venues frequented by the target audience over the November to March summer festival period.¹⁴⁷⁸ According to the DHS, an important element in the campaign was to highlight the ingredients in producing methamphetamine as well as the effects of it.¹⁴⁷⁹ It did not rely on shock images which the DHS felt had been 'overused in anti-drug advertising'. The campaign used 'unusual outdoor advertisements' such as placing posters and advertisements comprising the key campaign message — *Ice: it's a dirty drug* — and secondary messages about the ingredients used in its manufacture (for example *Fertiliser. One of the ingredients in Ice*) and its effects (for example, depression, paranoia, and panic attacks) at music festivals, in pubs and clubs, on rubbish dumpsters and in toilets.¹⁴⁸⁰ The locating of advertising in these places and on those items therefore aligned with the idea that the drug was 'dirty'.

The 'Montana Meth' Project — USA Ongoing

The Montana Meth Project (the Project) is a Montana based 'large-scale prevention program aimed at reducing methamphetamine use through public service messages, public policy, and community outreach'.¹⁴⁸¹ The approach of the Project is to prevent drug use in the first instance, by addressing what it views as the perception that there are 'many perceived benefits in using the drug, but little to no risk'.¹⁴⁸² The Project has primarily focused on shocking viewers about the risks of using methamphetamine by using photos of people suffering from the causes of crystal methamphetamine use; for example, people with damaged skin, before and after shots, addicts with skin lesions and body sores accompanied by messages such as 'you'll never worry about lipstick on your teeth again' and 'actually doing meth won't make it easier to hook up'.¹⁴⁸³

Although the Project initially focused on using advertising to highlight the risks of methamphetamine through shock-based commercials, more recently, it has shifted to a more integrated approach that combines an information portal, the above-mentioned public advertising and community based campaigning.¹⁴⁸⁴ In terms of its effectiveness, the Project claims to have achieved a decline in teenage methamphetamine use of 65% in Arizona, 63% in Montana, and 52% in Idaho.¹⁴⁸⁵ This success, however, as discussed below has been questioned by other researchers.

Effectiveness of the campaign

There has been debate about the effectiveness of the campaign in reducing methamphetamine use, particularly with regard to its use of shocking and graphic 'scare' images.

Early critiques of the campaign conducted in the years after the inception of the Project in 2005 were largely critical. An independent review by the Society for Prevention Research (US) in 2005 is representative of these views. It found that the advertisement campaign was not necessarily responsible for reducing meth use in Montana as the Project claimed.

1478 State Government of Victoria, *Ice campaign shows reality of a dirty drug*, Department of Human Services, Press Release, 4 November 2007.

1479 Lifelounge, 'The supply and use of 'Ice' In Victorian communities', slide 2 in Slideshow presentation supplied to the Committee by Mr Dion Appel, CEO, Lifelounge Agency, Public Hearing, Melbourne, 16 June 2014.

1480 Clay Lucas, 'Push to turn young off using ice', *The Age*, 5 November 2007.

1481 Montana Meth Project, *About Us*, accessed at <http://www.montanameth.org/About-Us/index.php>.

1482 Montana Meth Project, *About Us*, accessed at <http://www.montanameth.org/About-Us/index.php>.

1483 See Montana Meth Project, *View Ads*, accessible at <http://www.montanameth.org/Our-Work/view-ads.php>

1484 Montana Meth Project, *About Us*, accessed at <http://www.montanameth.org/About-Us/index.php>.

1485 Montana Meth Project, *Results*, accessed at <http://www.montanameth.org/Results/index.php>

Meth use had been declining for at least six years before the ad campaign commenced, which suggests that factors other than the graphic ads cause reductions in meth use. Another issue is that the launch of the ad campaign coincided with restrictions on the sale of cold and flu medicines commonly used in the production of meth. This means that drug use could be declining due to decreased production of meth, rather than being the result of the ad campaign (Erceg-Hurn 2008, p.257).

The review was also critical of the way the research was conducted:

It is impossible to conclude that the ad campaign had any effect on meth use. To draw such conclusions would require much more rigorous research. This would involve examining two groups of teenagers that were equivalent in terms of drug use, exposing only one group to the graphic ads, and then examining any differences between the groups in their drug use. The idea behind the ad campaign is that teenagers take meth because they believe it is socially acceptable, and not risky — and the ads are meant to alter these perceptions. However, this theory is flawed because the Meth Project's own data shows that 98% of teenagers strongly disapproved of meth use and 97% thought using meth was risky before the campaign started (Erceg-Hurn 2008, p.261).

It also found that the Meth Project had selectively reported their research findings, focusing on unrepresentative positive findings and ignoring data suggesting that the campaign may be associated with harmful outcomes. Such selective reporting of results may have led the media, politicians and the public to form distorted and inaccurate beliefs about the campaign's effectiveness.¹⁴⁸⁶ The review found that the Meth Project's data suggests that exposure to the graphic ads may lead to an *increase* in the percentage of teenagers who believe that taking meth is socially acceptable and *not* dangerous.

The review concluded that given the questions surrounding the Project's effectiveness and its flawed methodology, public funding and continued rollouts of Montana-style anti-methamphetamine graphic ad campaigns were inadvisable.

More recently, however, there has been a reconsideration of the effectiveness of 'Montana Meth'. A study undertaken in 2012 by researchers at Arizona State University published in the *Journal of Marketing Research* validated the effectiveness of the Meth Project's advertising in deterring crystal methamphetamine abuse.

The researchers tested the effectiveness of several advertisements and found that ads that relied on fear alone to convey their message did not lead to immediate changes in attitudes or behaviour. However, according to the study, the Meth Project ads that incorporated an element of 'disgust', such as rotting teeth, skin sores or infections, did compel viewers to 'undertake distancing behaviors', such as deciding not to use illegal drugs.¹⁴⁸⁷

The study concluded that 'the disgust inducing fear appeal of the ad...significantly reduced future drug use, making it more effective in terms of persuasion and compliance'.¹⁴⁸⁸

The Project has also been regarded more favourably because it is now run in conjunction with a raft of preventive and intervention programs that go beyond the advertising campaign. These include the mobilisation of community groups throughout Montana to spearhead education and prevention efforts; coordination with local, state, and federal agencies; health promotion activities and miscellaneous activities such as the 'Paint the

1486 Andrea C. Morales, Eugenia C. Wu, & Gavan J. Fitzsimons, *Journal of Marketing Research* (JMR), Online at: https://archive.ama.org/archive/AboutAMA/Pages/AMA%20Publications/AMA%20Journals/Journal%20of%20Marketing%20Research/TOCs/SUM_2012.3/disgust-fear-appeals.aspx.

1487 Andrea C. Morales, Eugenia C. Wu, & Gavan J. Fitzsimons, *Journal of Marketing Research* (JMR), Online at: https://archive.ama.org/archive/AboutAMA/Pages/AMA%20Publications/AMA%20Journals/Journal%20of%20Marketing%20Research/TOCs/SUM_2012.3/disgust-fear-appeals.aspx.

1488 Andrea C. Morales, Eugenia C. Wu, & Gavan J. Fitzsimons, *Journal of Marketing Research* (JMR), Online at: https://archive.ama.org/archive/AboutAMA/Pages/AMA%20Publications/AMA%20Journals/Journal%20of%20Marketing%20Research/TOCs/SUM_2012.3/disgust-fear-appeals.aspx.

State' public art program and community events such as presentations to schools, youth organisations and clubs, local community groups, businesses and service organisations.¹⁴⁸⁹

Community views on the Montana Meth Project and its applicability to Victoria

Despite the equivocal findings with regard to the effectiveness of Montana Meth, this type of campaign has been viewed with favour by some witnesses who gave evidence to the Inquiry. For example, Jacki Burgess a Victorian woman with a background in advertising was highly impressed with this approach. She approved of the use of hard hitting messages including the use of 'before and after' photographs to present the deleterious effects that methamphetamine can have on the body:

I suggest that an advertising programme should show the real life degeneration of 'ice' addicts, with the before and after shots that are readily available on the internet. This, together with the dates showing the incredibly short period of time over which the degeneration takes place, would surely be a most potent tum-off to any potential addict. Let more people see the 'ice' effects with their own eyes, and surely they will be far less likely to start taking such a devastating product.¹⁴⁹⁰

On the other hand Stu Fenton, a former ice 'addict', told the Committee that the sort of images as portrayed in Montana Meth and other campaigns of that type were not particularly helpful in assisting users or potential users of crystal methamphetamine.

It is a little bit like the spectre in the HIV ads, like it is a scare tactic. It probably had some sort of effect but an effect in scaring people off temporarily. They [before and after images] are the worst case scenarios when people are in the final quarter of getting really addicted to it. I told you I am a member of a 12-step meeting for this and I was in Sydney on the weekend where there were 50 people sitting in the room. None of them looked like that, that I can remember. A lot of those were people who have just come into recovery, only been there for a month to two months. I do not think that is a very realistic representation of what ice does. People might see that image and they will just say, 'Well, my other five friends use ice and they don't look like this.'¹⁴⁹¹

Drugs educator Paul Dillon was also sceptical about the effectiveness of campaigns such as Montana Meth or at least aspects of the advertising campaign relying on the graphic images of users portrayed:

A lot of scare campaigns such as Montana Meth have come out of America. For example, there are the ageing ones that we have where you have got the mug shots over 10 years. There are lots of websites that completely look at those campaigns and show that they are factually incorrect. They are campaigns put out by the US drug enforcement agency that absolutely show 10 years of someone who happened to take methamphetamine but they also were HIV positive and the kind of people who lived on the streets and worked as sex workers, so it is no surprise they look like that after 10 years. It is not necessarily just the methamphetamine that did that.

I think one of the dangers that we have had is that a lot of the campaigns, particularly from America, and a lot of the media stories about methamphetamine are about, 'One puff of crystal and you are addicted', and, 'If you use, your body will decay looking like this — methed out'. I am sure you have had evidence about that — you know, 'Smoke it and all your teeth fall out'. In fact the evidence is quite clear. Yes, if you do not clean your teeth, all your teeth will fall out, but if you puff on methamphetamine occasionally and clean your teeth, you most probably will not have a problem.¹⁴⁹²

Professor Wakefield was less convinced that Montana Meth was a useful campaign in that as a 'mass reach' campaign it was targeting messages at populations who were largely not affected

1489 See www.montanameth.org

1490 Ms Jacki Burgess, Submission, 24 September 2013. Ms Burgess attached the following link to her submission which includes many of the graphic images of methamphetamine users she details in her submission. <http://www.rehabs.com/explore/meth-before-and-afterdrugs/infographic.html>

1491 Mr Stuart Fenton, Drug and Alcohol Counsellor, Public Hearing, Ballarat, 18 November 2013.

1492 Mr Paul Dillon, Director and Founder, Drug and Alcohol Research and Training Australia, Public Hearing, Melbourne, 3 February 2014.

by the drug. The types of messaging that were a feature of this campaign, graphic imagery, personal stories, can in her view be an effective communication tool in cases of relatively high prevalence behaviours such as tobacco smoking which is not true of methamphetamine.¹⁴⁹³

Success of the campaigns overall

When asked about the success of the various campaigns on ice, Gino Vumbaca from the Australian National Council on Drugs (ANCD) told the Committee:

They are always difficult to evaluate. The evaluations the Commonwealth does on the national campaigns are about recall, about whether people saw the ad. That is generally how it seems to be measured. And there is a debate within the drug and alcohol community about the value of public education campaigns. It is a difficult area, but we know that with tobacco, public education campaigns have shown quite a level of success and helped as part of the broader strategy about reducing tobacco use.

The government did have a specific methamphetamine advertisement. I recall it was one about someone going into a hospital waiting room and causing trouble, and there were different images that were part of that national campaign. What we saw — and it may have been coincidence; this was hard to work out — was a levelling off of ice use. Those campaigns are good. Someone who is already using and has problematic use is not going to see that ad and think, 'I should stop using ice'. But if you are someone who has not used it and you may have some fears already about what the implications are, that can reinforce that in someone as a preventive measure. If they do get in a situation where they are offered it or can access it and that image is there, it may well have preventive influence on them choosing whether to use that drug. They might be a bit more scared of the drug.¹⁴⁹⁴

Mr Vumbaca told the Committee that whatever the overall merits of the campaigns outlined, one of the common threads that *was* useful was the attempt to disassociate the term ice from the view that it was a fresh or clean drug:

That is what we talked about in the original campaign that the federal government undertook. We have to break this image. The name, ice, refers to something clean and sharp. People who manufacture and market these drugs understand how to market them. At the same time there was a whole range of beer products that came out with the term 'ice', promoting that clean, crisp image. There was an argument that they were tapping into that sort of view. You do have to undermine that view within the broader community that ice is somehow okay or clean.¹⁴⁹⁵

Dion Appel from Lifelounge made similar observations when he gave evidence to the Committee. His marketing company in their 'Ice: It's a dirty drug' campaign took the angle of disassociating ice from any perception that it could be a 'clean drug':

There was a big misconception in the marketplace around the purity and cleanliness of the drug ice, purely by the name and also by the sight of the substance when in actual fact things like paint thinner, battery acid and fertiliser are all ingredients of this and to think that that is something that you would put into your body by choice goes very much against what the name of the actual product suggests.

This was a campaign we developed to help educate the market around the ingredients within ice. The way we actually delivered it to market was very much around the notion that the ingredients are not pure and clean but the ingredients are very much filthy and dirty. With 'Ice: It's a dirty drug', the mediums we used and the visual communications with this outdoor site in a prominent area within St Kilda — over an eight-week period the vines really took over the billboard and on the other side of that it said, 'Fertiliser: one of the ingredients of ice' and 'Ice: It's a dirty drug' — really started to bring that notion to market.¹⁴⁹⁶

1493 Prof. Melanie Wakefield, Centre for Behavioural Research in Cancer, Cancer Council Victoria, Public Hearing, Melbourne, 31 March 2014.

1494 Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

1495 Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

1496 Mr Dion Appel, CEO, Lifelounge Agency, Public Hearing, Melbourne, 16 June 2014.

The media and the reporting of methamphetamine

The role of the media in reporting issues pertaining to drug use can be complex and controversial. According to Degenhardt and Hall policies towards drugs, particularly illicit and newly emerging drugs, can be 'often made in response to media stories and in ignorance of the scale of their use and the problems arising from it' (2012, p.66). Sensationalist and emotive accounts of drugs such as crystal methamphetamine that use terms such as epidemics, or even pandemics, can contribute to, or even create, 'moral panics' about the extent of the drug use and the consequences for local communities, in effect manufacturing a crisis that may not in reality exist (Groves and Marmo 2009). Such problems may particularly arise when this type of media reporting contributes to kneejerk political responses and 'highly charged' environments' (Fulde & Wodak 2007). As Ritter remarked in responding to an earlier 'crisis' about methamphetamine: 'We are at risk of losing track of our existing knowledge and evidence base in the face of media, political and community cries for responses to the "crisis"' (Ritter 2007, p.227).

Bearing these concerns in mind it is also true that the media can perform a valuable service in addressing and illuminating issues of contemporary concern such as methamphetamine use.

Reporting on methamphetamine in Victoria 2013– June 2014

During the course of this Inquiry there has been a huge coverage on crystal methamphetamine and its effects, particularly in the print media. This has been the case in metropolitan dailies, suburban, rural and regional papers.

A media analysis was done for this Inquiry by the Victorian Parliamentary Library utilising the library's News Archive database.¹⁴⁹⁷ This database included most Victorian and national newspapers, however it was not able to separate the suburban local papers from the rural and regional press. It is therefore not possible to give a more accurate summation of the media coverage on crystal methamphetamine in individual rural and regional towns and communities. A broad breakdown of reporting on crystal methamphetamine for the period September 2013 to early July 2014 is given in Table 24.2 below.

Table 24.2: Methamphetamine and ICE in the news, 3 September 2013–2 July 2014

	No. of articles
Metro & National papers[^]	331
The Age	105
Sunday Age	17
The Australian	43
Australian Financial Review	27
Herald Sun	116
Sunday Herald Sun	23
Suburban & Regional papers & AAP Newswires	1117
TOTAL Newspapers	1448
Radio and TV news clips	62
TOTAL	1510

Source: Compiled by Victorian Parliamentary Library, 3 July 2014.

¹⁴⁹⁷ The analysis commenced at the outset of the Inquiry and was completed on 2 July 2014.

The stories have varied from reactive reports responding to a particular issue such as a ‘meth’ related crime, to major features and opinion pieces and editorials.¹⁴⁹⁸ These accounts have ranged from informed and well researched journalism to stories which are arguably exaggerated, sensationalist or misleading.

Radio coverage on the issue has also been prevalent with metropolitan and regional stations regularly reporting on crystal methamphetamine in local communities. Even prominent radio broadcasters such as Melbourne’s Neil Mitchell and Jon Faine, and the Triple J station have presented radio forums on crystal methamphetamine in an attempt to address the issues and push for solutions to the perceived ‘crisis’.

The Committee heard mixed views on whether this media attention has contributed positively to addressing crystal methamphetamine use within Victorian communities:

I have been in the media quite a lot over the past six weeks saying it is not an epidemic, it is something that is an issue out there in the community, but certainly promoted that there are other drugs and it is a drug problem. Instead of being a war on drugs, it is a war on drug addicts, because they are the poor buggers that end up being left without treatment options. I think that is really important. The media really only want to report what is wrong.¹⁴⁹⁹

Similarly, Cristofer Beal, Coordinator of Tanderra AOD Services in Bairnsdale, told the Committee:

I do think that the media are prone to — maybe ‘exaggerating’ is the wrong word; ‘hyperbole’ is probably a more appropriate word — picking up on individual stories. It is an issue affecting us all. We need to hear what we can do about it, not just how terrible it is. This is about the tools and the strategies. You can say, ‘It’s awful, it’s awful, people are dying, people are dying’. What can we do about it? What can we do to change that? It is about sort of understanding that it is here with us now and as a country we need to address that. It is not to put it on one social group or it is not to talk about the importers. It is about how we can deal with that problem. It is about education. It is about people knowing that maybe it is not so addictive that you look at a bag of it and you are never going to be able to let it go.¹⁵⁰⁰

A submission from Mackillop Family Services stated that the stigma associated with crystal methamphetamine, ‘largely due to negative media reporting of ice users’ could result in young users of crystal methamphetamine being less open about their use and consequently unlikely to seek treatment.¹⁵⁰¹ Dr Roger Volk of SEADS told the Committee it was hard enough having to address a serious problem such as methamphetamine use without media reports exaggerating either its prevalence or effects:

In terms of being an escalating problem, I would want to say that the press has done the most fabulous sales job for any ice dealer that you could ever expect. I will give you a very brief example. In the *Age*

1498 See for example:

‘Ice use devastating rural Victoria’, Richard Baker and Nick McKenzie, *The Age*, 29 August 2013.

‘The Ice Crisis: Crystal meth probe as addiction grows’, Julia Medew, *The Age*, 16 September 2013.

‘Deadlier than ever: Welcome to the new ice age’, 13 November 2013. News.com.au at <http://www.news.com.au/national/deadlier-than-ever-welcome-to-the-new-ice-age/story-fncynjr2-1226758663681>

‘The drug that’s shaping as our worst nightmare’, Andrew Rule, *Herald-Sun*, 14 November 2013.

‘Mildura Mum’s Plea to Take a Stand on Ice’, Anthony Dowsley, *Sunday Herald-Sun*, 25 January 2014.

‘Ice: how a modern day scourge hurts us all’, various reporters, *Sunday Herald-Sun*, 2 March 2014 pp.18-19.

‘Tide of Evil: Drug ice linked to killings of 14 people in 14 months across Victoria’, Mark Butler, *Herald Sun*, 27 March 2014.

‘Australia warned its ice problem is reaching pandemic proportions’, Keith Moor, *Herald Sun*, 30 April 2014.

1499 Mr Geoff Soma, Chief Executive Officer, The Western Region Alcohol and Drug Centre (WRAD), Public Hearing, Warrnambool, 3 March 2014.

1500 Mr Christofer Beal, Coordinator, Tanderra AOD Services, Bairnsdale, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

1501 Ms Micaela Cronin, Chief Executive Officer, MacKillop Family Services, Submission, 21 October 2013.

a month or so ago, there was a dealer boasting — and there was no counter narrative — of having turned on a whole town in Gippsland.

I was at a public meeting about two weeks after that and we were talking about that. This woman puts up her hand and says, 'I am from that town and I can assure you the whole town is not turned on to ice'. The research point of that is that the perception that everyone is doing it makes it easy to cross a threshold of non-use into use. So I think a tremendous disservice is done by reports that do not have a counter narrative like that. But the fact is more people think others are doing it than are actually doing it.¹⁵⁰²

In short, such witnesses have argued the media have come close to constructing a 'moral panic' on the use of methamphetamine in Victoria, something particularly noticeable in the United States:

Moral panic occurs when social circumstances are ignored and social problems are blamed on the effects of a drug, often without an objective assessment of the actual threat and prevalence of the problems associated with the drug. According to a review by Weidner (2009) this has occurred with [methamphetamine] in the United States, where the media has focused on the evils of [methamphetamine] use, prompting comments such as 'it's very hard to go to any part of Oregon and not experience the effects of methamphetamine on ordinary people' (p.229). The risks of moral panic are further isolation of and withdrawal of support from families where ATS use is present, and possibly greater difficulty for policy-makers to suggest evidence-based interventions, due to hysteria. One way for minimising moral panic is to increase community understanding, not only of the issues associated with ATS use but also of the impact of panicked community responses (Ross 2012, p.92).¹⁵⁰³

On the other hand, some witnesses believed the media has also been used in very positive ways to get the message out on crystal methamphetamine and its impacts. According to Superintendent Paul Naylor of Victoria Police in Mildura, local media have been useful in liaising with police over the methamphetamine issue:

We have an extremely supportive media — radio, print and television — in regard to this issue. They clearly have a great understanding of the impacts it is having on the community, as you would imagine. Certainly Victoria Police would be silly if we did not also act and give as much opportunity as possible for the media to give the full picture that we can provide. A great part of our role is about that disruption to the use and particularly the dealing in amphetamine-type substances and the manufacturing of it. Part of that disruption process is to have the media briefed as best we can, lawfully remembering the rules around sub judice etcetera, but we certainly, through that medium more than any other, attach it to the tactical response to a particular investigation.

So if we have had an operation in regard to amphetamine-type substances and there are arrests and people spoken to, then we would, on every occasion, provide a media story.¹⁵⁰⁴

This is also the view of another senior ranking police officer. Superintendent Don Downes of Victoria Police in Warrnambool told the Committee:

1502 Dr Roger Volk, Forensic and Other Drugs Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

For other accounts from witnesses critical or questioning of media accounts of the methamphetamine 'crisis', see Mr Alan Fisher, Clinical Leader, Drug and Alcohol Community Treatment Services, Albury Wodonga Health, Public Hearing, Wodonga, 24 February 2014; Mr Peter Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 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.

1503 On the need to avoid moral panics or alarmism in the reporting of crystal methamphetamine in Victoria, see also Mrs Sue Medson, Chief Executive Officer, Gippsland Lakes Community Health, Submission, 21 October 2013; Dr Karen Adams, Researcher, Victorian Aboriginal Community Controlled Health Organisation, Submission, 18 October 2013.

1504 Superintendent Paul Naylor, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013.

The media is a very powerful tool that enables us to give a message out to quite a broad representation of the community. We have a strong relationship with the media. We see them as certainly supportive of community safety.¹⁵⁰⁵

Other witnesses were equally pleased with the efforts of local media to publicise and promote the work being done by community agencies to address methamphetamine use. This was particularly true of communities in regional and rural areas where it can be harder to 'get out the message' to locals on issues such as ice. For example, in the context of Project Ice in the Mildura region, Michelle Withers told the Committee:

Perhaps there has been some intimation that this is a bit of a beat-up and it [increase in ice use] is not really reflective of what is going on in the community. [But] the media is actually a dedicated strategy that has come from Project Ice. Project Ice employed a local public relations and communications consultancy, so that we have actually driven this media that you are seeing. It is not something that people have grabbed and run away with. The relationships with the local media are excellent. We have a very good working relationship, and as such we have been able to drive this campaign. It is not a beat-up. This is a campaign that is very structured. It is founded on local information and local knowledge.¹⁵⁰⁶

The 'Breaking Bad' phenomenon — An example of methamphetamine use in popular culture

It is not only media reporting that informs the public about issues such as methamphetamine use. Films, theatre and television can also play an important role in forming our views as to contemporary issues in society. *Breaking Bad*, for example, is a very popular American television show that has become deeply embedded in the popular culture. This show portrays Walter White, a former professor of chemistry at an American high school and his descent into a life of crime as a clandestine manufacturer of crystal methamphetamine.

Drugs educator Paul Dillon told the Committee that the presentation of methamphetamine portrayed in *Breaking Bad* could in fact create the impression that the use of the drug crystal methamphetamine was more prevalent than it actually is:

I would love to see somebody who has done a media analysis of the situation [the extent of ice use]. In America it is called the breaking bad phenomenon. You had the finale of this TV program that really sort of captured the imagination of a viewing public. It got lots of media attention at the time of its final episode. I think around that time what happened was there were media outlets that were looking for any methamphetamine story that they could run in conjunction with this. I think that may have happened in Victoria, because certainly if you look at the timing of this, this is when the stories first started. If you look at regional areas, if there is a problem with a drug in a regional area and a regional paper gets hold of it and they have people who will speak to it [then it becomes perceived as a greater problem than it is. But I need to say one more time to make it very clear that I am certainly not saying that this is not an issue. This is a very, very problematic drug].¹⁵⁰⁷

Magistrate Peter Mellas told the Committee that the type of portrayal shown of methamphetamine users and manufacturers led to the drug having a particular social mystique:

I think a couple of times I have used the term in court — where someone has pleaded guilty to trafficking or behaviour of that kind, it is accompanied by the sort of behaviour that I can only describe as being almost like out of the TV series *Breaking Bad*. I had a young man, 23 years of age, recently, pleaded guilty, thought it was a great idea to have photos of himself holding bags of ice on his phone,

1505 Superintendent Don Downes, Western Region, Division 2, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

1506 Ms Michelle Withers, Integrated Services Coordinator, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

1507 Mr Paul Dillon, Director and Founder, Drug and Alcohol Research and Training Australia, Public Hearing, Melbourne, 3 February 2014.

holding weapons, the whole gangster idea seems to have taken hold. This is a drug which has some kind of social mystique about it. It gives you social status, social credibility in amongst the people that you are moving about, and that is a problem.¹⁵⁰⁸

Bill Wilson from Gateway Community Health in Wodonga was even more critical of the show believing it essentially glorified crystal methamphetamine and made it appear less harmful than it was:

Films like *Breaking Bad* glorify the production and the use of drugs. That is probably the worst thing that could have ever happened because it did certainly glorify it and make it look like it was not that bad a thing that even a schoolteacher can get rich from doing it.¹⁵⁰⁹

Conversely, some witnesses did not think shows such as *Breaking Bad* would necessarily have the effect of promoting the type of behaviours portrayed in that show. Debbie Stoneman of Latrobe Community Health Services agreed the show tended to romanticise crystal methamphetamine but it also highlighted the 'horrors involved' with its use.¹⁵¹⁰ John Thompson from Mitchells Advertising did not believe it would encourage copycat behaviour:

Even watching *Breaking Bad*, which is a TV show I have thoroughly enjoyed, there is nothing that has made me want to go out and start my own meth lab or smoke methamphetamine. When you see the people and the impacts that are depicted, even a stylised Hollywood version, it makes my skin crawl.¹⁵¹¹

Conclusion

Community action strategies and partnerships can be effective mechanisms in addressing drug-related issues including that of crystal methamphetamine in local communities. They can address the public's need for basic information on the drug and provide useful referrals for people whose concerns about crystal methamphetamine arise from personal experience, for example a family member with a crystal methamphetamine related problem. Mechanisms such as community forums and community partnerships may also make people feel as if they are active participants in a process of addressing the problem rather than passive and helpless bystanders. This may be particularly the case in close-knit rural communities. As the feedback to the Grampians Region Community Forum on Ice reported: 'Rural and regional communities are resilient and come together to address major issues such as this' when given proper information and direction (Anex 2014, p.13).

The evidence as to the effectiveness of public awareness campaigns however is equivocal. While such campaigns, often delivered by the media, are useful in providing basic facts and raising awareness, they may be counterproductive when produced in isolation of other strategies to address methamphetamine. It is also doubtful whether 'shock tactics' of themselves are a useful component in addressing methamphetamine use. They certainly cannot be the *whole* answer to addressing methamphetamine-related harms.

Prevention initiatives including information and education strategies and community action plans can be an essential part of any demand reduction strategy to address crystal methamphetamine consumption. For some people, however, their use of crystal methamphetamine may have progressed to a point of requiring interventions that go further than simple preventive measures. Harm reduction and ultimately tertiary measures such as treatment may be required. This does not mean that prevention and harm reduction measures are mutually exclusive. As the Chapter 26 discusses, sometimes they may be used concurrently.

1508 Mr Peter Mellas, Magistrate, Warrnambool Magistrates' Court, Public Hearing, Warrnambool, 3 March 2014.

1509 Mr Bill Wilson, Youth Outreach, Alcohol, Tobacco and Other Drugs Team, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014.

1510 Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

1511 Mr John Thompson, General Manager, Mitchell & Partners, Public Hearing, Melbourne, 24 March 2014.

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.

25. The Need for Workforce Development and Training for Professionals

Introduction

The Australian workforce involved in the prevention and treatment of drug misuse is highly varied, 'spanning a diverse range of employment sectors, industries and communities' (Department of Health and Ageing 2011, p.20). Generally, the Australian alcohol and other drugs (AOD) workforce is highly skilled and knowledgeable, however with regard to methamphetamine some workers 'feel that their knowledge of amphetamine type substances isn't as comprehensive as they would like and therefore the advice and support they can provide isn't up to their usual standard' (Pawsey & Hynan 2012, p.157).¹⁵¹²

The importance of a well-trained and qualified AOD workforce has also been recognised in the latest National Drug Strategy (NDS):

An appropriately skilled and qualified workforce is critical to achieving and sustaining effective responses to drug use. The *National Drug Strategy 2010–2015* is committed to addressing a range of factors affecting the ability of the workforce to function with maximum effectiveness (Ministerial Council on Drug Strategy 2014, p.20).

As the Strategy notes, exposure to people who misuse drugs and the consequences of their drug use varies across the workforce. Each of the following groups has unique and specific workforce needs that require comprehensive and systematic training and workforce development programs:

- ◆ Alcohol and other drug workers
- ◆ Police and Paramedics and Emergency Workers
- ◆ Health and allied health personnel
- ◆ Mental health workers
- ◆ Aboriginal health workers
- ◆ Pharmacists and pharmacy support staff
- ◆ Teachers and education support staff.

The training and education requirements of each of these groups will be discussed in this chapter.

¹⁵¹² Pawsey and Hynan write these comments in the context of mental health workers specifically but they are equally applicable to other sectors of the AOD workforce.

This point was also raised by a number of witnesses to the Committee. 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.

The need for a highly trained and supported workforce

The importance of a well-trained and knowledgeable workforce particularly in the AOD field has been raised by the leading body on workforce training for the AOD and related sectors — the National Council on Education and Training on Addiction (NCETA).¹⁵¹³ As NCETA has commented:

The past few decades has seen substantial changes in the AOD field that have major implications for the development of a responsive, effective, and sustainable AOD workforce. The ability of AOD agencies and individual AOD workers to provide quality and timely responses has been impacted by:

- changing patterns of substance use
- increased prevalence of polydrug use
- a growing recognition of mental health/drug use comorbidity issues
- an expanding knowledge base
- advances in treatment protocols, and
- an emphasis on evidence based practice.¹⁵¹⁴

Further to this, NCETA recognises that drug use and related problems are a concern to a *range* of health and human service workers that extend beyond traditional AOD workers.

There is growing demand for services, policies and programs from specialist AOD agencies and individual AOD workers, as well as generalist health and human service workers. Apart from specialist workers, currently priority groups within the AOD workforce who require appropriate training are nurses; indigenous workers; rural/remote workers; and police.¹⁵¹⁵

The treatment sector comprises generalist workers, who work in the mainstream workforce, and specialist workers, who work within AOD-specific programs or services (Roche & Pidd 2010). Among the Victorian AOD workforce, 59 percent are over 40 years old and more than 61 percent have tertiary qualifications in a health-related area (Roche & Pidd, 2010), pointing to a generally skilled and experienced workforce. However, the median length of AOD related service is less than five years, supporting the anecdotal view of the sector as one with high turnover.

It is not surprising then, despite more than a decade of availability of training and resource development in effective responses to methamphetamine use, that some workers believe their knowledge in this area is inadequate, as the quote in the Introduction reveals.

However, a high sector turnover and a focus on development of training and qualifications can mean that as workers are lost from the sector, important knowledge is also lost.

NCETA has observed that in the AOD field, workforce development for both generalist and specialist staff is best undertaken at a national level — most suitably through a National Strategic Framework.

Workforce development (WFD) includes, but goes far beyond, simple training. Professor Ann Roche from NCETA defines WFD as:

...a multi-faceted approach which addresses the range of factors impacting on the ability of the workforce to function with maximum effectiveness... Workforce development should have a systems focus. Unlike traditional approaches, this is broad and comprehensive, targeting individual,

1513 For a comprehensive overview of workforce development in the Australian AOD sector see, *Alcohol and Other Drugs Workforce Development Issues and Imperatives: Setting the Scene* (Roche & Pidd 2010).

1514 <http://nceta.flinders.edu.au/workforce/why-is-wfd-necessary/>

1515 <http://nceta.flinders.edu.au/workforce/why-is-wfd-necessary/>

organisational and structural factors, rather than just addressing education and training of individual mainstream workers (Roche & Pidd 2010, p.2).

Workforce development should have at its highest level, government policy and strategy that supports and guides organisational-level capacity building activities through policies, procedures and systems changes, which in turn supports workers to develop and maintain the skills that equip them to carry out their professional roles.

Describing the evolutionary phases of workforce development, Nicholas et al. (2013) note that early workforce development strategies focused on education and training of individual workers. However by the early 2000s, the limitations of this approach were becoming apparent, because training does not always translate to sustainable changes in work practices. This recognition led to a shift in emphasis to internal systems including recruitment and retention strategies, information management, leadership development, professional and career development, provision of clinical supervision and evaluation. In a further more recent shift, there has been a growing awareness of the increasing complexity of AOD treatment and that no single group can hope to meet all the needs and expectations of people who use drugs, nor can these groups continue to work in isolation. Nicholas et al. (2014) note the importance of measures to ensure greater integration of AOD health sector with other sectors, including justice, policing, human services and education, requiring a much more strategic approach than has been the case in the past.

The need for a national strategic approach to workforce development and training

Researchers into workforce development in the AOD field have commented that a strategic approach to training works best if implemented at a national level (Roche & Pidd 2011). In this regard the 2009 evaluation of the NDS stated that:

An appropriately sized, skilled and qualified workforce is critical in sustaining effective delivery of interventions. Capacity to implement programs has been limited by staff shortages and turnover, and skill gaps in the alcohol and other drug (AOD) sector specifically and in the Australian workforce generally. The NDS contribution to training programs and resources is highly valued, as is the work of NCETA in developing a concept of workforce development far broader than education and training. More attention is needed to building the capacity and profile of professionally-trained, specialist AOD workers. Attention is needed to competitive pay and conditions, incentives and benefits. A new national AOD workforce development strategy, as proposed by NCETA and recently discussed by IGCD, will be an important initiative (Siggins Miller 2009, p.53).

Roche and Pidd argue that whilst state initiatives are important, a nationally coordinated strategic approach to workforce development would allow for:

- a more strategic and planned approach
- a more proactive approach rather than ad-hoc, reactive responses
- consistency across sectors and jurisdictions
- more efficient use of resources
- higher quality workforce development initiatives
- better outcomes for both clients of services and the community at large (2010, p.17).

The NDS evaluation noted above stated that in particular there is a need for investment in the recruitment of new workers, the retention of the existing workforce and modelling to estimate future needs and identify strategies to ensure a future supply of an appropriately skilled and qualified workforce. However, no comprehensive national framework has been

developed and implemented to date.¹⁵¹⁶ At a state level, however, Victoria has been proactive in developing frameworks for local AOD workforce development and training.

Victoria’s Alcohol and Drug Workforce Framework and Implementation Plan

The need for a more integrated and strategic approach to AOD workforce development was recognised at Victorian state government level with the introduction of an AOD Workforce Development Plan in 2005. One of the most important aspects of this Plan was the introduction of minimum qualification standards for AOD work (Victorian Government Department of Human Services 2005).

Five other important strategic directions were also identified in the 2005 Victorian plan

- specialist AOD workforce skill development
- AOD workforce recruitment and retention
- Koori AOD workforce development initiatives
- generalist health and welfare worker AOD skill development
- quality standards for AOD treatment services (Roche & Pidd 2010, p.14).

This recognition of the need for a comprehensive approach to training the workforce in alcohol and drug issues was more recently emphasised and updated at state level. In 2011-12, after a period of consultation, the Department of Health undertook the drafting of Victoria’s Alcohol and Drug Workforce Framework 2012–22 and the Alcohol and Drug Workforce Implementation Plan 2012/13–2014/15. These policy documents have carried over and extended the strategic directions of the 2005 Plan.

The Framework provides a long-term vision for the workforce to ensure Victoria will have a:

[c]ompetent, capable and sustainable alcohol and drug workforce that has the necessary knowledge, attitudes, values and skills to deliver timely, high quality treatment and support that meets the needs of people with alcohol and drug issues and their families.¹⁵¹⁷

The Implementation Plan relates to the delivery of activities in the first three years of the framework from 2012/13–2014/15. Both the Framework and the Plan have been designed to be responsive to, and supportive of, the *New directions for alcohol and drug treatment services: A roadmap* (2012), as well as the Victorian Whole-of-Government Alcohol and Drug Strategy 2012–22 currently in development.

The need for a better trained and resourced workforce in the context of methamphetamine

Considerable evidence has been given to the Committee that the current increase in crystal methamphetamine use has ‘seriously impacted upon the AOD workforce to address unprecedented challenges’.¹⁵¹⁸ Consideration therefore has to be given to how the workforce can be supported and resourced. The peak agency Anex has been heavily

1516 Currently a National Alcohol and other Drug (AOD) Workforce Development (WFD) Strategy is being developed at the request of the Intergovernmental Committee on Drugs. The strategy development is being undertaken by the National Centre for Education and Training on Addiction (NCETA) at Flinders University and the project is being managed by the Northern Territory Department of Health. See <http://nceta.flinders.edu.au/general/news/national-alcohol-and-other-drug-workforce-development-strate/>

1517 <http://docs.health.vic.gov.au/docs/doc/Victorias-alcohol-and-drug-workforce-framework:-Strategic-Directions-2012-22>

1518 Ms Vera Boston, Chief Executive Officer, North Yarra Community Health, Submission, 21 October 2013; See also Ms Pip Carew, Australian Nursing & Midwifery Federation (ANFM Vic Branch), Submission, 21 October 2013, on the need for nurses qualified in mental health and addiction management in order to address the needs of patients presenting with methamphetamine-related episodes.

involved in providing training to a variety of personnel in some way associated with crystal methamphetamine. As Anex, CEO John Ryan told the Committee:

Late last year we started receiving a number of requests from services in the country and in the city to assist them to deal with what they perceived to be a dramatic increase in the consumption of methamphetamine. Since late last year we have trained about 2500 front-line workers, and the front-line workers are obviously drug and alcohol workers but they are also, just as importantly, domestic violence workers, ambulance officers and police officers. The range of front-line services that are impacted on by methamphetamine use is extremely broad because of the interaction of methamphetamine users with the system.¹⁵¹⁹

Similarly, Sam Biondo, Executive Officer of the Victorian Alcohol and Other Drugs Association told the Committee that given the unprecedented rise in methamphetamine-related harms and presentations, additional resourcing and training for the AOD sector was a necessity.¹⁵²⁰

A submission to the Inquiry from the Northern Mallee Community Partnership (NMCP) also stated that a lack of training was particularly noticeable in rural and regional parts of Victoria. Because people in rural areas have no ready access to specialised health care, it was essential that general health workers in primary health care networks receive training to deal with alcohol and drug problems including those pertaining to methamphetamine 'especially in subjects such as rapid assessment, counselling and crisis management where no alternative exists'. E-learning could be a particularly useful way of training workers in country areas.¹⁵²¹ The NMCP and several other agencies also stated that it was essential staff across the board including AOD, health workers, security officers and general staff, receive training with regard to dealing with potential aggression and violence displayed by ice users and making appropriate risk assessments.¹⁵²²

Witnesses providing evidence to the Inquiry emphasised the importance of WFD in the area of methamphetamine. For example, Ms Belinda McNair stated:

We all need to have the ability to respond in terms of what these service providers do. Service providers do need to review clinical practice service models to ensure that appropriate treatment models are available to meet the needs of clients [and] enhance positive outcomes... Ensure that staff has robust knowledge around these types of drugs and an understanding of the relevant and most appropriate treatment interventions. Build capacity in staff to effectively manage and respond to clients displaying challenging and difficult behaviour. Be aware of and respond to the health, social and economic harms associated with amphetamine type substances, including those harms not directly related to the drug itself but are a consequence of using the drug, and that allows staff to identify brief interventions and health promotion activities.¹⁵²³

The importance of training and education on methamphetamine

Whilst workforce development in the drug field is not *only* about education and training, this is clearly an important aspect of it. Many witnesses from a variety of workforces felt there were clear gaps in addressing methamphetamine use, even those who work directly or

1519 Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

1520 Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol and Drug Association, Public Hearing, Melbourne, 14 October 2013.

1521 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

1522 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013. See also Ms Melanie Raymond, Youth Projects, Submission, 22 October 2013; Mr Raymond Blessing, Chief Executive Officer, TaskForce, Submission, 24 October 2013; Dr David Edey, 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; Ms Rachael Edginton, Director of Police & Public Affairs, Australian Medical Association (Victoria) Limited (AMA Victoria), Submission, 31 October 2013.

1523 Ms Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013.

closely with methamphetamine users. For example Mr David Giles from Anglicare Victoria stated:

Our workers have usually not had sufficient training and education to conduct this work as effectively as possible and lack much-needed tools, such as a common risk assessment and practice framework for families affected by ice use and the effective referral opportunities to alcohol and other drug and mental health services that actually practise the no-wrong-door policy they preach.¹⁵²⁴

Anex also spoke of the need for workers to be aware of best practice responses:

The AOD treatment sector needs to be resourced in order to have the capacity to respond to people using methamphetamine who want treatment. This requires that service providers are aware of best practice in the area of methamphetamine treatment and able to engage with people using methamphetamine for the length of time they require.¹⁵²⁵

Such training was particularly important in Anex's view for needle and syringe program (NSP) workers:

Having a qualified workforce is a major step towards guaranteeing service quality yet, currently, there are no minimum training requirements for workers within the NSP. Additional and much-improved workforce development strategies are required if the issue of methamphetamine use is to be usefully and holistically addressed by NSP workers.¹⁵²⁶

Current training activities

Whilst there has been a call for more training opportunities for those who work with methamphetamine users, during the last year a number of training programs have been initiated to address the gaps in service delivery. In addition to the community and stakeholder forums conducted by Anex throughout 2013 and 2014,¹⁵²⁷ a number of other training activities in relation to methamphetamine have been conducted in Victoria recently. For example, the Northern Mallee Community Partnership in Mildura notes the popularity of training sessions and information on methamphetamine and its effects:

We realised that demand was outgrowing our budget, so we decided to train local professionals to be able to go and deliver information sessions on this particular issue. As mentioned, there have been 29 to date that registered about 630 people... Last week we launched a Facebook page from one of our younger staff members who knows how to do that. As of yesterday afternoon at about 3.30 p.m., she brought the stats up and there were 89 576 people who had read the Project Ice Facebook page, with 2000-odd likes, if you know your Facebook terminology¹⁵²⁸.

Odyssey House Victoria (OHV) has also been involved in delivering training sessions on methamphetamine to both Aboriginal and non-Aboriginal communities. OHV was funded in 2009 to develop nationally accredited training on amphetamine type stimulants (ATS) and in 2013 was funded to provide training across Victoria. The training has been well received:

To date the funding has provided for 160 places for online study and 72 places for face to face delivery. The online places were filled within 4 weeks of advertisement.¹⁵²⁹

Since late last year we have trained about 2500 front-line workers... [including] drug and alcohol workers...domestic violence workers, ambulance officers and police officers. The range of front-line

1524 Mr David Giles, General Manager, Family and Community Services, Anglicare Victoria, Public Hearing, Melbourne, 3 February 2014.

1525 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

1526 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

1527 See discussion in Chapter 24.

1528 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

1529 Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, Submission, 21 October 2013.

services that are impacted on by methamphetamine use is extremely broad because of the interaction of methamphetamine users with the system.¹⁵³⁰

The benefits of training

A submission to the Inquiry from Peninsula Health also spoke to the great benefits of having a well-trained workforce in this area. Workers from Peninsula Health's Drug and Alcohol Program (PenDAP) had been able to take advantage of scholarships to visit 46 agencies with expertise in methamphetamine treatment and attend international conferences on methamphetamine. As a result of such professional development:

- ◆ A SMART recovery group was established
- ◆ Components of the US Matrix model of treatment have been incorporated into PenDAP service provision
- ◆ Spiritual assessments have been incorporated into aged AOD treatment
- ◆ A guideline to managing methamphetamine users presenting to the Emergency Department was developed
- ◆ 24 staff presentations were conducted with facilitated discussions
- ◆ On a confidence scale of 1 to 10, PenDAP staff confidence improved from a 5 in 2008 with respect to confidence around methamphetamine treatment prior to the project, to a 9 at project end in 2010.¹⁵³¹

The submission stressed, however, that it was imperative that budget allocations for AOD and health services take into account the time needed for staff to continue to undertake these valuable training and workforce development activities.¹⁵³²

Training and education needs of particular groups

Whilst there may be training and education material that can be generically applied for a variety of staff who work with, or come into contact with, methamphetamine users, some training programs might need to be tailored for individual workforces and professions. For example, the knowledge requirements of teachers with regard to methamphetamine may not need to be of the same degree of specificity as the level required by drug and alcohol workers. The following sections will outline the challenges facing each of the profiled professional groups in addressing gaps in training and education on methamphetamine.

The lack of knowledge of health professionals

An issue that was raised continually throughout the Inquiry was the need for general practitioners (GPs) and those working in the primary care sector generally to be trained to a sufficient level to recognise and address methamphetamine-related problems.¹⁵³³ This is particularly important given that 'many people who use ice will never seek treatment from specialist AOD services' but would go to their local GP to deal with health issues.¹⁵³⁴

1530 Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

1531 Dr Sherene Devanesen, Chief Executive, Peninsula Health, Submission, 21 October 2013.

1532 Dr Sherene Devanesen, Chief Executive, Peninsula Health, Submission, 21 October 2013.

1533 Other witnesses who spoke about concerns in relation to GPs' ignorance or at least lack of training with regard to drug-related conditions include Dr David Eddey, Director of Emergency Medicine, Barwon Health, Public Hearing, Geelong, 28 October 2013; Ms Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013; Ms Cath Murphy, Director of Disability and Mental Health Services, Mallee Family Care, Public Hearing, Mildura, 5 December 2013.

1534 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.

This point was stressed by a number of other witnesses or in submissions including Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

Indeed for this reason Baker and Lee (2012) have suggested that health professionals, particularly general practitioners and nurses, are seen by (methamphetamine) users as important sources of assistance. As such, training on methamphetamine for GPs and allied health professionals is crucial and shared care arrangements between GP surgeries and treatment agencies should be encouraged in this regard (Baker & Lee 2002). Despite the need for such training, drawing from research by Hando et al. the authors have commented that ‘most health practitioners remain largely unfamiliar with amphetamine/methamphetamine related problems and that education is required’ (2002, p.324).¹⁵³⁵

A submission from the Burnet Institute stated in this regard:

Many of those who use methamphetamine cease use with little in the way of professional support. Indeed, the main reported barrier to treatment utilisation among participants was a lack of perceived need, despite experience of methamphetamine-related harms and involvement in risk behaviours. Many of these [users] had extensive contacts with services outside of specialist drug treatment. This suggests the importance of up-skilling services outside of the specialist drug treatment sector, such as those in the employment, housing and wider primary health sectors (particularly general practice and mental health), in responding to methamphetamine use including how to screen for methamphetamine related problems and refer people to services appropriate to their needs.¹⁵³⁶

The need for greater investment in training for GPs and primary health professionals in drug-related interventions including methamphetamine was also recognised in a submission from the Australian Medical Association to the Inquiry.¹⁵³⁷ Some witnesses who gave evidence suggested that such education should not only take place once the health professional has commenced their practice but it was also essential that sufficient instruction on drug-related issues be given to doctors, nurses, paramedics and allied professionals during their undergraduate courses.¹⁵³⁸

Some witnesses told the Committee that it wasn’t only the lack of knowledge of general health professionals about methamphetamine that could be problematic. Some doctors and general nurses could also be embarrassed to ask patients about their drug use or feel to do so was being inappropriately intrusive.¹⁵³⁹ Others may be judgemental towards drug users and this may adversely impact on their ability to address their presenting issues, as discussed below.

Front-line responders: Police, paramedics and emergency workers

Police and paramedics are in the frontline of addressing methamphetamine use. Often they may be the first persons that a methamphetamine user ‘in crisis’ may encounter (Eade 2012, p.142). It is essential therefore that both police and paramedics have sufficient knowledge of ice and its effects to be able to respond appropriately to users of methamphetamine, particularly in cases where a user may be exhibiting psychotic symptoms or is a danger to him or herself or members of the community.

1535 It is not only GPs who are in need of better training on drug-related issues. Dr Ellen Bowman from the Royal Women’s Hospital’s Women’s Alcohol and Drug Service (WADS) told the Committee that at least 25 percent of hospitals do not screen pregnant women for drug use as should be required. In 2012 WADS did a survey of all maternity service providers in Victoria. In response to a question as to what hospital staff really needed, the overwhelming response was ‘more education as to how to manage these [ice] patients’.

Dr Ellen Bowman, Paediatrician, Royal Women’s Hospital Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

1536 Professor Paul Dietze, Deputy Director, Centre for Population Health, Burnet Institute, Submission, 21 October 2013.

1537 Ms Rachael Edginton, Director of Police & Public Affairs, Australian Medical Association (Victoria) Limited (AMA Victoria), Submission, 31 October 2013.

1538 See for example, Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

1539 Dr Cath Peake, Clinical Coordinator, Drugs and Alcohol Services, Barwon Health, Public Hearing, Geelong, 28 October 2013.

As McKetin et al. argue:

Confrontation by police may provoke or escalate hostility that occurs in the context of psychotic symptoms, thereby increasing the risk of assault or property damage. Police therefore need to be provided with strategies to safely approach and apprehend methamphetamine users who are experiencing psychosis (McKetin et al. 2007, p.239).

As McKetin, McLaren and Kelly suggest, appropriate resources need to be directed towards training frontline workers including both police and paramedics in the identification of methamphetamine psychosis and also towards the development of safety protocols to manage people suffering from methamphetamine psychosis (2005, p.xix).

Victoria Police currently is undertaking training on illicit drugs through a number of education modules. This occurs at both entry level and as part of an ongoing education package. For recruits, Probationary Constables and Protective Services Officers modules are offered in basic training that cover topics such as the nature of the drugs; drug effects and harms; understanding harm minimisation principles and dealing with drug affected people.¹⁵⁴⁰ Further ongoing education on illicit drugs is offered to all other members through an e-learning package. Similar topics to those offered at entry/probationary level are provided.¹⁵⁴¹ A table outlining the specific illicit drug education modules offered as both basic and ongoing training is attached as Appendix 12.

Witnesses from both Victoria Police and Ambulance Victoria commented in evidence on the need to be educated on the nature of ice and its effects. Superintendent Naylor from Victoria Police, Mildura, told the Committee that an essential part of police understanding crystal methamphetamine and its associated consequences was through ongoing partnerships with health, welfare and community agencies.¹⁵⁴² In the Mildura context, the Project Ice partnership discussed in Chapter 24 is one way of enabling individual agencies including the local police to learn from each other's experience and knowledge. Discussing the wide range of people from a variety of workplaces who make up the Partnership, Superintendent Naylor told the Committee how they could learn from each other:

For this particular problem [of ice] we believe we have pulled together the people who actually have the knowledge. It is by enriching that knowledge that we get better collaboration and a greater understanding, which then goes on to actually having the people at the table who have not only the knowledge but also the ability to make decisions on behalf of their area.¹⁵⁴³

According to Superintendent Naylor, such informal approaches to knowledge acquisition do not negate the need for comprehensive training in alcohol and drug issues at both the Police Academy and on an ongoing basis.¹⁵⁴⁴

Paramedics are clearly another group of frontline workers for whom up-to-date training on methamphetamine is crucial. Ambulance Victoria is currently looking at its training protocols, guidelines and requirements for dealing with patients who have used methamphetamine, particularly those displaying aggression, psychosis or who are generally 'out of control'.¹⁵⁴⁵ Most ambulance personnel who spoke to the Committee, however, thought that a combination of ongoing training and experience gained as a result of many

1540 Information provided in Correspondence from Tracy Linford, Acting Deputy Commissioner (Strategy), Victoria Police, 8 August 2014.

1541 Information provided in Correspondence from Tracy Linford, Acting Deputy Commissioner (Strategy), Victoria Police, 8 August 2014.

1542 See also discussion below.

1543 Superintendent Paul Naylor, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013.

1544 Superintendent Paul Naylor, Division 6, Western Region, Victoria Police, Public Hearing, Mildura, 5 December 2013.

1545 Mr Steven Fumberger, Group Manager, Sunraysia Region, Ambulance Victoria, Public Hearing, Mildura, 5 December 2013.

years in the job were an important grounding for addressing not only methamphetamine but any 'new' drugs that had surfaced over the years.

Terry Marshall, MICA Paramedic and Group Leader from the Barwon District, whilst acknowledging ongoing training was important also believed there was an 'experience gap' which might result in some younger paramedics not being sufficiently equipped to deal with the challenges presented by an 'out of control' crystal methamphetamine user:

My main concern is for the health and safety of paramedics. Over the last five years we have seen a large increase in the number of paramedics who have been brought in to Ambulance Victoria from various universities around Victoria — Monash, Australian Catholic University, Victoria University. When I joined I had been a tradesman for six years, a foreman, and I came to the service at 28 or 29. We now have a lot of young kids coming in at 21 or 22. Generation Y is very different from how we come into the service. We are finding that we have to provide them with an enormous amount of support. They are young people and they have gone from school to university into full-time work. There is a lot of education we have to do with them to get them to that point of the accountability and responsibility of being an employee.¹⁵⁴⁶

Grant Hocking, Clinical Support Manger with Ambulance Victoria (Grampians Region) told the Committee that for the most part he thought paramedics were well equipped to deal with the challenges arising from methamphetamine use:

Our paramedics are well educated and continually train and do education sessions. We have one of our staff as a member of Turning Point, so he is an ambulance representative as part of Turning Point. I would think that we are pretty well versed in the use and effects of ice in particular. We continually update our clinical practice guidelines that I mentioned earlier, and recently — I would say in the last five years — we have introduced new clinical guidelines to manage those specific patients that have not only ice on board but other drugs as well.¹⁵⁴⁷

Finally, emergency physicians and nurses are another group for whom some witnesses believe knowledge about methamphetamine and its effects is necessary. For Tyler Tricarico, a specialist AOD worker at Goulburn Valley Health, the ideal scenario is for an AOD worker such as himself to have a dedicated position upskilling emergency room staff on crystal methamphetamine and other problematic drug and alcohol presentations. This type of liaison role seems to work successfully in his hospital and emergency staff can use him as an access point to find out more about the drug and how users may present.¹⁵⁴⁸

Teachers

The training needs of teachers have already been discussed in the context of school drug education in Chapter 23. It is important to note, however, that there are many demands on a schoolteacher's time other than preparing lessons or marking homework. As the Commonwealth Government Report *Keeping in Touch — Working with Alcohol and other Drug use* stated:

There are many demands made on school staff to attend professional development sessions across a broad spectrum of curriculum, student support and administrative issues. These issues compete for the limited time available to school staff to engage in activities in addition to meeting their core

1546 Mr Terry Marshall, MICA Paramedic and Group Manager, Ambulance Victoria, Barwon District, Public Hearing, Geelong, 28 October 2013.

1547 Mr Grant Hocking, Clinical Support Manager, Grampians Region, Ambulance Victoria, Public Hearing, Ballarat, 18 November 2013.

1548 Mr Tyler Tricarico, Alcohol and Other Drug Technician, Goulburn Valley Health, Public Hearing, Shepparton, 25 February 2014. On the need for AOD services to take a primary 'train the trainer' role in upskilling other professionals on crystal methamphetamine, see Ms Kerstin Bichel, Manager AOD Service, Gippsland Lakes Community Health Centre, Public Hearing, Traralgon, 28 January 2014; Ms Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013; Mr Alan Fisher, Clinical Leader, Drug and Alcohol Community Treatment Services, Albury Wodonga Health, Public Hearing, Wodonga, 24 February 2014.

commitments in the classroom, student services and administrative areas... The capacity to effectively manage drug and alcohol issues that arise in the school setting will be influenced by a number of different factors, including the nature and frequency of the issues arising and the resources available to the school, and the capacity of staff (time, knowledge, skills and attitudes). Responses to issues will be governed by school policy and procedures (what we say we will do) and staff practices (what we actually do). To ensure effectiveness it is necessary to monitor and review policies and procedures on a regular basis (Commonwealth of Australia 2006, pp.121-122).

The Committee sought information from the Victorian Department of Education and Early Childhood Development as to what training Victorian school teachers receive on drug education during both their undergraduate studies and once they qualify and commence their careers as teachers. The Department responded:

The Department does not have specific detail in relation to content within undergraduate training. Many organisations, as well as the Department, may run a range of professional development for teachers — this varies year to year and schools can choose to participate in accordance with their local needs. There are also a range of online learning activities available to school staff related to health promotion, mental health and managing behaviours [including modules] on:

- Student Mental Health
- Psychological First Aid:

Online professional learning is available to all government and non-government Victorian schools to build the capacity of school staff in dealing with the impact of traumatic events and equip children and young people with the recovery skills they need. The modules focus on Psychological First Aid and Skills for Psychological Recovery.¹⁵⁴⁹

Certainly, it has been recognised that in the somewhat contentious area of school drug education, 'programs are most successful when teachers receive adequate resourcing, training and support, particularly in the use of interactive teaching strategies which are a key component of the social skills elements of the curriculum' (Commonwealth of Australia 2004, p.42).

Indigenous health and AOD workers

There is a recognised need for Aboriginal workers particularly in the health and AOD fields to receive comprehensive education and training in drug-related issues including methamphetamine (ANCD 2011, p.65).¹⁵⁵⁰ Whilst there are some accredited health courses specialising in Aboriginal health issues, many of these are in New South Wales and Western Australia and/or are not specialising in drug education.¹⁵⁵¹ In Victoria, the Victorian Aboriginal Community Controlled Health Organisation (VAACHO) offers certificate courses in Aboriginal Primary Health Care, Indigenous Mother and Baby Health and Indigenous Spiritual and Emotional Wellbeing. Graduate courses in specific health topics are also run through the Institute of Koorie Education at Deakin University. Mainstream courses with Aboriginal health components are also offered by Partners in Training Australia.¹⁵⁵²

Both Aboriginal workers in mainstream settings and Aboriginal specific services require comprehensive training in drug and alcohol issues, particularly crystal methamphetamine.

1549 Mr Darren Brown, Chief of Staff, Office of the Hon Martin Dixon MP, Minister for Education, Information provided to the Law Reform, Drugs and Crime Prevention Committee 11 July 2014.

1550 See also comments of Ms Lisa Briggs, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (via teleconference), Public Hearing, Canberra, 11 February 2014.

1551 A number of certificate and diploma courses for Aboriginal health and allied health workers are offered around Australia, mostly in Western Australia, New South Wales (particularly at the Aboriginal Health College) and Queensland. See <http://www.healthinfonet.ecu.edu.au/health-infrastructure/health-workers/health-workers-workforce/training>.

1552 <http://www.healthinfonet.ecu.edu.au/health-infrastructure/health-workers/health-workers-workforce/training>.

This is especially the case for rural and remote communities due to the importance of retaining health staff:

[It has been] highlighted that workforce related issues [are] a major barrier in providing appropriate services to Aboriginal people who [use] drugs. Two main issues have been highlighted: staff training and education and variance in training levels; and staff retention within both Aboriginal health services and mainstream health services... Identified training needs include[d] the importance of client confidentiality; exploring the issue of stigma and discrimination associated with injecting drug use; and the benefits of harm reduction and services such as those provided by NSPs.

...Retention of qualified health workers is particularly important in Aboriginal health services as familiarity and trust of staff members are crucial when building relationships with Elders and key community members...When staff turnover is high in an organisation these trust relationships are often lost and take time to rebuild...and organisational knowledge can be lost (ANCD 2011, p.72).

Cristofer Beal from Tanderra AOD Services in Bairnsdale told the Committee it was absolutely crucial that resources were allocated to train up more Aboriginal community workers on culturally appropriate approaches to crystal methamphetamine including Aboriginal health workers and community elders:

One thing I would like to raise is the need to train up the community [so they can provide the information]. Our workforce contains very few Aboriginal people. I sit here as an Englishman, Jon here is an Australian non-Aboriginal person, and this is pretty much how the system works. I think we really need to drive getting the community working for their own communities.¹⁵⁵³

Mr Beal's colleague Jon Borkowski added that:

One of the other big issues is, and has always been, the salaries that are being paid for these workers. You are expecting people to finish school, or at least year 10, then go on and do another year or two at TAFE, learning the counselling area, or go to university. Yet they can walk out of school at 15, walk into a shop and earn as much money as a retail assistant. We are not giving them the encouragement, really the financial encouragement, to actually go on and do additional training. Quite a lot of the people that I know that are in the drug and alcohol sector only last a few years because it is a very, very trying occupation and it has a very high burnout rate. If they are not getting the financial encouragement to stay there, you are not going to get the people in.¹⁵⁵⁴

As discussed in Chapter 12 it is also imperative that non-Aboriginal staff working in Aboriginal services or coming into contact with Aboriginal clients receive 'specific training to develop an appropriate level of cultural sensitivity and understanding' (ANCD 2011, p.62).^{1555 1556}

Pharmacists

Pharmacists and their staff have an important role to play because of their close contact with drug users through the provision of opioid substitution treatment and NSPs. Pharmacists can be a first 'port of call' for many drug users who may otherwise not seek general or specialist health or treatment services. They are therefore in a unique position to give advice and assistance to users on matters pertaining to their drug use and when appropriate put them in contact with

1553 Mr Christofer Beal, Coordinator, Tanderra AOD Services, Bairnsdale, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

For further discussion of the need for culturally appropriate interventions for Aboriginal people, see Chapters 12 and 29.

1554 Mr Jon Borkowski, Coordinator Alcohol and Other Drug (AOD) Services Morwell, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

1555 See also evidence from 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; Ms Kit-e Kline, Drug & Alcohol Worker, Wathaurong Aboriginal Co-operative, Submission, 22 October 2013; Mr Rudolf Kirby, Chief Executive Officer, Mildura District Aboriginal Services, Submission, 21 October 2013.

1556 Further discussion on the need for culturally appropriate education and training for both Aboriginal and non-Aboriginal workers is found in Chapter 12 of this Report.

treatment and support agencies.¹⁵⁵⁷ To perform this role, however, they need to be sufficiently trained on the properties and effects of methamphetamine.

Pharmacists also play an important role in precursor control and preventing pharmaceutical misuse. Peak organisations such as the Pharmacy Guilds of the various states may offer some form of training on pharmaceutical diversion for illicit drug production, particularly through in-house and industry publications.¹⁵⁵⁸ Police forces around the country have also developed components on chemical diversion for Pharmacy courses as part of both undergraduate and ongoing training (Cherney, O'Reilly and Grabosky 2005).¹⁵⁵⁹ The Australian Medical Association also recognised the need for comprehensive training of pharmacists, among others, on pharmaceutical diversion:

It is important that government funding facilitates widely available education and training opportunities for health professionals responsible for managing patient access to pseudoephedrine-based medications, including doctors, pharmacists and pharmacy support staff; educational seminars and training courses can help to prevent inappropriate, supply, misuse and diversion of these medicines in the community.¹⁵⁶⁰

Training for other workers

The Committee also received evidence that prison officers, social workers and child protection workers should also be given training on crystal methamphetamine and its effects to assist in their professional work.

Given the high numbers of prisoners and those associated with the criminal justice system who have problems associated with illicit drug use, including methamphetamine, it is appropriate that those staff who come into contact with crystal methamphetamine users have a sufficient degree of training and education about the drug and its effects.¹⁵⁶¹ In Victoria, correctional staff do have training in alcohol and drug-related issues both as part of their pre-service training and on an ongoing basis. Such training is currently provided through the Australian Community Support Organisation and Community Offenders Advice and Treatment Service program (ACSO/COATS) discussed in Chapter 21 and covers a variety of contemporary drug and alcohol issues including crystal methamphetamine and its effects.¹⁵⁶²

Social workers and child protection workers may often come into contact with methamphetamine users and therefore require an understanding of the drug and its effects. As Theresa Lynch of the Royal Women's Hospital WADS told the Committee:

We cannot help but remember the important role of the Department of Human Services. I started my speech saying that over 75 percent of our women have involvement with the Department of Human Services, so I think it is really critical that they be resourced and supported to better understand the needs of infants and women who are affected by drug and alcohol use. In our service we do a lot of education and give support to their staff to better understand. But it is critical that they do, because it can be quite challenging for us in terms of our discharge planning and care.¹⁵⁶³

1557 See Mr Angelo Pricolo, Chair, Strategic Harm Minimisation in Pharmacy (SHarP) Advisory Group, Pharmacy Guild of Australia — Victoria, Public Hearing, Melbourne, 3 February 2014; Mr Allan Crosthwaite, Director and Mr Stan Goma, Manager — Professional Services, The Pharmacy Guild of Australia — Victoria, Submission, 10 December 2013.

1558 Mr Allan Crosthwaite, Director and Mr Stan Goma, Manager — Professional Services, The Pharmacy Guild of Australia — Victoria, Submission, 10 December 2013.

1559 See also *Reducing the methamphetamine problem in Australia: Evaluating innovative partnerships between police, pharmacies and other third parties*, NDLERF Monograph no. 39 (Ransley et al. 2011).

1560 Ms Rachael Edginton, Director of Police & Public Affairs, Australian Medical Association (Victoria) Limited (AMA Victoria), Submission, 31 October 2013.

1561 See discussion in Chapter 14.

1562 Ms Michelle Wood, Assistant Director, Community Correctional Services, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014.

1563 Ms Theresa Lynch, Manager, Royal Women's Hospital Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

Similarly, Ms Lynch commented that agency social workers who may come in contact with pregnant crystal methamphetamine users are in some circumstances insufficiently knowledgeable to address their clients' crystal methamphetamine use.

Our role, really, is educating and it is supporting other service providers and people in the sector to actually get women into us as early as possible. It is quite surprising sometimes how community agencies might be aware of a woman who is using alcohol and drugs and they do not bring her into pregnancy care. It is just that lack of knowledge and understanding of how critical it is to get a woman in these particular circumstances.¹⁵⁶⁴

David Giles from Anglicare also told the Committee that through no fault of their own, their social and child welfare workers struggled at times to understand the issues associated with the crystal methamphetamine use of their clients. Mr Giles gave the example of an overburdened community service worker in his agency who was expected to address the problems of an at-risk child in a very dysfunctional family where the parents used crystal methamphetamine:

In this particular case it was our worker, the community services worker, who was left to try to assist this family. The worker had studied social work, a course which does not provide extensive or practical education around how to work with families affected by ice use. The only training this worker had undergone with regard to this issue was a half-day seminar that she had attended the year before. Unfortunately the Department of Human Services, which funds family services programs, does not pay a sufficiently high unit price for agencies like Anglicare Victoria to be able to provide our workers with all the extensive training that we would otherwise wish to. As a result, this worker said to me that she did not feel confident about her ability to accurately assess, engage or assist this family, particularly in light of there being no assessment and practice frameworks, which are both family focused and specifically informed regarding ice-related issues, for doing so.¹⁵⁶⁵

Training issues to be addressed

Attitudinal issues

One problem associated with service provision for people with methamphetamine-related problems, particularly in the treatment sector, is that 'treatment settings are not value free environments' (Dwyer et al. 2012, p.66). In other words, service providers including AOD workers, paramedics, health workers and police can share the same preconceptions and biases about methamphetamine users as the general public — particularly that crystal methamphetamine users are invariably aggressive, 'out of control' or untreatable:

[Interviews]¹⁵⁶⁶ with service providers suggested that many service providers consider methamphetamine users to be 'in denial' about the impact of drug use on their lives. Service providers offered this as a key reason for why so few methamphetamine users access treatment services. Such representations construct people who use methamphetamine as lacking insight into and decision making capability around their drug use. In doing so, service providers relinquish the responsibility of services to improve their responsiveness to and understanding of the needs of methamphetamine users... (Dwyer et al. 2012, p.66).

Moreover, interviews with methamphetamine users suggest they sometimes believe that professionals with whom they come into contact, *including* AOD workers, are not always knowledgeable about crystal methamphetamine: 'One service user said that his counsellor was not "well educated on ice use". She was not well educated on the pharmacology or the scene of how a user feels' (Dwyer et al. 2012, p.66).

1564 Ms Theresa Lynch, Manager, Royal Women's Hospital Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

1565 Mr David Giles, General Manager, Family and Community Services, Anglicare Victoria, Public Hearing, Melbourne, 3 February 2014.

1566 These interviews were conducted by Nicola Thomson one of the co-authors of the text quoted above.

Certainly one of the ex-users of methamphetamine who gave evidence to the Committee believed that many doctors, including some of those he presented to, could be judgmental of users if they worked outside of specialist AOD clinics. After having what he thought might have been a heart attack associated with his crystal methamphetamine use this witness took himself to a local hospital:

I went to see a doctor about it. To be honest — this was over in Albury — the medical practitioner I seen refused to help me. He said, ‘We do not help people like you whatsoever’, and kicked me out of the hospital. I think something needs to be done with that where people can go in there and get help because I was refused. I am lucky I am not dead. Twelve hours after that I had a toke on the pipe and I was back in the same situation 12 hours later.¹⁵⁶⁷

It is not only ex-users who have told the Committee about such attitudes. AOD specialists including AOD doctors have also criticised their fellow practitioners for their attitudes towards drug users. Acknowledging that crystal methamphetamine users in particular can be confronting they have called for better training in medical schools and as part of an ongoing professional development program. Dr Paul MacCartney from Primary Care Connect (PCC) in Shepparton told the Committee that one of the reasons for PCC establishing its specialist AOD clinic was in fact a result of the negative attitudes of local practitioners towards drug users:

GPs in general do not have time to spend. They are not that interested in spending time with this population of people. In this town we have been doing some work in the four years that I have been coming, trying to encourage the treatment of people who are dependent on drugs that we have excellent treatments for. But even that has been a bit like banging our heads against a wall. It has really been hard work. If we have got individuals who are interested in doing the treatment, their practice principals have prevented them from doing so. The people who own their practices have said, ‘We don’t want these people in our treatment’ — I heard Dave on the radio, who spoke to you yesterday from Wodonga, saying the same thing about hospitals — ‘We don’t want to treat your sort of people’. It is all too common... The challenge is also having enough local GPs interested in the topic; that is the real challenge.¹⁵⁶⁸

Mental health workers, particularly those working with dual diagnosis clients, also require a value free approach to working with methamphetamine clients:

The attitude of the [mental health worker] to working with clients who present with co-morbid drug issues is one of the key issues governing how they may respond and what the likely outcome will be for both worker and client...While it appears obvious that possessing sufficient skill is critical, it is in fact workers; and the services’ attitude, values and beliefs that will often be crucial in providing good service... (Pawsey & Hynan 2012, pp.155).

Pawsey and Hynan state that some of these attitudes and beliefs are based on and influenced not only by professional experience and personal bias, but also by a lack of relevant evidence-based knowledge and training around drug use:

Sometimes mental health workers resent working with people with AOD issues and often make statements like ‘I am a mental health worker not an AOD worker’. Still all too evident in the mental health sector is the argument over which issues (substance use or mental health) is the primary one and which is secondary — sometimes used to exclude DD [dual diagnosis] clients from service response; for example the person presents intoxicated to the mental health service and staff decide it’s an AOD issue not a mental health issue and so don’t respond. In recent times the media hype around ATS has focused on aggression and violence. This influences not only the general public but may also influence the worker and increase anxiety.

The need for systematic training and ongoing professional development and support of mental health staff around the dual diagnosis issues is vital if attitudes, skills and approaches to dual diagnosis clients

1567 Mr David Reid, Public Hearing, Wodonga, 24 February 2014.

1568 Dr Paul MacCartney, Medical Practitioner, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014.

are to be improved.¹⁵⁶⁹ The Victorian Dual Diagnosis Initiative is one good example of an approach that is addressing the issue (Pawsey & Hynan 2012, pp.155-156).

Part of the training provided to professionals on crystal methamphetamine therefore needs to have components on addressing the needs of crystal methamphetamine users in knowledgeable, value neutral and non-judgemental ways.

Working in partnership

One way of addressing deficits in training on methamphetamine, particularly in rural areas and amongst general health and AOD workers is to enter into partnerships with specialist agencies. For example, Anex has provided a substantial amount of training on crystal methamphetamine to generalist workers through its seminars, forums and training packages.¹⁵⁷⁰ Individual training arrangements have also been entered into; for example Mallee District Aboriginal Services (MDAS) have engaged Odyssey House Victoria to provide its accredited course 'Working with Clients with Amphetamine Type Stimulant Issues' to staff within MDAS.¹⁵⁷¹ Lead tenant and housing worker staff and volunteers from the Melbourne City Mission have also undertaken training from Anex, Odyssey House and various TAFE Institutes. Whilst Melbourne City Mission staff described such training as 'very useful', it was also thought more practical advice in handling clients who have been using crystal methamphetamine was required.¹⁵⁷²

Importance of clinical supervision

Nicholas et al. (2013) note that providing clinical supervision is an important capacity building measure within a systems workforce development framework. The importance of clinical supervision has been demonstrated in a number of studies.

Clinical supervision is structured professional support and professional development for health practitioners. It can be group based or individual. It differs from management or administrative supervision, which focuses more on work performance.

Bambling et al. (2005), for example, compared client outcomes among health practitioners treating clients with depression who received one of two types of clinical supervision or no supervision. They found no difference between the supervision types but practitioners who received any type of supervision showed better working alliance, reduced client depression scores, better client rated treatment evaluations and better treatment completion rates than practitioners who received no supervision.

Heaven et al. (2006)¹⁵⁷³ have demonstrated that clinical supervision is an important mechanism for the transfer of skills learned during training to the workplace. They found that while training improved communication skills among nurses during training, only those that received supervision showed transfer of those skills when they returned to their usual workplaces.

Victorian Department of Health has developed clinical supervision guidelines for mental health that includes development of policies and procedures that cater to various professional requirements, are clear about the distinction between supervision and performance management, clarify the responsibilities of both the supervisor and supervisee and outline confidentiality issues.

1569 The authors state the Victorian Dual Diagnosis Initiative is one good example of an approach that is addressing the issue.

See [http://docs.health.vic.gov.au/docs/doc/Victorian-Dual-Diagnosis-Initiative-\(VDDI\)-Bulletin--October-2013](http://docs.health.vic.gov.au/docs/doc/Victorian-Dual-Diagnosis-Initiative-(VDDI)-Bulletin--October-2013)

1570 See discussion in Chapter 29.

1571 Mr Rudolf Kirby, Chief Executive Officer, Mildura District Aboriginal Services, Submission, 21 October 2013.

1572 Rev Ric Holland, Chief Executive Officer, Melbourne City Mission, Submission, 1 November 2013.

1573 <http://www.sciencedirect.com/science/article/pii/S0738399105002454>

The importance of system-wide support to develop the AOD workforce

Nicholas et al. (2013)¹⁵⁷⁴ note that a range of system-wide strategies are important for effective workforce development. Important processes include:

- Foster formal and informal linkages with health and human service professionals and AOD services to increase access to appropriate services, particularly those required by patients/clients with complex and high severity problems
- Appoint professional AOD support specialists for relevant health/human service professions
- Develop client/patient AOD intervention policies and guidelines for human service professionals
- Update job descriptions to include AOD tasks, activities, skills and knowledge
- Examine/produce current AOD guidelines for relevant health professions
- Develop AOD resources for managers
- Provide financial incentives for health professionals to intervene in AOD issues (p.6)

Ms Raymond, Chair of Youth Projects, emphasised to the Committee the range of issues that need to be taken into account in training and preparing AOD workers for work at 'ground level':

Therefore the responses need to take into account workforce planning and issues around how the sector in alcohol and other drugs and mental health are able to respond and assist with recommendations that you might want to make, and our experience of how this is changing and how confronting and challenging this is to people who are absolutely at the ground level.¹⁵⁷⁵

Conclusion

There have been substantial changes in the AOD field in recent decades that have major implications for the development of a responsive, effective, and sustainable AOD workforce. The increase in the use of crystal methamphetamine and the consequences of that for a wide range of AOD, health, law enforcement and other workers is a challenge for workforce development.

These changes include the increased complexity of AOD issues and growth in demand for AOD services, together with issues facing the wider Australian workforce such as advances in technology, an ageing workforce, and a tight labour market. These complex and diverse changes have led to increased recognition that a coordinated strategic approach is needed to develop the capacity of the AOD workforce to effectively respond to current and emerging AOD issues.¹⁵⁷⁶

In addition to the governmental frameworks discussed earlier in the chapter, a number of other workforce development initiatives have also been introduced by research, peak and individual AOD bodies including clinical guidelines, training directories, resource kits, and targeted training programs.¹⁵⁷⁷ However, whilst Roche and Pidd observe that overall workforce development efforts, both government and private, have been increasing:

They nonetheless remain piecemeal and unco-ordinated. Clearly there has also been a steady growth in the recognition and understanding of the importance of workforce development and its implications for the long term development of the AOD field. What is needed at this point in time is a nationally co-ordinated approach to progress strategies that are ripe for implementation (2010, p.73).

1574 http://nceta.flinders.edu.au/files/6413/7938/7718/Literature_review_final.pdf

1575 Ms M. Raymond, Chairperson, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

1576 <http://nceta.flinders.edu.au/files/4912/7200/2031/EN422%20Roche%20%20Pidd%202010.pdf>.

1577 See Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol & Drug Association (VAADA), Submission, 11 November 2013; Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013; Mr John Rogerson, Chief Executive Officer, Australian Drug Foundation, Submission, 28 October 2013.

The evidence presented in the research literature and the views of witnesses to the Inquiry support the need for greater training and workforce development to increase awareness, understanding and an ability to respond to crystal methamphetamine and its effects. The provision of such training and the support of co-workers, supervisors and the work organisation can positively influence worker wellbeing and worker effectiveness. Whether the delivery of workforce development and training is undertaken on a national or state basis (or a combination of both) it is clearly an important priority.

As Roche and Pidd comment, such workforce support is crucial in 'a work environment such as the AOD field within which high workloads and high levels of work stress are evident' (2010, p.17). This may particularly be the case when workers need to address issues pertaining to methamphetamine use.

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.*

Recommendation 16

The Committee recommends that the Victorian Government:

- a) *Ensure that the available guidelines on methamphetamine are updated and disseminated widely to practitioners and services*
- b) *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*
- c) *Ensure all workers in alcohol and other drug treatment settings have available to them appropriate and regular professional supervision*
- d) *Ensure that agencies have policy and procedures in place to support the implementation of methamphetamine-specific treatment.*

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.

26. Harm Reduction Approaches to Methamphetamine Use

Introduction

There are a range of harm reduction interventions that can be utilised in both prevention and treatment approaches to address methamphetamine use. Harm reduction is one of the key principles underpinning Australia's longstanding national strategic approach to drug policy of 'harm minimisation'.¹⁵⁷⁸ The rationale for harm minimisation is based on the view that:

Harm minimisation tries to assess the actual harm associated with any particular drug use and asks how this harm could be minimised or reduced. This approach accepts that:

- Psychoactive substances are and will continue to be part of our society;
- Their eradication is impossible; and
- The continuation of attempts to eradicate them may result in maximising net harms for society.

The objectives of the harm minimisation model are:

- The identification of the harmful consequences for individuals, those around them and the community overall; and
- The implementation of strategies to minimise this harm. (Hamilton, King & Ritter 2004).

Harm minimisation is an overarching term that includes harm reduction as its third pillar. Sometimes the terms harm minimisation and harm reduction are used interchangeably. The accepted view, however, is that harm reduction is a subset of the broader concept of harm minimisation which also includes the 'pillars' of supply reduction and demand reduction (Commonwealth Department of Health 1999, pp.15-16).

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 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.

Recognising the reality of drug use

Harm reduction compared to other drug interventions does not necessarily aim to stop drug use:

The philosophy of reducing harm acknowledges that we live in a drug using society. It acknowledges drug use as a reality, serving many purposes for people of all ages. [Harm reduction] also recognises the different stages of change, and that a comprehensive and balanced approach is required that offers a range of options (Commonwealth of Australia 2009 p.56).

¹⁵⁷⁸ See the discussion of the National Drug Strategy and related policy issues in Chapter 2.

Essentially harm reduction interventions are about recognising the reality of drug use. As John Ryan from Anex told the Committee in the context of methamphetamine use:

[w]e need to be realistic. There are a lot of incentives to use methamphetamine, as is proven by the number of people using it, so we have to be realistic enough to deal with that fact and therefore provide people who use methamphetamine with safety strategies in terms of its use. For example, going on a bender for four or five days is an extremely risky way to consume methamphetamine, and we have to be talking to people about the unnecessary risks they are taking. Their use may continue, but we need to actually ameliorate some of the damage from that use, and part of that is by better informing meth users.¹⁵⁷⁹

In short, harm reduction aims to achieve a reduction in drug-related harms regardless of reductions in drug use itself.

Harm reduction as part of an education model

Harm reduction interventions are essentially educative tools used to address a person's short or long-term drug use. Gino Vumbaca, Executive Director of the Australian National Council on Drugs (ANCD), was emphatic as to the educative merits of harm reduction principles in addressing a person's drug use, particularly those who may be relatively 'new' to such use:

Harm reduction is about education and providing advice and information to people that is realistic and credible. By that, sometimes you have to accept that people are going to use the drug. There is no point giving out information that only says, 'Don't use the drug'. What you need advice about is, if you are going to use this drug, how to do it safely and how to avoid situations that will cause harm to yourself and others.

Professor Richard Midford echoed these comments when he gave evidence to the Committee:

I think harm minimisation is the way to go, particularly with the more pertinent drugs, because if people are using, giving an abstinence message is not going to be particularly effective. The harm minimisation message about keeping oneself safe and being aware of how to negotiate and navigate the dangers of drug use will keep them safe. I feel that a skills-based, realistic, harm minimisation drug education program is probably the best thing you can do for kids of that age who are on the cusp of making decisions about drug use.¹⁵⁸⁰

As discussed in Chapter 23, in terms of 'getting the message across', drug education experts agree that the use of social networks such as peer led interventions, including the use of social media are optimal harm reduction measures (Colfax et al. 2010). 'There is a potential greater role for the internet with this being a common source of information among young users' (Falck et al. 2004 in McKetin et al. 2012a, p.18).¹⁵⁸¹

Harm reduction and methamphetamine use — What is possible?

There are a number of ways in which harm reduction measures can be used to address methamphetamine use. 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). Harm reduction measures may also be differently targeted at specific groups such as women or young people.

1579 Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

1580 Professor Richard Midford, Professor of Health in Education, School of Education, Charles Darwin University, Public Hearing, Melbourne, 3 February 2014.

However, as Midford has written elsewhere, this does not mean harm reduction approaches cannot use abstinence approaches, just these aren't the ends in themselves (Midford 2009, p.1692).

1581 See Chapter 23 for a discussion of social media as a tool for drugs education.

Harm reduction measures for non-dependent users

A range of brief interventions that take a harm reduction approach have been tailored for experimental, recreational, occupational and/or non-injecting users who are not dependent and not considering ceasing their use. Such clinical interventions include:

- Cut[ting] down the amount of speed used at any one time;
- Use[ing] in the presence of other people;
- Continu[ing] to practise alternatives to injecting;
- Reduc[ing] the risks of injecting and other routes of administration.

In addition, education about the range of possible adverse consequences of use such as mood disturbances, paranoid ideation, irritability and health consequences have been recommended to encourage early intervention by users if adverse consequences do arise. A recommendation that a person receive vaccination for hepatitis B might [also] be appropriate (Baker et al. 2003, p.71).

Peter Wearne, Director of Services for the Youth Support + Advocacy Service (YSAS), has commented that for young people, particularly those whose initiation into methamphetamine use was relatively recent, instruction in harm reduction techniques is very important in those cases where the client is showing no inclination to cease use. He told the Committee:

So if someone came to me and they said, 'I'm using methamphetamine every week', and they did not want to give it up, I would say, 'Let's try only using it every fortnight. Let's start reducing the time between your use so your body and your mind have time to recover'.¹⁵⁸²

Harm reduction measures for users in treatment

Regardless of treatment goals, a best practice approach in clinical practice includes a focus on the reduction of harms. High rates of relapse mean that harm reduction is crucial in clinical practice, and is not incompatible with an abstinence goal.

We Help Ourselves (WHOS), an abstinence based residential rehabilitation provider in NSW, has successfully implemented a formal harm reduction program and offers harm reduction packs, including clean injecting equipment, condoms and harm reduction educational material, on discharge, demonstrating harm reduction strategies can be compatible with an abstinence oriented philosophy.

Harm reduction in clinical practice recognises that even when a methamphetamine user is motivated to quit, it can be a difficult task and relapse rates are high. For those who continue to use, even small amounts, harm reduction brief advice can be helpful, including:

- A recommendation to use sterile injecting equipment when continuing to inject;
- Education regarding signs and symptoms of severe adverse consequences including toxicity
- Rest periods...to enable the body to recover;
- Adequate nutrition and fluid intake;
- Offering ongoing reviews of the person's physical and mental health to ensure early intervention if problems should occur;
- Information to take home [resource guides etc] (Baker et al 2003. p.72).

Hall et al. have recommended that in the context of injecting methamphetamine there are some harm reduction suggestions that clinicians, including general practitioners, could raise with their patients: For example:

¹⁵⁸² Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

[c]linicians should discuss the hazards of injection, without exaggerating the risks of occasional oral use of low doses. For current users, they recommended providing advice to avoid injection and daily use. There are no recommended safe limits for amphetamine use, but Hall and Hando have offered the following rules of thumb as ways of reducing the risk of experiencing adverse effects of amphetamine use: to use less than twice a week and to use no more than half a street gram (in Baker & Lee 2003, p.326).

A harm reduction approach in treatment can result in positive treatment outcomes. For example, Carrico et al. (2014)¹⁵⁸³ examined outcomes of more than 200 methamphetamine-using men who have sex with men (MSM) involved in a best practice cognitive behavioural intervention (The Matrix Model) implemented from a harm reduction perspective. They found reductions in stimulant and other drug use, improvement in employment, increased treatment engagement for those who were HIV positive, and reductions in sexual risk taking.

Such approaches can be usefully viewed as interim measures that ensure a person may not irreparably damage his or her health in the period before either cessation of use or the person seeks formal treatment to address their problematic use (Oppenheimer 2012).¹⁵⁸⁴

Tailoring harm reduction approaches to specific at-risk groups

Attention also needs to be paid to how methamphetamine may impact upon different populations at risk from particular health complications. These may include groups such as pregnant women, people with pre-existing mental health disorders or those at risk from cardiovascular complications (Loxley et al. 2004). The diverse needs and issues faced by such groups may give rise to a diverse range of potential harm reduction responses such as:

- Reducing the risks of drug adulterants and the risks that can arise from variation in purity across purchases;
- Raising awareness of the harms and negative consequences of use in particular contexts (eg impaired driving or work performance);
- Managing sleep and nutritional disorders;
- Avoiding, managing and reducing adverse mental health outcomes;
- Preventing transition to higher risk drug administration such as injecting;
- Reducing risks associated with injecting; (eg needle and syringe programs) (Allsop 2012, pp.179-180).

Harm reduction strategies should not only be focused on the individual user, interventions to assist the friends and families of users may also be important.¹⁵⁸⁵ In the latter category for example, children can often be exposed to the dangers associated with living in proximity to clandestine drug laboratories. Harm reduction strategies to reduce these risks such as environmental clean ups should be implemented, although there is little evidence regarding their impact (Watanabe-Galloway et al. 2009).

Some commentators have argued that the understanding of what counts for harm reduction needs to be broadened. For example, with regard to illicit drugs such as methamphetamine, programs that divert users from the criminal justice system and into health based interventions can rightly be seen as harm reduction as 'they have helped increase the chances of recovery and reduce the likelihood of individual recidivism harming the community' (Department of Health and Ageing 2011, p.16). Roadside drug testing programs can also be harm reduction interventions in this broader sense as they can contribute to lessening the toll of road trauma related death and injury (Department of Health and Ageing 2011, p.16).

1583 Carrico AW, Flentje A, Gruber VA, Woods WJ, Discepola MV, Dilworth SE, et al. Community-Based Harm Reduction Substance Abuse Treatment with Methamphetamine-Using Men Who Have Sex with Men. *Journal of urban health : bulletin of the New York Academy of Medicine*. 2014.

1584 For an account of some of the key interventions used by Victoria's peak body for harm reduction, Harm Reduction Victoria (HRV), particularly in the area of injecting drug use, see Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013. See also the website of HRV at <http://hrvic.org.au/>.

1585 See Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013, and the discussion in Chapter 26.

Engaging users — Needle exchange programs as harm reduction interventions

Whilst all the above approaches and programs may be useful interventions to address methamphetamine use, probably the most proven harm reduction measure thus far to reduce or prevent harms associated with 'ice' use is the provision of needle and syringe exchange programs (NSPs).

NSPs provide a unique opportunity to support the health and wellbeing of people who inject drugs, and to provide education and referral when needed.¹⁵⁸⁶ They are interventions that have proven success particularly in reducing the level of blood borne infections and diseases such as HIV and Hepatitis C (HCV) (Colfax et al. 2010; Degenhardt et al. 2010).

Gino Vumbaca from the ANCD worked in the first NSP established in Darlinghurst, Sydney in the mid-1980s. He stressed to the Committee how important NSPs are in delivering information on reducing the harms associated with drug use and getting users to think about their drug use in the long term:

NSPs provide a unique opportunity to engage with people who generally do not engage with the health system... When [Kings Cross NSP] opened up we were seeing people we had never seen in the drug and alcohol service. They were coming to our service, and it provided an opportunity for us to engage with them. You did not badger people, but you went up to them and said, 'Listen, if you ever want to talk about this, there are people here you can talk about it with'. For the first time they were engaging one-on-one with myself and colleagues — counsellors — working at that service. That is the unique opportunity it provides: engaging with this hidden population, in a way.¹⁵⁸⁷

Mr Vumbaca added that NSPs whilst useful venues for generalist advice on drug use and health promotion were obviously particularly suitable for engaging clients who are injecting users of methamphetamine and other drugs:

With injecting, for instance, you can say, 'Don't inject because of the problems [associated with it], but if you're going to inject, make sure it is a clean needle. Make sure it is this. Make sure there is someone else there with you. Make sure you are aware of what you are using. Make sure you are in an environment that is safe. Don't use alcohol or other drugs with it'. It is about getting that advice to people. If you present advice to people that is useful to them in a non-judgemental way, then they are more likely to think, 'Okay'. That at least gets them thinking about what they are doing.¹⁵⁸⁸

Mr Vumbaca also endorsed the provision of safe injecting rooms when he spoke to the Committee. Whilst controversial, sanctioned injecting rooms could also be useful in providing information outreach and harm reduction messages:

With injecting rooms, there are particular areas where it makes sense. In Kings Cross [Sydney] — it makes sense. There may be an area in St Kilda that makes sense, but you need community support. That exists in Kings Cross. There is not an injecting scene in Kings Cross because the injecting room is there;... It is not something you put in every suburb or around the state or the country, but there are particular hot spots where we know people go to engage in injecting drug use. If you live in that area, you know that public amenity is an issue; people injecting in stairwells and needles and syringes being found everywhere is not a great environment for those people. In the last survey I saw of Kings Cross residents, there was something like 78 percent support for the injecting room because it has had a positive impact on their community. If you live in that area, you are not then confronted with people injecting. You are walking your kids to school or whatever and there is someone in the stairwell injecting — you are not confronted with that as much, and that is positive for them.¹⁵⁸⁹

1586 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

1587 Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

Many other witnesses testified to the importance of NSPs as essential points of contact for engaging drug users on harm reduction practices in non-judgemental ways. See for example, Mr Hamish Fletcher, Chief Executive Officer, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014.

1588 Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

1589 Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

Mr Vumbaca stressed that, unlike the provision of needle and syringe vending machines, NSPs and safe injecting rooms were ideal harm reduction measures because they were usually staffed by people who could give non-judgmental advice and information on health promotion including safe injecting practices. They could also be used to refer clients on to other services, including treatment services, when the client is ready to engage with ongoing support:

I would think that vending machines provide an opportunity sometimes [for clean needle dispensation] in rural locations where you just cannot afford to have a staffed needle/syringe program, but I would be worried about only having that, because then I think you lose the value of that interaction and ability to refer people on and deal with other issues that they may present with, such as health problems.¹⁵⁹⁰

The Committee received evidence from addiction medicine specialist Dr David Jacka who also stressed the importance of both NSP and safe injecting rooms as ways in which users can receive harm reduction messages:¹⁵⁹¹

I think the evidence is so strong that it [safe injecting rooms] is a really good way of engaging people who are otherwise not engaged with health services. We know that particularly methamphetamine users are not well engaged. They do not talk to their GPs, they do not talk to needle and syringe programs and they do not talk to their pharmacies. They go out and buy syringes, but they do not talk to anybody about it, so they do not know the risks, they do not know what they are buying and they do not know how to reduce the harm of what they are doing.¹⁵⁹²

The Medically Supervised Injecting Centre Evaluation (New South Wales)

The Safe Injecting Centre in Sydney, formally known as the Medically Supervised Injecting Centre (MSIC), favourably referred to by the witnesses above, was subject to a 10-year trial from its inception in 2001 to 2011. The trial finished in 2011 after the MSIC's operations were evaluated by KPMG. The trial commenced with the New South Wales Government's stated objectives being to:

[d]ecrease drug overdose deaths; provide a gateway to drug treatment and counselling; reduce problems associated with public injecting and discarded needles and/or syringes; and reduce the spread of disease such as HIV and Hepatitis C.¹⁵⁹³

The KPMG evaluation reviewed the MSIC's operations for the period 2007–2011. This evaluation, which also drew on evaluations conducted in earlier years, concluded that:

[t]he MSIC positively impacts on clients, has a high level of support from local residents and businesses, has not been shown to cause an increase in local crime or drug use and saves at least \$658,000 per annum over providing similar health outcomes through other means in the health system.¹⁵⁹⁴

With regard to the stated objective of decreasing overdose deaths the evaluation found:

The MSIC provides a safe injecting environment and has a record of managing overdose events. Since opening, the MSIC has managed 3,426 overdose events with no deaths onsite. It is reasonable to assume

1590 Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

1591 A complicated and contentious issue is the issue of whether NSPs should be introduced as a harm reduction measure in prisons. The legal, policy and ethical dilemmas pertaining to the introduction of such a proposal were canvassed by Corrections Victoria Commissioner Jan Shuard when she gave evidence to the Committee. See Ms Jan Shuard, Commissioner, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014.

See also the discussion of methamphetamine use by prisoners in Chapter 14.

1592 Dr David Jacka, Addiction Medicine Specialist, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

Contrary to Dr Jacka's observations, Angelo Pricolo from the Pharmacy Guild of Victoria believes pharmacies are an excellent location for dispensing harm reduction advice for methamphetamine and other drug users, particularly when they operate as needle exchanges. Community pharmacies in his view are excellent access points to 'discuss what is going on' in the user's life.

1593 NSW Health/KPMG — *Further Evaluation of the Medically Supervised Injecting Centre during its extended trial period(2007-2011)*. Accessed 27 May 2014 at: http://www0.health.nsw.gov.au/resources/mhdao/pdf/msic_kpmg.pdf.

1594 NSW Health/KPMG — *Further Evaluation of the Medically Supervised Injecting Centre during its extended trial period(2007-2011)*. Accessed 27 May 2014 at: http://www0.health.nsw.gov.au/resources/mhdao/pdf/msic_kpmg.pdf.

that a proportion of these overdose-related events managed at the MSIC would have led to overdose injury or overdose death had they occurred in another location (public place or a private dwelling) that did not have accessible medical supervision and intervention. Analysis of external data sets suggests that the MSIC appeared to have a positive impact on reducing the average monthly number of public opioid overdoses (resulting in ambulance attendances) in areas closest to its vicinity.¹⁵⁹⁵

Most importantly in the context of a discussion of harm reduction and the use of NSPs as a conduit for information provision and possible treatment referrals, the evaluation found:

The MSIC reaches a socially marginalised and vulnerable population group of long-term injecting drug users who have frequently (40%) had no previous interaction with any form of drug treatment or the wider service system. From service commencement in 2001, the MSIC provided 8,508 referrals to other services, nearly half of which were related to drug treatment (3,871). The more frequently a client visited the MSIC, the more likely they were to have accepted a referral to a drug treatment service. The rate of referral stabilised at a lower level in the last four years in comparison to the five years previous to that — most likely reflecting the stabilisation in the rate of new client registrations and the mix of MSIC clients attending the MSIC at particular frequencies (e.g. overall, more visits were attributed to frequent MSIC attenders, while a lower proportion were attributed to those that attend infrequently). During the evaluation period, the rate of uptake of drug treatment from these referrals has significantly increased compared with 2001-02 rates. Overall, evaluation findings indicate that the MSIC acts as a gateway for drug treatment.¹⁵⁹⁶

Subsequent to the publication of the evaluation Report and its acceptance by the NSW Government, the MSIC is now recognised as a permanent facility of NSW Health.

The value of needle and syringe programs for methamphetamine specific users

Whilst NSPs and safe injecting centres are utilised for all forms of injecting drug use, Colfax et al. note that they may be particularly important opportunities for interventions for methamphetamine injectors specifically¹⁵⁹⁷ as:

[i]njectors of amphetamine group substances are often less likely to engage and access [treatment] services than opioid injectors and might have different needs for social and other support services. [The research] findings point to the need for further tailoring of needle exchange and drug treatment programs to address both sexual risk and injection related harms that could be unique to users of amphetamine type substances (Colfax et al. 2010, p.7).

This difference between opioid users and methamphetamine users is important. Harm reduction approaches that also take into account improving the physical, social and mental health of methamphetamine users may be more effective than the traditional focus on treatment, often provided to heroin users. This may particularly be the case given specialised treatment modalities for methamphetamine use are unproven and research has indicated that methamphetamine users are not for the most part interested in formal treatment (Kenny et al. 2011).¹⁵⁹⁸

Reforming the provision of NSP services in Victoria

Whilst the provision of NSP services have been acknowledged as contributing to the reduction of harms associated with injecting drug use, there has also been recognition that the sector is in need of reform, improvement and increased recurrent funding in

1595 NSW Health/KPMG — *Further Evaluation of the Medically Supervised Injecting Centre during its extended trial period(2007-2011)*. Accessed 27 May 2014 at: http://www0.health.nsw.gov.au/resources/mhdao/pdf/msic_kpmg.pdf

1596 NSW Health/KPMG — *Further Evaluation of the Medically Supervised Injecting Centre during its extended trial period(2007-2011)*. Accessed 27 May 2014 at: http://www0.health.nsw.gov.au/resources/mhdao/pdf/msic_kpmg.pdf

1597 The drug most often used by attendees at the Medically Supervised Injecting Service in Sydney was heroin; (41%-56% of new registrants at the Centre). However amphetamines were the second most frequently used drug (15%-28% of new registrants). NSW Health/KPMG — *Further Evaluation of the Medically Supervised Injecting Centre during its extended trial period(2007-2011)*. Accessed 27 May 2014 at: http://www0.health.nsw.gov.au/resources/mhdao/pdf/msic_kpmg.pdf

1598 See Chapter 27.

Victoria. The Penington Institute, the peak body for the drug harm reduction sector in Victoria, has argued in a recent Report (*Be Crystal Clear: Integrated action to reduce the toll from methamphetamine and other drug-related harm in Victoria*) that such funding:

[i]s necessary to ensure Victorian capacity to address current and emerging drug trends and related harms, especially in non-metropolitan areas that are generally not captured in existing key drug trend research programs and where drug use trends differ to those in Melbourne. It will target areas of unmet need including workforce development, the capacity of the sector to respond in a rapid and coordinated way, knowledge management and engagement using new technologies (2014, p.3).

In particular, the Report argued that despite its good work in providing evidence-based and effective measures to promote the health and well-being of people who use drugs:

[the sector] is not adequately resourced to address dynamic and shifting drug markets and drug consumption practices in a systematic and knowledgeable way.

Recent studies have highlighted the areas of unmet need in the sector including:

- Growing and changing demand for services including access and coverage of current service operators, and
- The changing nature of drug use in the community with the emergence of new patterns of drug consumption including synthetic drugs such as methamphetamine, increasing use of performance and image enhancing drugs (PIEDs) and misuse of pharmaceutical drugs (Penington Institute 2014, p.4).

The Institute argued that the rise of crystal methamphetamine across Victoria and its challenges to rural communities, demonstrates there is a need for harm reduction services to continually evolve:

Current models of NSP in operation have changed little in the past 20 years, despite changing drug use trends and despite rapid technological advances and the rise of a digitally connected society. We need to ensure that models of harm reduction service provision are addressing need such as providing better access to primary health and other recovery oriented opportunities (Penington Institute 2014, p.4).

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.

John Ryan, Chief Executive Officer of the Penington Institute has told the Committee there needs to be increased funding and a better and more flexible funding model to increase the number of primary NSPs:

The proportion of syringes accessed at Secondary NSPs has increased from 32% in 2002 to 45% in 2013). The proportion of contacts reporting to have shared used syringes since the last NSP visit has shown a downward trend since 2004 at Primary NSPs. This has not been found at Secondary NSPs, where the reported sharing rate was 4.3 times higher across Victoria in 2013, and 8.4 times higher in metropolitan Melbourne.¹⁵⁹⁹

In particular Mr Ryan believes that funding needs to be provided to upskill workers at Secondary NSPs so they can provide information and education services in addition to dispensing clean injecting equipment:

The evidence suggests that rates of unsafe injecting and subsequent blood-borne virus transmission would be reduced by increasing education for injecting drug users (IDU) at Secondary NSPs. More brief interventions including engagement toward drug treatment is required.

The Penington Institute [should be funded] to increase Secondary NSP staff mentoring and direct face-to-face IDU education by strategically posting eight to twelve Mobile NSP Support (MNS)

1599 Mr John Ryan, Chief Executive Officer, Penington Institute, Submission, 3 August 2014.

workers across eight catchments, with each MNS worker supporting a number of Secondary NSP sites, focussing on high-volume locations. With each MNSPS responsible for ten or more sites, the model would reach staff and clients at over 80-100sites.

The MNS workers would mentor Secondary NSP staff at their NSP service and concurrently expertly engage in direct face-to-face IDU education. By strategically posting MNS workers across catchments, each MNS worker would support a number of Secondary NSP sites, focussing on high-volume locations or particularly vulnerable services or populations.

MNS workers could also be tasked to support Secondary NSP agencies to establish after-hours access and to promote new NSPs, particularly in areas of need such as outer metropolitan Melbourne.¹⁶⁰⁰

The Committee acknowledges the call for more flexible provision of NSP and harm reduction services and has made a recommendation accordingly.

Barriers to using harm reduction approaches

Despite the general approval in the alcohol and other drugs (AOD) sector of using harm reduction interventions to address problematic substance abuse, there have been criticisms made of the utilisation of the concept, particularly in the context of methamphetamine. Some of the barriers to successfully using harm reduction are outlined in this section.

Harm reduction — condoning drug use?

Harm reduction approaches as they apply to illicit drugs can be difficult in gaining support because of the perception that they are somehow condoning, even encouraging, illegal activities. This has certainly been the case with interventions such as safe injecting rooms, or pill testing stations for so-called 'party drugs'. Harm reduction may be much easier to justify in cases where drug use is normative, such as alcohol (Midford et al. 2014).

Harm reduction is even more difficult to 'sell' as a concept when it is aimed to use it as part of a drugs education approach. This is particularly true in the United States where a powerful conservative parent movement has put pressure on American policy-makers and legislators to promote abstinence and 'zero tolerance' approaches to drug education (Midford 2009). Even in Australia, according to Midford, 'an officially supportive jurisdiction' for harm reduction interventions, the harm reduction in education approach 'is handled very carefully because of the potential for misunderstanding and public backlash' (Midford 2009, p.1693). Teachers, for example, have expressed concern in some cases that harm reduction approaches may condone or even encourage drug use.¹⁶⁰¹

Some AOD workers have also expressed misgivings as to whether harm reduction methods can apply to methamphetamine in the same way they can be utilised for alcohol and other drugs:

[w]ith alcohol and marijuana — which are two other drugs widely used in our [Aboriginal] community — you can go down the harm minimisation pathway. You can talk about, 'Look, why don't you drink mixed drinks, beer or light beer? Have a glass of water in between drinks, minimise how many days of the week you're going to drink so that you're not sort of overdrinking. Think about your health', and all that sort of stuff. It is the same with marijuana, 'Don't use bong. Perhaps smoke a joint instead of a bong. Perhaps only smoke at night if you think it helps you sleep. Try not to smoke during'...you can go through all those strategies to try and reduce risk. But with this it is so difficult. What do you say? You can say, 'Don't shoot it up. Perhaps snort it all or smoke it', but that does not sit right either for a counsellor or the commission to say that about this drug.¹⁶⁰²

1600 Mr John Ryan, Chief Executive Officer, Penington Institute, Submission, 3 August 2014.

1601 For comparative accounts of harm reduction interventions to address methamphetamine use in Asia, see Wodak 2006. In countries such as Vietnam for example, the 'default response' to addressing methamphetamine use has been law enforcement crackdowns. Attempts to incorporate harm reduction approaches in such countries are slowly being introduced but incarceration in prisons or compulsory treatment centres is still common (United Nations Office on Drugs and Crime 2008). Accessed 20 April 2014 at: https://www.unodc.org/southeastasiaandpacific/en/Projects/2008_12/ATS_prevention.html.

1602 Mr Peter Treloar, Emotional Wellbeing Nurse, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013.

Attitudes of users and those associated with them

The most difficult aspect of utilising harm reduction interventions with methamphetamine users may be related to the fact that these users do not necessarily identify themselves with 'drug users' and as such do not seek help from traditional AOD and health services (Allsop 2012, p.187). As the World Health Organization (WHO) has noted:

ATS users rarely use harm reduction services, largely because they do not identify themselves with opioid users, often belong to different networks of users, and thus do not perceive harm reduction services as relevant. The result is the needs of ATS users are neglected and few services are geared to their special needs (2011, p.2).

Even specialist services that give harm reduction advice to illicit drug users recognise that methamphetamine users distance themselves from the label 'drug user'. For example, Jenny Kelsall, Executive Director of Harm Reduction Victoria, Victoria's peak body for harm reduction information and support, told the Committee:

I think part of the problem in 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...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.¹⁶⁰³

There may also be resistance to incorporating harm reduction interventions from non-using members of the community. For example, there is evidence that some Aboriginal community members including elders may be mistrustful of harm reduction approaches that seemingly condone illicit use; preferring abstinence based models of treatment and support. This may particularly be the case with regard to needle exchange programs or opioid substitution therapies, especially where the benefits of the program have not been sufficiently explained in advance to community elders or when the approach taken is not culturally appropriate to local norms and practices (ANCD 2011, pp.56ff).¹⁶⁰⁴

As such, it has been argued that it is important that training for Aboriginal health workers in the area of alcohol and drug use incorporate harm reduction concepts and applications and that in turn these workers can inform community members that in some circumstances harm reduction is a suitable approach for Aboriginal people and is not necessarily incompatible with abstinence (Haines & Watts in ANCD 2011). As a key informant to the ANCD survey stated:

I believe people get mixed up sometimes...around what is harm reduction for different areas of drug use. Harm reduction isn't in competition with abstinence at all. Abstinence is a form of harm reduction, it's the ultimate form of harm reduction (ANCD 2011, p.79).

Harm reduction and prevention — poor cousins of treatment?

An emphasis on the supposed efficacy of treatment at the expense of prevention and education programs means that there is little tested research evidence as to the effectiveness of harm reduction approaches:

The overall lack of evidence has contributed to a neglect of prevention and public health activity. For example, in a recent World Health Organisation technical brief on the principles of prevention and treatment of ATS, all nine principles addressed treatment, while none specifically highlighted prevention activity (Allsop 2012, p.174).

A lack of emphasis on prevention and harm reduction has also been one of the issues raised in evidence to this Inquiry. It has been suggested that harm reduction measures need to be introduced far earlier in the 'drug use cycle' than is currently the case particularly through

1603 Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013.

1604 See also the discussion in Chapter 12 on Aboriginal use of methamphetamine.

prevention education, outreach and proactive networking.¹⁶⁰⁵ For example, Simon Ruth from the Victorian Aids Council told the Committee that one of the major problems with harm reduction interventions particularly for methamphetamine users is that they tend to be used in the treatment sector, often when a person's drug use may be well advanced – 'by the time they are coming into treatment they are more than likely dependent and we have possibly missed the boat on the opportunity to work on harm reduction with them'.¹⁶⁰⁶

Harm reduction: An essential component of addressing methamphetamine abuse

Many submissions to the Inquiry stressed that harm reduction is an essential component of an overall strategy to address methamphetamine use, particularly given the lack of proven treatment modalities. For example, Odyssey House stated:

Greater investment in education and prevention strategies is required across the state, including in regional and rural Victoria, to provide up to date information about Ice for professional workers, families and the general community. Ice users, especially those who are treatment naïve and are at risk of progressing to injecting, also require better access to harm reduction information and programs to prevent the sharing of injecting equipment, risky sexual behaviours, and the spread of blood borne viruses.¹⁶⁰⁷

Similarly, Anex's submission to the Inquiry stated:

Harm reduction interventions for people who use methamphetamine should be further developed, delivered and evaluated. For example, building the knowledge and capacity of people who use to reduce their own risks and to intervene positively in their social networks. Further, both AOD and community services including primary care and emergency services should be provided with the capacity and frameworks for provision of harm reduction interventions as part of routine management of people who use methamphetamine.

Innovative strategies to ensure harm reduction interventions are delivered to the broad range of people who use methamphetamine should be developed and evaluated. Other avenues of harm reduction for people using methamphetamine that could be explored include general practitioners (GPs), hospital staff and mental health workers. These interventions could range from brief interventions addressing overall physical and mental health such as information on getting enough sleep and eating well, to information about some of the possible long term effects of methamphetamine use, the harms associated with smoking and injecting this drug, and how to address acute harms such as overdose and/or drug toxicity.¹⁶⁰⁸

Harm reduction interventions can play a significant role in reducing the physical and mental risks of methamphetamine use, including preventing or delaying an initiation to injecting methamphetamine. Harm reduction services should be seen as an important front line element in an overall whole of government system which integrates initiatives directed towards the promotion of public health, community safety and efficient use of taxpayer funds.¹⁶⁰⁹

1605 See Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013.

1606 Mr Simon Ruth, Director of Services, Victorian AIDS Council, Public Hearing, Melbourne, 14 October 2013.

1607 Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, Submission, 21 October 2013.

1608 Anex is critical of the amount of government expenditure spent on law enforcement measures (64.1 percent) compared to harm reduction (2 percent) and prevention (10 percent).

'Yet, judging by research on public attitudes commissioned by Anex in 2009, Victorians are in favour of greater balance between taxpayer funding on law enforcement measures to address illicit drug-related issues and harm reduction interventions.'

Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

1609 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

The Pharmacy Guild of Australia also gave evidence to the Committee that prevention and harm reductions strategies are integral to reducing illness and disease as a result of unsafe administration of methamphetamine and as such should be strongly supported:

The Guild strongly believes that community pharmacy is ideally placed [to deliver harm reduction] through assist[ing] in the distribution of sterile injecting equipment, advice and referral to treatment services

To this end the Guild recommends that:

- Public health information be placed on needle and syringe packs by the manufacturer or supplied by pharmaceutical wholesalers via portable data entry. This would ensure a quick and effective distribution of information to consumers.
- A series of universal health fact-cards focused on illicit drug use be made available, or distribution to community pharmacy in each State and Territory. Distribution through the current pharmaceutical wholesaler chain would ensure cost-effectiveness.¹⁶¹⁰

In short, many agency representatives from the health and AOD sector who gave evidence to the Committee strongly recommended that more energy, time and funding be put into harm reduction to address methamphetamine use both in its early and later stages.¹⁶¹¹

A contentious issue — the use of ‘ice pipes’

Traditionally many users of methamphetamine who smoke the drug have used a glass apparatus known as an ‘ice pipe’ to inhale the substance. As discussed in Chapter 18 of this Report, the sale and promotion of these pipes has been banned in Victoria and most other states of Australia.¹⁶¹²

As an effort to reduce the harms associated with methamphetamine and other illicit drug use some jurisdictions allow and even encourage the utilisation of such drug paraphernalia. In Vancouver, Canada, for example, in an effort to reduce infections amongst methamphetamine and other drug users, crack or ice pipe vending machines have been installed to dispense new and clean smoking apparatuses. The pipes are made of durable Pyrex and retail for 25 cents each. Pyrex is used as it is less likely to cut a user’s mouth than other forms of glass and thus minimises the risk of blood borne disease spreading. Spokespeople for Vancouver’s Drug Users Resource Centre (DURC) argue that not only may the use of such pipes prevent the transition to injecting drug use, having them installed at the DURC may result in users accessing treatment in the long run or at least having access to the health professionals on site.¹⁶¹³

The use of such interventions has been approved of or at least suggested for consideration by some AOD and health organisations in Victoria. Anex, recognising that there is no research studies providing incontrovertible evidence of their efficacy, stated in their submission to the Inquiry that:

1610 Mr Allan Crosthwaite, Director and Mr Stan Goma, Manager — Professional Services, The Pharmacy Guild of Australia — Victoria, Submission, 10 December 2013.

1611 See for example, Mr Simon Ruth, Director of Services, Victorian AIDS Council, Public Hearing, Melbourne, 14 October 2013; Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013; Dr David Jacka, Addiction Medicine Specialist, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014; Mr Angelo Pricolo, Chair, Strategic Harm Minimisation in Pharmacy (SHaP) Advisory Group, Pharmacy Guild of Australia — Victoria, Public Hearing, Melbourne, 3 February 2014; Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013.

1612 See Chapter 18.

1613 *Crack-pipe Vending Machines a Boon to Vancouver Users*. Accessed 20 May 2014 at: <http://www.theglobeandmail.com/news/british-columbia/crack-pipe-vending-machines-a-boon-to-vancouver-users/article16769973/>.

Vancouver Now Home to Canada’s First Crack Pipe Vending Machines. Accessed 20 May 2014 at: <http://www.theprovince.com/Vancouver+home+Canada+first+crack+pipe+vending+machines/9490689/story.html>.

The provision of smoking equipment is a harm reduction intervention for methamphetamine and ‘crack’ users that has been investigated in Canada and the US. Research with a group of people using ‘crack’ found that providing smoking equipment increased their contact with services and also caused some participants to shift from injecting to smoking (Leonard, DeRubeis et al. 2006). However, research with Australian treatment seekers found that people who injected and also smoked methamphetamine had similar rates of risky injection behaviours as those who only injected methamphetamine (McKetin, Ross et al. 2008). This means that the provision of smoking equipment may not provide a simple route to address injection-related harm; however, given the serious harms associated with injecting, it is an avenue that warrants further exploration and evaluation.¹⁶¹⁴

The differing views of witnesses to the Inquiry reflected these equivocal findings regarding the use of ice pipes.

Those that supported the [re]introduction of ice pipes stressed their benefit in not only preventing the transmission of communicable diseases and damage to health but also their potential to stop a person from transiting from smoking to injecting crystal methamphetamine. Simon Ruth from the Victorian Aids Council, for example, told the Committee:

One of the very specific things that came out of the last Victorian strategy was the banning of ice pipes, and for a lot of our agencies we would see that if you take out the opportunity to smoke a drug, then you just increase the number of people who move through to injecting a drug, so it may be counterintuitive to remove that as a method of use, because the people will then step up to the more extreme method of use. As a drug treatment provider, our goal is to stop people injecting drugs if we can, because there are all the associated harms that go along with injecting drugs around blood-borne viruses and overdose, and it is more likely to lead to addiction.¹⁶¹⁵

Similarly Dr Stefan Gruenert from Odyssey House¹⁶¹⁶ remarked that sometimes there can be unintended consequences from a specific policy direction, and in the case of banning ice pipes there had been some young people starting to use broken light bulbs to light their drug — with the attendant risks to health that could result.¹⁶¹⁷ Dr David Jacka told the Committee that he strongly supported the reintroduction of ice pipes arguing:

I think we should also be selling crack pipes rather than having banned them. If you ban a product, then people will find another way of taking that product... until we have taken one of the safest ways of using methamphetamine off the market, in a sense — well, they are still readily available through the black market — and are encouraging people to go another route, which is often injecting. I would much rather people were smoking rather than injecting.¹⁶¹⁸

However, Dr Rebecca McKetin, a specialist on methamphetamine research was more equivocal about whether the banning of ice pipes would result in a greater transition from

1614 Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013.

1615 Mr Simon Ruth, Director of Services, Victorian AIDS Council, Public Hearing, Melbourne, 14 October 2013.

1616 Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria in conversation with the Law Reform Drugs and Crime Prevention Committee, 19 October 2013

1617 Representatives of Youth Projects were also concerned about the removal of ice pipes. They commented that in addition to using broken light bulbs substituting tinfoil to smoke your ‘ice’ was also injurious to your health.

The Youth Projects representatives also believed there had been a shift from smoking to injection since the ban on ice pipes. See Ms Melanie Raymond, Chairperson, Youth Projects, Public Hearing, Melbourne, 3 February 2014; Mr Richard Michell, Manager, Youth Outreach, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

1618 Dr David Jacka, Addiction Medicine Specialist, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

Other comments in support of ice pipes or at least questioning the wisdom of their withdrawal came from Angelo Pricolo of the Pharmacy Guild of Victoria. ‘I know that crack pipes have been withdrawn from sale. Is that really a great harm minimisation strategy? It is a policing strategy, but it just pushes people towards the syringe. I would much rather somebody smoke crack than use a syringe. There are fewer evils and problems associated with smoking compared to breaking the integrity of your skin.’

Mr Angelo Pricolo, Chair, Strategic Harm Minimisation in Pharmacy (SHarP) Advisory Group, Pharmacy Guild of Australia — Victoria, Public Hearing, Melbourne, 3 February 2014.

crystal methamphetamine smoking to injecting or whether the harms would be greater because of such bans:

...I think it is a big jump for someone to move straight into injection and I do not see how having a pipe would prevent that transition from happening. In fact once people start smoking with a pipe and they become dependent they would be as likely to move on to injecting as they would anyway — What I see in the data and in interviewing people is that you get people who are both injecting and smoking, so your injectors actually smoke as well. It just depends on the context. They prefer injecting but the pipes are there so they smoke as well. Then you actually see more harm because they are using more of the drug. Personally I cannot see how banning the pipes would cause people to move to injection because it is a more confronting method of administration. The other question is: would banning pipes reduce smoking if people can make their own pipes? We do not have an answer to that.¹⁶¹⁹

Conclusion

Harm reduction is a concept that attracts a great deal of misunderstanding and even hostility, particularly in an area as contentious as approaches to minimise the harms associated with crystal methamphetamine. This seems to stem from the fact that harm reduction would appear to mean different things to different people. It also runs the risk of being loaded down with ideological meanings across the political spectrum that have little to do with what the term or the concept actually means — for example, that reducing harm equates with condoning or even encouraging drug use. Yet harm reduction principles at both Commonwealth and state levels have been an accepted part of drug policy across the political divide for many years now. As long ago as 1998 the former Drugs and Crime Prevention Committee of the Victorian Parliament wrote the following in its Occasional Paper on harm minimisation principles:

A comprehensive and complex drug strategy will succeed in minimising harm only if it also has the capacity to manage those things that threaten its continued viability. Different threats will arise in different ways at different times, and strong social and political vigilance and commitment to harm-minimisation will be needed to overcome them as they arise. But two major forms of threat are worth explicitly noting here: (i) objections to a harm-minimisation approach that result from misinformation or misunderstanding of its meaning and purposes; and (ii) the public misperception that the ‘use-tolerant’ dimension of harm-minimisation constitutes an official acceptance of drug use, with the effect that this acts to normalise that use.

To address both threats, a harm-minimisation framework should come bundled with appropriately targeted public education that outlines the motives, rationales and processes of harm-minimisation, and also seeks to redress any inadvertent normalisation of drug use that “use-tolerant” harm-reduction might engender (Drugs and Crime Prevention Committee 1998, p.18).

These words are arguably as true today as they were when written. Sixteen years later this Committee (Law Reform, Drugs and Crime Prevention Committee) would simply add that any program that applies harm reduction principles of any kind should be supported by appropriate research, evaluation, training and a planned and coordinated approach. Moreover, it needs to be remembered that for some drug users, particularly those who have become dependent, intensive treatment interventions may be the only long-term options left to address that person’s use. The problematic area of treatment for methamphetamine users is therefore covered in the next Part of this Report.

¹⁶¹⁹ Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

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.

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.

PART H

Treatment Issues

27. Barriers to and Challenges for Treatment

Introduction

The majority of people who use methamphetamine do not require intensive treatment,¹⁶²⁰ however attracting and retaining people who are experiencing methamphetamine-related problems into specialist drug treatment centres, including those who are dependent on methamphetamine, presents a significant challenge for alcohol and other drug services.

Related to this challenge and the barriers that need to be overcome, is determining the percentage of methamphetamine users who require treatment for dependency and other issues related to their drug use, and whether this rate is increasing. This then informs the discussion on challenges and the development of appropriate strategies to meet them.

The chapter begins by outlining the extent to which users require treatment and the nature of their needs. It then discusses in detail the various barriers and challenges which confront users in seeking treatment, as well as those facing health workers in attracting dependent users into treatment, particularly at an early stage of their use, and providing appropriate services.

Extent and needs of users seeking or in treatment

Whilst there are no recent published data on the rates of dependence on methamphetamine users, the 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 (Australian Institute of Health & Welfare (AIHW) 2014), which is likely to indicate dependence. The rate among crystalline methamphetamine users is likely to be higher given its greater potency and the routes of administration, which are associated with higher risks of dependence (McKetin, Ross et al. 2008).

Data from the National Minimum Dataset (NMDS) (AIHW 2013c) for alcohol and other drugs (AOD) shows that people whose primary drug of concern is methamphetamine are presenting for treatment in greater numbers in Victoria than in previous years. According to the written submission from the AIHW, the number of closed treatment (completed) episodes for amphetamine use nearly doubled in recent years, increasing from 2,666 (5.4% of all closed drug treatment episodes) in 2009-2010 to 4,876 (9.8% of all closed drug treatment episodes) in 2011-2012.¹⁶²¹ Therefore methamphetamine users have increased the rate at which they seek treatment and now appear to be seeking treatment at a rate that reflects the level of dependence in the community.

¹⁶²⁰ As Dr Nick Thomson, Research Fellow School of Population and Global Health and Field Director, Whole of Victorian Government Hotspots Project, University of Melbourne, told the Inquiry at a Public Hearing in Melbourne on 24 March 2014: 'Because we are so conditioned to talk about drug use and therefore its need for treatment, we always contextualise drug use through a treatment paradigm. So anyone who uses amphetamine must need treatment. Reality is not everyone does need treatment, so we adapted a WHO brief intervention screening test to sort of assess what level of dependence or problematic use the amphetamine users were experiencing. According to the governments in the region, anyone who was using drugs required treatment. If you really look at it, 1½ percent of people actually required some form of treatment.'

¹⁶²¹ Mr David Kalisch, Director, Australian Institute of Health and Welfare, Submission, 23 January 2014.

Dr Belinda Lloyd from Turning Point Alcohol and Drug Centre told the Inquiry of an increase in calls to Victoria's AOD telephone helpline *DirectLine* from people with methamphetamine-related concerns:

We have seen a real increase over the past few years in stimulant-related and amphetamine-related calls, and that is really driven by crystal methamphetamine concerns. As you can see, there is a really substantial increase from 2011 to 2012. It is not the most common reason for people to call, but it is certainly increasing quite substantially. That will be influenced by a range of things, such as the increasing use in harm we are seeing at a population level, but also because people are more likely to call and seek information when they are more aware of the drug. People here may not necessarily be seeking treatment but they may be seeking information about the drug, the effects of the drug and what to do if they are concerned about their use.¹⁶²²

Of all closed treatment episodes for amphetamine use in 2011-2012, 59.1% were counselling, 17.2% were withdrawal management, 11.1% were support and case management, 7.5% were assessment only, and 4.6% were rehabilitation.¹⁶²³ These data were supported by submissions from treatment services.¹⁶²⁴

In his submission Dr Stefan Gruenert, CEO of Odyssey House advised that:

Over the past three years, there has been a 110% increase in the proportion of clients presenting to Odyssey House Victoria (OHV) for help with amphetamine problems, rising from 10% in 2010 to 21% in 2013. Some of those presenting with Ice problems appear to be younger and from a higher socio-economic demographic group, less commonly seen in public drug treatment programs for illicit drug use.¹⁶²⁵

Mr Laurence Alvis, Chief Executive Officer, UnitingCare ReGen also noted an increase in methamphetamine users seeking treatment:

Probably for the last two years methamphetamine has been certainly the fastest growing drug that we have been seeing people in treatment for. It was about 5 percent five years ago. Up to two years ago it just maintained its level...about 6 percent of people were seeking treatment for methamphetamine. Two years ago it jumped to 12 percent, and in the last quarter of this year that we have just had — finishing 30 June 2013 — the numbers were up to about 14 percent.¹⁶²⁶

Table 27.1 compares methamphetamine treatment outcomes to that of other main drug types. Compared to other drug users, methamphetamine users complete treatment at about the average rate of other drug users, spend about the same median days in treatment for all treatment and for counselling.

1622 Dr Belinda Lloyd, Strategic Lead, Population Health Research, Turning Point Alcohol and Drug Centre, told the Inquiry at a Public Hearing, in Melbourne, 30 September 2013.

1623 Mr David Kalisch, Director, The Australian Institute of Health and Welfare, Submission, 23 January 2014.

1624 Also see Mr Terry Robinson, Co-ordinator, Barwon Youth, Public Hearing, Geelong, 28 October 2013; Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013; Ms Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013; Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Public Hearing, Traralgon, 28 January 2014.

1625 Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, Submission, 21 October 2013.

1626 Mr Laurence Alvis, Chief Executive Officer, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013. See also written submission from Mr Laurence Alvis, Chief Executive Officer, UnitingCare ReGen, Submission, 11 April 2014.

Table 27.1: Comparison of methamphetamine treatment outcomes to that of other main drug types

	% completed treatment	Median days in treatment	Median days in counselling
Methamphetamine	62	26	53
Cannabis	70	24	52
Heroin	58	32	67
Alcohol	66	25	62
Overall mean	64	27	59

Source: National Minimum dataset 2011-12.

These data suggest that potentially dependent methamphetamine users come into treatment at about the rate expected, if not a little higher, and that once engaged in treatment, methamphetamine users do about as well as other users on the main treatment outcome indicators available.

The need for earlier engagement with treatment

However, as Figure 27.1 shows, the time between first regular use and first problems is very short on average (around six or seven months) but the time between first experiencing problems and first methamphetamine-related treatment is at least five years. In that intervening five years, methamphetamine users reported experiencing significant mental health problems and seeking mental health treatment.

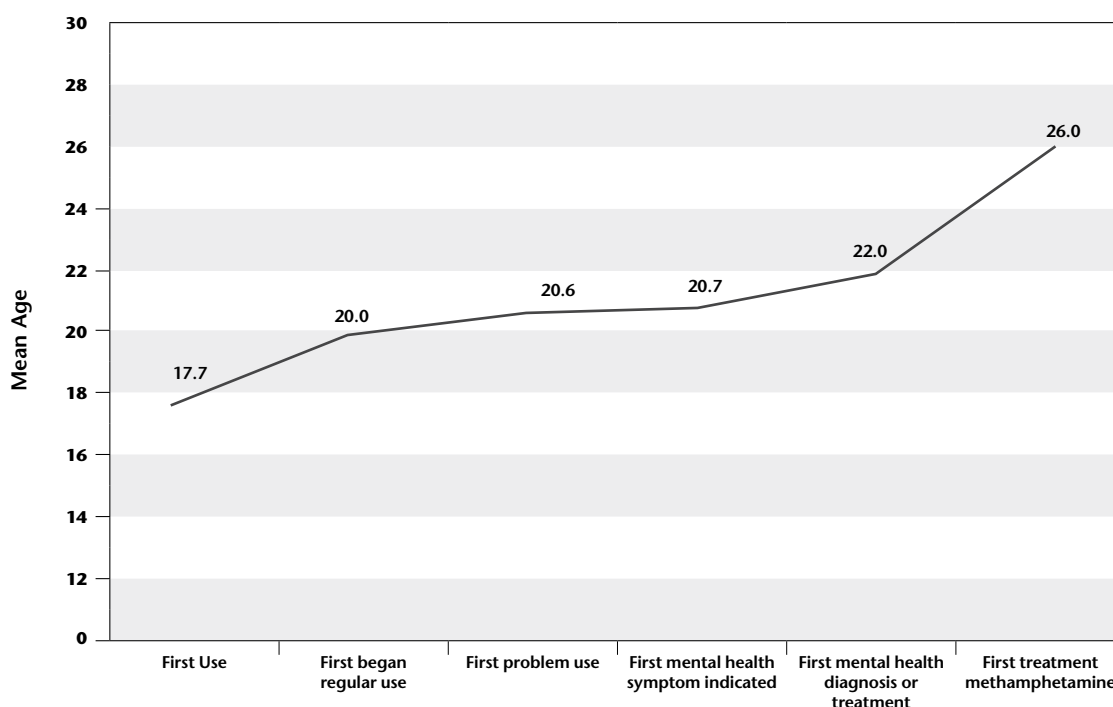
This means that in general, regular methamphetamine users are likely to experience a range of problems quite quickly but tend to wait until those problems are quite severe before they enter treatment. So while methamphetamine users come into treatment at around the expected rate and stay in treatment as long as other illicit drug clients, they may present with greater severity of symptoms than other types of user. Therefore *earlier* engagement of regular users into treatment could have a significant preventative outcome.

The severity of presentation and its impact on health services is supported by testimony from a number of witnesses. For example, Ms Donna Ribton-Turner from Uniting Care ReGen said:

... a lot of people who are using amphetamines do not come into treatment, and that is absolutely true. We are concerned about the group that is now coming into treatment, and they are a very challenging group. They are challenging because of their behaviours not only while they are intoxicated but also during withdrawal. They are aggressive, and we have seen a real increase in the number of violent incidents that we are dealing with around methamphetamine withdrawal.¹⁶²⁷

¹⁶²⁷ Ms Donna Ribton-Turner, Director, Clinical Services, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013.

Figure 27.1: Temporal relationship between methamphetamine use and first drug treatment



Source: Lee, Harney & Pennay 2012, pp.23-31.

Given the importance of treating methamphetamine users in the early stages of their use, the following section examines the various reasons why people delay seeking treatment, or do not seek it, and how these can be addressed.

Barriers to people seeking treatment

The perceptions of people about their use

Research shows that many regular users of methamphetamine are often unaware of methamphetamine-related problems until the problems became severe; choose to self-manage withdrawal from methamphetamine in the first instance; and believe that treatment services primarily target users of other drug types such as heroin and alcohol and are therefore unable to meet their specific needs (Kenny, Harney et al. 2011).

A recent study with methamphetamine users in Melbourne (Quinn, Stoové et al. 2013), reported similar findings to those reported by Kenny and colleagues. Professor Paul Dietze from the Burnet Institute, a member of the research team, told the Inquiry:

I guess the most common reason we were able to identify in our study of treatment service use was that most people basically felt they did not have a problem. The sorts of things that predicted them not being in contact with services and thinking they were okay were things like being employed and using the drug less frequently. Not surprisingly, if you are able to manage your use and so forth, then people are going to think that they really do not have a problem, but half of those people were methamphetamine dependent according to the measures we were using.¹⁶²⁸

The reluctance of users to seek professional assistance early, when their problems are less severe, is by no means a new phenomenon. Research conducted in the 1990s with people who used amphetamine in South Australia found that people preferred to self-manage issues

¹⁶²⁸ 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.

initially. It was not until they experienced significant depression and aggressive outbursts that they were prompted to ask for professional help (Vincent, Shoobridge et al. 1999).

The belief by some users that they can self-medicate their problem and are not dependent was an issue also raised by Dr Anshuman Pant from South West Healthcare in Warrnambool:

The other thing was the attracting methamphetamine users. We are not really geared up for methamphetamine, the reason being because most of methamphetamine users when they come down and crash, they self-medicate with alcohol and benzodiazepines. They do not really feel the need to have an inpatient detox like opioid dependent users or the benzodiazepine dependent users or alcohol dependent users. I have bed patients saying, 'I don't want to be with junkies'.¹⁶²⁹

Similar issues were raised by several witnesses to the Inquiry.¹⁶³⁰

Relationship between consumers and treatment providers

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. The importance of the relationship developed between treatment provider and client to positive outcomes from psychological therapy, known as 'therapeutic alliance', is widely described (Leahy 2008). There are several key ingredients that facilitate the development of a therapeutic alliance, two of which rely on the worker clearly communicating to the client a belief in the effectiveness of treatment, and a belief that the client can achieve her or his treatment goals.

However, research conducted with 24 AOD workers from metropolitan, rural and regional Australia into their perceptions of treatment for methamphetamine withdrawal showed that providers are pessimistic about treatment outcomes; for example one treatment provider in that study said: 'It [methamphetamine treatment] just doesn't work and they know it. It's the only group who I have complete failure with. It exasperates and disheartens me' (Pennay & Lee 2009, p.638).

In discussing the differences in patterns of methamphetamine use and the attitudes of people seeking treatment, Dr Rodger Brough observed:

I think one of the reasons why — sometimes users are under-appreciated for what they know, they are not stupid. One of the things they know is that we do not have specific medications and drugs that are going to be helpful for amphetamine withdrawal specifically or for longer-term management. That is one of the reasons why they do not front up. I suspect too that it is associated with the party scene and the younger age groups who are perhaps a little more reluctant to seek out help from traditional medical services too.¹⁶³¹

Participants in this study also identified the behavioural characteristics of some people who use methamphetamine — described as 'impulsive', 'erratic', 'chaotic', 'and unpredictable' — as barriers to providing withdrawal treatment. Evidence to the Inquiry also reflected this view. For example, Ms Debbie Stoneman told the Committee that extra effort is required to build alliances with people who use methamphetamine:

I find that people who are using ice are so much more chaotic and it is sometimes more difficult to build a rapport with them. If we are in a situation where we can spend the time to build that rapport,

1629 Dr Anshuman Pant, Director of Psychiatry, South West Healthcare, Public Hearing, Warrnambool, 3 March 2014.

1630 See evidence from Dr Amy Pennay, Senior Research Fellow, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013; Ms Kerstin Bichel, Manager AOD Service, Gippsland Lakes Community Health Centre, Public Hearing, Traralgon, 28 January 2014.

1631 Dr Rodger Brough, Drug and Alcohol Physician, South West Healthcare, Public Hearing, Warrnambool, 3 March 2014.

then we can explain that, 'Our job is not to then ring the police to let them know that you're using'. Then we can elicit all of that information and run with the treatment.¹⁶³²

The findings from the Pennay and Lee study were also referred to by Dr Karen Adams from the Victorian Aboriginal Community Controlled Health Organisation in a submission to the Inquiry:

The authors suggest that AOD service providers are not clear about the best way to respond to clients seeking methamphetamine withdrawal treatment and identified general pessimism about withdrawal treatment for this group. The authors concluded that treatment services should consider improving withdrawal protocols, educating clinicians and reconsidering entry criteria to better respond to methamphetamine users who have made the important first step into withdrawal treatment.¹⁶³³

The lack of clarity of service providers is also demonstrated in testimony from Ms Belinda McNair, Salvation Army, Kardinia:

There are some in the sector that would argue there is no clinical evidence to demonstrate a withdrawal syndrome for amphetamines... Up until very recently there was still a couple of detox services not taking clients for amphetamine withdrawal because their view was there is no clinical evidence to demonstrate there is a withdrawal syndrome. We would certainly argue — and most people that I would speak to in the sector would argue — that there is definitely a withdrawal syndrome...¹⁶³⁴

If treatment is to be effective then it is crucial for AOD workers to be well trained and have a positive attitude towards treatment outcomes.¹⁶³⁵

Waiting lists for treatment and withdrawal

Waiting to access treatment was identified as a significant barrier by many witnesses to the Inquiry. Lack of timely responses by services with limited capacity was also suggested to result in missing a crucial window period in which a person may be ready for treatment, as motivation often quickly wanes.¹⁶³⁶ While this is true for any person who seeks treatment for AOD use in general, waiting for treatment may be even more problematic for people who use methamphetamine regularly due to problems with focusing attention, controlling impulses, and the intense cravings to use the drug often experienced in early abstinence. With the increase in demand for methamphetamine treatment, and the longer time required for treatment, growing waiting lists seem inevitable.

Many service providers and users gave evidence to the Inquiry about the waiting lists for services. Donna Ribton-Turner from UnitingCare ReGen noted that the few services that have specific methamphetamine programs continue to have long waiting lists across their services:

Given that ReGen is one of the few services that are taking people into our residential services, we experience waiting lists — up to two weeks sometimes to have an assessment, and that is not a bed. We have got a six-week wait for counselling, and we have got fourteen people unallocated who have been referred to us through forensic services for counselling, so there is an additional demand created by this group.¹⁶³⁷

1632 Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

1633 Dr Karen Adams, Researcher, Victorian Aboriginal Community Controlled Health Organisation, Submission, 18 October 2013.

1634 Ms Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013.

1635 Workforce development strategies outlined in Chapter 25 may assist with supporting the workforce and increasing optimism about responding to methamphetamine users.

1636 See for example Ms Leanne Dellar, Nurse Unit Manager, Emergency, Mildura Base Hospital, Public Hearing, Mildura, 5 December 2013; Dr Tony Chan, Emergency Department Director, Latrobe Regional Hospital, Public Hearing, Traralgon, 28 January 2014; Mr Bill Wilson, Youth Outreach, Alcohol, Tobacco and Other Drugs Team, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014.

1637 Ms Donna Ribton-Turner, Director, Clinical Services, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013.

The problem is especially concerning in the rural and regional areas. Mr Robyn Reeves from Ballarat Community Health Centre noted:

Currently there are no detox facilities apart from some youth detox throughout the entire Grampians region and the same thing applies for rehabilitation services, so we have staff spending a great deal of time transporting people around the state, but if people are forced to leave their family support, the opportunities for them to access treatment and to access that support that they need is really quite remote, particularly if they are employed and they need to be maintaining their employment.¹⁶³⁸

Ms Stoneman from Latrobe Community Health Services expressed a similar view:

When we look at hospital admissions for withdrawal, we are limited in this region to be able to admit a person to a local hospital primarily for a withdrawal, and of course beds are at such a premium that often we cannot keep people in hospital long enough anyway to get through a withdrawal.¹⁶³⁹

And Ms Kline from Wathaurong Aboriginal Co-operative also highlighted the lengthy waiting list:

For me to get someone into detox at the moment is about a six-week wait. That is what you are looking at. Then there could be a three-month wait on rehabilitation. There is definitely a lack of services and a big gap.¹⁶⁴⁰

Strategies for demand management to reduce wait times

The Committee notes that in 2008 the Victorian Government released a report entitled 'Towards a demand management framework for community health services' (Department of Human Services (DHS) 2008) that outlined some systems-wide demand management strategies that are suitable for alcohol and other drug services. These included:

1. Prioritisation of clients

A range of strategies have been proposed to reduce waiting lists. This is achievable through effective triage to ensure allocation to the right service, prioritisation based on risk and need and prioritisation based on specific high risk groups, including complex needs.

2. Active management of waiting lists by:

- Providing written information to the client about anticipated wait times, how to initiate a review of their place in the waitlist, who to contact and how, and options for interim management
- Staying in contact with the client by calling those on the waiting list at regular intervals to ensure their contact details are up-to-date or that their circumstances have not changed.

3. Appointment processes

Well-functioning appointment processes can assist with reducing waitlists through reduced non-attendance. Non-attendances policies and procedures, clearly communicated to clients can assist. Recall and review processes and assertive follow-up procedures for complex clients can help reduce crisis presentations.

4. Models of service delivery

A range of service delivery responses can assist in reducing wait times, including:

- Goal focused intervention
- Evidence based practice

¹⁶³⁸ Ms Robyn Reeves, Chief Executive Officer, Ballarat Community Health Centre, Public Hearing, Ballarat, 18 November 2013.

¹⁶³⁹ Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

¹⁶⁴⁰ Ms Kit-e Kline, Drug and Alcohol Worker, Wathaurong Aboriginal Co-Operative, Public Hearing, Geelong, 28 October 2013.

- Group information sessions for clients prior to treatment
- Single session therapy
- Access to group therapy
- Access to self-help and self-management programs
- Multidisciplinary collaboration
- Ensuring the workforce is effectively utilised to accommodate the clients entering treatment.

5. Outflow and exit procedures

Strategies that may assist with maintaining throughput include:

- Effective referral to other services
- Regular review of the need for ongoing treatment
- Exiting intervention for clients who are no longer able to benefit from further intervention.

Implementing these strategies across alcohol and drug services (not just for methamphetamine users) can assist in improving flow through and greater capacity to attend to people on the waiting list, potentially reducing waiting times and enabling greater access to treatment, thereby reducing one of the main barriers to access. The extent to which services have implemented these strategies is unclear. Review and application of this policy is the first step in services reducing waiting lists and increasing access to methamphetamine users (and others). Such a review and application of this policy also presents an immediate opportunity to address this barrier to early treatment access without requiring additional funding. Services that have flexibility to trial new models of service delivery within their existing funding arrangements should measure waiting list times as an outcome.

Services are not always orientated to the needs of people who use methamphetamine

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.

Structural issues could include: difficulty navigating the treatment sector; an appointment system for assessment and counselling sessions; lengthy periods of time in open waiting rooms, particularly during peak periods and those which are highly stimulating and noisy (e.g. television on, children present, multiple people coming and going); and lengthy waiting lists for appointments, to name a few.

A number of witnesses to the Inquiry highlighted ways that traditional services may pose a barrier for people who use methamphetamine. The Committee was advised by Ms Donna Ribton-Turner:

I think it is the fact that people are only really now just coming into treatment. We have not had much experience with methamphetamine users in treatment, which is why I think nothing has happened in terms of working out what is the best treatment.¹⁶⁴¹

The Committee also heard from Ms Leanne Dellar, Nurse Unit Manager, Emergency, Mildura Base Hospital that:

¹⁶⁴¹ Ms Donna Ribton-Turner, Director, Clinical Services, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013.

There is only a small window of opportunity for most of these clients to actually access the service. It takes some time for them to be willing and physically able to come forward and say, 'I need to access the service', and to be accepting of that. The waiting lists are things that often are at odds with those sorts of decisions once the clients make them. To refer someone locally to our drug and alcohol services is not an immediate referral. Oftentimes they will not be seen this week, let alone next week or, sometimes, the week after, depending on the availability of staff. So that very small window of opportunity that you have when a client determines that they are ready for treatment is oftentimes at odds with what we can do for them, purely because of the lack of resources that are available to refer them to. One of the best things we could have as an outcome is that referral services were more resourced to provide response in a timely fashion.¹⁶⁴²

Also Dr Amy Pennay, Senior Research Fellow, Turning Point Alcohol and Drug Centre stated that:

Our current treatment system is really geared to deal with alcohol and heroin problems because they are the issues that they have historically seen. Methamphetamine users feel that there is a lot of stigma going into a treatment service that is usually full of heroin users; they do not want to go. Dr Frei talked about the typical methamphetamine user being more likely to be employed. We need to think a little more carefully about the way treatment services can respond to methamphetamine users.¹⁶⁴³

Adapting clinical practice to better meet the needs of people who use methamphetamine

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.

As an example, in evidence to the Inquiry Ms Donna Ribton-Turner noted some simple changes that UnitingCare ReGen, a mainstream service, has made to services in relation to withdrawal processes to better accommodate methamphetamine users.

We have changed the program so that people can crash for that first few days, and we have gone right back to basic nursing care — giving people fluids and food and keeping them in a low-stimulus environment for the first three days, and then gradually introducing a much lower stimulus program. We are offering 10-day admissions, but even something like that has the capacity to reduce our throughput by about 200 episodes a year, and we are trialling a step-up, step-down approach, where someone can step down to non-residential withdrawal support, which needs to be for at least four to six weeks after, because they are still experiencing withdrawal systems in that period.¹⁶⁴⁴

As Dr Stefan Gruenert indicated in a submission to the Inquiry:

Treatment services generally need to make small changes to accommodate the needs of amphetamine users. These changes are especially important early on in treatment, where disrupted sleep patterns, anxiety and agitation require greater flexibility in treatment expectations, routines, use of medication and a longer period of withdrawal than for other drugs.¹⁶⁴⁵

Helpful adjustments could include appointment reminders, shorter and more frequent sessions, simplified content of sessions, using visual aids to impart important information, and teaching emotion regulation skills in the context of managing mental health and mood swings. An emphasis on assisting people to recognise and focus on natural reinforcers

¹⁶⁴² Ms Leanne Dellar, Nurse Unit Manager, Emergency, Mildura Base Hospital, Public Hearing, Mildura, 5 December 2013.

¹⁶⁴³ Dr Amy Pennay, Senior Research Fellow, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

¹⁶⁴⁴ Ms Donna Ribton-Turner, Director, Clinical Services, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013.

¹⁶⁴⁵ Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, Submission, 21 October 2013.

(including social supports) has been recommended as part of treatment for all drug use problems (Volkow & Li 2004), and may be particularly relevant for people who are newly abstinent from methamphetamine. As Ms Belinda McNair told the Inquiry, people in early abstinence have a similar presentation to those with Acquired Brain Injury and require constant reminders to engage in planned activities.¹⁶⁴⁶

Services could also consider strategies for an immediate response to treatment-seeking such as brief advice or single session clinics, using a structured drop-in model, to foster engagement if waiting lists for access to specialist treatment are lengthy. In addition, as a significant proportion of methamphetamine users are employed, offering after hours appointments may be helpful. Similarly, providing a dedicated and separate counselling room and/or appointment times for counselling, and promoting the service to the local community as a provider that specialises in the treatment of methamphetamine problems, may help to increase opportunities for earlier intervention. Assertive follow-up for missed appointments, or reminders to keep appointments, can also assist in retaining people in care (see for example, Pennay et al. 2010).

Throughout the Inquiry the AOD services informed the Committee that they adjust their services to take into account the needs and concerns of family members.¹⁶⁴⁷

Learning from a specialist methamphetamine treatment service to overcome barriers in mainstream services

Turning Point Alcohol and Drug Centre in collaboration with Access Health established 'Access Point' specialist methamphetamine clinic in Melbourne in 2007 (discussed in Chapter 28).

Some of the key features of the model were:

- ◆ A separate waiting area to mainstream drug treatment services
- ◆ A separate telephone number to mainstream treatment services
- ◆ A separate website to mainstream treatment services
- ◆ Multidisciplinary team of specialists in stimulant treatment
- ◆ A clinical case management model — clinical case management combines clinical intervention with case management services
- ◆ Counselling based on Baker et al's best practice 4 session intervention
- ◆ Extended hours services.

While this intensive specialist model may not be financially feasible to establish throughout Victoria, some of the features of the Access Point model can be drawn upon in mainstream services to better orient service systems towards responding to methamphetamine users.

Challenges for treatment services

Providing appropriate treatment to methamphetamine users, and in a timely fashion, faces many challenges. These include dealing with people affected by neurocognitive effects, treating people who use a mix of drugs, having personnel trained specifically in treating methamphetamine users, having appropriate pharmacotherapy, mandating treatment in certain circumstances and having up-to-date and sufficient resources for treatment provision.

¹⁶⁴⁶ Ms Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013.

¹⁶⁴⁷ For further discussion see Chapter 29.

Neurocognitive effects of regular methamphetamine use and implications for treatment delivery

The extensive neurocognitive effects of methamphetamine can make treatment engagement and retention challenging for users and pose significant challenges for the delivery of treatment.¹⁶⁴⁸ Changes to the way in which treatment is offered is required to address this barrier.

As outlined in Chapter 6, long-term regular use of methamphetamine results in prolonged and artificially elevated levels of neurotransmitters (particularly dopamine), which can cause significant damage to brain structures and functions up to one year following cessation of methamphetamine use (Volkow, Chang et al. 2001).

A meta-analysis of research into the neuropsychological effects of methamphetamine use was conducted by Scott and colleagues who concluded that deficits in executive functioning (decision making and higher level planning), memory, information processing, and motor skills can occur after long-term use (Scott, Woods et al. 2007). A later study by Salo and colleagues found that people who were abstinent from methamphetamine for less than one year had difficulty focusing their attention (Salo, Nordahl et al. 2009), which in combination with other findings has implications for engaging with and delivering treatment to this discrete group. As Dr Nic Reid from Barwon Health told the Committee:

There is a huge issue of underlying cognitive function. Cognitive function is brain function. We know that methamphetamine is directly toxic to nerve studies. There is the acute intoxication in their mental state — agitation, aggression, their heart is racing, they might have palpitations, there might be a range of issues but with longer-term use, not just related to methamphetamine, but we have a few people who have escalated from solvent use who have solvent injuries, acquired brain injuries who are now using methamphetamine. The problem is that when they are well and they are clear of substances, some of the individuals do not function terribly well. To engage in treatment you have to understand there is a problem, whereas they often do not see that.¹⁶⁴⁹

Addressing methamphetamine use in the context of poly-drug use

Another challenge facing both primary care health providers and specialist treatment services is that addressing problematic methamphetamine use can be compounded by the person using the drug in the context of alcohol and/or other licit and illicit substances. As discussed in Chapter 10, poly-drug use amongst methamphetamine users is more often the norm than the exception. Depending on the nature of the compound and its interaction with methamphetamine, concomitant drug use can seriously impact upon the person's health and make treating the underlying condition difficult. For example, methamphetamine reduces the feelings of intoxication associated with alcohol, which in turn increases 'the risk of alcohol poisoning or accidents due to a false sense of feeling sober and in control' (Ali, Meena & Gowing 2012, p.221). Similarly, cannabis used in conjunction with methamphetamine has been associated with augmenting psychotic symptoms in some individuals particularly those associated with schizophrenia. Other combinations of methamphetamine and other drug use may exacerbate or heighten feelings of anxiety and depression. All these manifestations of poly-drug use will need to be addressed in formulating a plan for methamphetamine withdrawal and treatment (Jenner & Lee 2008). As Kenny et al. indicate, many methamphetamine users combine their drug use with substances such as cannabis, alcohol and heroin to compliment or interact with the effects of methamphetamine or alternatively use these drugs to help with the symptoms of crystal methamphetamine withdrawal. '[T]his indicates that treatment for methamphetamine use should incorporate a focus on other drug use' (2011, p.5).

¹⁶⁴⁸ For a discussion of these effects see Chapter 5.

¹⁶⁴⁹ Dr Nic Reid, Emergency Staff Specialist, Emergency Department, Barwon Health, Public Hearing, Geelong, 28 October 2013.

The challenge of delivering treatment services in 'silos'

Another problem associated with delivering treatment options to people with problematic substance use or dependency is that sometimes services can be delivered in 'silos'. This is particularly the case when a person may have *both* a drug-related problem and a mental health disorder. Despite such well received programs as the Victorian Dual Diagnosis Initiative, according to some witnesses who gave evidence to the Inquiry there are still some users who 'fall through the cracks'. In this respect David Giles from Anglicare Victoria told the Committee that specialist services that could address both substance abuse and mental health issues were few and far between. Moreover a service that Anglicare *had* used in the past had recently closed down and this left one of their workers who was dealing with a crystal methamphetamine dependent mother with very few avenues to utilise:

Of most frustration to our workers was the lack of availability of specialist services... A good primary mental health care service which had operated nearby to this family would have been best placed to assess and treat this woman's concurrent substance abuse and mental health problems. However, this service had been defunded and closed just prior to our worker picking up this case...

Our worker did not attempt referral to any other mental health services in the area, as she knew firsthand that the remaining services would not effectively engage this mother. Despite all the rhetoric of the no wrong door policy, many mental health services continue to insist that people experiencing concurrent mental health and drug problems deal with their substance issues before they can provide them with assistance regarding their mental health issues. The same is true in reverse, with many alcohol and other drug services insisting that people deal with their mental health problems before the substance problems can be addressed.¹⁶⁵⁰

This was also the experience of Paul Cranage, AOD Manager for Uniting Care Ballarat in terms of the interface between treatment services, Indigenous agencies and mental health workers:

One of my major concerns in relation to providing a service particularly with Indigenous services is our poor relationship with those providers. I am involved in interagency meetings for our region. We discuss issues in relation to our clients all the time and yet workers from our Indigenous services do not turn up. We continually invite people to come and talk about these issues and there is just this split in service. It is a bit of the ownership around clients. It is a real concern. We have tried a range of ways of trying to be inclusive and, for whatever reason, it has been a real challenge.

We had the same issue with mental health services a number of years ago. There seemed to be some issues around, I think, the mental health services not respecting drug and alcohol workers. I think what has changed that is the increase in education for drug and alcohol workers to have a higher standard of knowledge. It is a concern. We have had workers provide supervision to Indigenous services for their workers in the past, but it continually seems to fall over. I have not got a good answer for that. It is something that we have really struggled with in Ballarat for a number of years. We have certainly tried to be very inclusive but it has been very difficult.¹⁶⁵¹

As indicated in the quote from Mr Cranage, part of the problem may relate to insufficient training and workforce development for AOD, mental health and other workers particularly with regard to issues that are so interrelated to their own areas of expertise.¹⁶⁵²

1650 Mr David Giles, General Manager, Family and Community Services, Anglicare Victoria, Public Hearing, Melbourne, 3 February 2014.

1651 Mr Peter Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013.

See also the comments of Mr James Dale, Acquired Brain Injury and Alcohol and Other Drug Clinical Consultant, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

1652 On the issue of the need for comprehensive training and workforce development generally to address methamphetamine use, see the discussion in Chapter 25.

Lack of approved pharmacotherapy to treat methamphetamine dependence

In the context of alcohol and drug treatment, pharmacotherapy refers to the management of substance dependence with medicines approved for the specific purpose. Methadone, buprenorphine and buprenorphine-naloxone combination, have been the mainstay of maintenance (or substitution) treatment for heroin and opioid dependence in Australia for decades. Methadone and buprenorphine are functional agonist medicines, meaning they possess similar properties to opioids, bind to the same receptors in the brain, and exert a similar effect for the person taking them (although it is much less intense). Through these mechanisms, a 'stable' dose is achieved when opioid withdrawal symptoms are eliminated and cravings to use diminish. Nicotine replacement therapies (NRT) such as nicotine patches and gums, are also agonist therapies and work in similar ways to opioid agonists, that is by reducing nicotine withdrawal symptoms and cravings.

In a recent review of the literature, Brensilver and colleagues described three main targets for pharmacotherapies:

1. The biological mechanisms that maintain a person's desire to use drugs including the reward pathway in the central nervous system;
2. Withdrawal symptoms and cravings that also serve to maintain drug use; and
3. Co-occurring mental health problems that complicate drug treatment (Brensilver, Johnson et al. 2012).

Pharmacotherapies are also available to treat alcohol dependence (e.g. acamprosate, naltrexone and disulfiram),¹⁶⁵³ and while they are not agonist type medicines, they nevertheless act to reduce cravings to drink and block the reinforcing effects of alcohol.

There is extensive evidence for the benefits of opioid pharmacotherapies in not only reducing heroin use, but in improving people's health and wellbeing on a range of important indicators, including reducing risks related to injecting, reducing crime, improving quality of life, retaining people in drug treatment and preventing relapse (Kimber, Copeland et al. 2010). NRT has also been shown in multiple studies to help quit smoking (Cahill, Stevens et al. 2013).

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 (Brensilver, Johnson et al. 2012).

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.

Several witnesses highlighted some of the problems with the pharmacotherapy trials to date. For example, Dr Rebecca McKetin from the Australian National University told the Committee:

¹⁶⁵³ Disulfiram is an 'aversive agent' that acts by inhibiting alcohol dehydrogenase that is required for alcohol metabolism, resulting in severe adverse reactions such as intense headache, flushes and vomiting, should alcohol be consumed.

The substitution therapy issue is a complex one. We like the idea because it has worked well for heroin with methadone and buprenorphine, but stimulant use is quite a different beast and there are a lot of questions about whether providing substitution therapy for stimulant use will actually work because you are putting someone on a stimulant drug every day and what you tend to see are a lot of side-effects. It increases the risk of heart attack and it exacerbates the risk of psychosis. There are a lot of problems with substitution therapy.¹⁶⁵⁴

Mr Alan Fisher from Albury–Wodonga Health described the difficulties faced in trying to replace the intensely euphoric effects of methamphetamine with a prescribed medicine:

Dexamphetamine has been trialled in an attempt to replace the methamphetamine. It is a bit of a David and Goliath because dexamphetamine has problems in the sense that there are very stringent prescribing requirements. They did get some dispensation but the outcomes were not good and there were trials in England some years ago and they were not that favourable, simply because you need so much amphetamine to replace the equivalent of methamphetamine. At this stage with the current drugs that are available it is not, from what I have seen, looking very promising. That is not to say that down the road there will be a long-acting pharmaceutical amphetamine that can carry people through 12 hours or 24 hours between getting dispensed the drug. A little bit of dexamphetamine does not really make up for lot of methamphetamine. People are using \$300 or \$400 a day injecting it. It is pretty hard to compete with that with an oral tablet which is relatively low strength.¹⁶⁵⁵

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.¹⁶⁵⁶ The lack of available pharmacotherapy was also identified as a potential barrier for people seeking treatment. Dr Yvonne Bonomo from the Royal Women’s Hospital told the Inquiry that the absence of pharmacological treatment options may also affect referral practices:

The bottom line is that engagement in treatment earlier rather than later improves outcomes. Unlike with heroin and other opiates, where we have methadone and buprenorphine to offer people, there is not a specific pharmacotherapy for ice use yet. I think that might be why a lot of people think it is not worth referring to a treatment service, and I think a lot of women do not engage in services because they think, ‘Well, there’s nothing in it for me, and if anything there is a risk because of potentially disclosing the substances being used’.¹⁶⁵⁷

Mr Gino Vumbaca, Executive Director of the Australian National Council on Drugs (ANCD)¹⁶⁵⁸ told the Inquiry that the ANCD had commissioned a systematic review of the evidence for the use of medicines to treat amphetamine-type stimulant dependence and withdrawal. The report discusses the range of drug trials in some detail and will be released in the near future. The review found that drugs such as dexamphetamine, modafinil, bupropion, methylphenidate and naltrexone showed promise in the treatment of methamphetamine dependence for some people under controlled research conditions, however further investigation is required (Lee, Jenner & Nielsen, in press).

1654 Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

1655 Mr Alan Fisher, Clinical Leader, Drug and Alcohol Community Treatment Services, Albury Wodonga Health, Public Hearing, Wodonga, 24 February 2014.

1656 See testimony of Mr Eion May, Alcohol and Drug Worker, Gippsland Lakes Community Health Centre, Public Hearing, Traralgon, 28 January 2014; Ms Kerstin Bichel, Manager AOD Service, Gippsland Lakes Community Health Centre, Public Hearing, Traralgon, 28 January 2014; Ms Melissa Lonsdale, Team Leader, Drug Treatment Services, Sunraysia Community Health Services, Public Hearing, Mildura, 5 December 2013; Ms Mary Bassi, Manager, Primary Health, Sunraysia Community Health Services, Public Hearing, Mildura, 5 December 2013; Mr Bill Wilson, Youth Outreach, Alcohol, Tobacco and Other Drugs Team, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014; Ms Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013.

1657 Dr Yvonne Bonomo, Addiction Specialist, Royal Women’s Hospital Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

1658 Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014.

Mandated treatment for methamphetamine use

A challenge raised during the Inquiry is whether there are circumstances that warrant compulsory treatment for meth users. Mandated or compulsory drug treatment refers to treatment that is directed by legislation, usually in lieu of justice-focused sanctions, such as prison. There are a variety of types of compulsory treatment, including pre-arrest police diversion, post-conviction diversion through the general or specialist drug courts, prison pre-release programs, as well as various acts that authorise police to detain drug-dependent people for assessment and treatment.¹⁶⁵⁹ An example of the latter is the *Severe Substance Dependence Treatment Act 2010 (Vic)* (the SSDTA). The SSDTA is civil legislation that allows in certain circumstances a person to be detained and provided with treatment for their drug dependence. Under Section 3 of the Act such detention and treatment should only be initiated when it is necessary to save the life of a person with severe substance dependence or to prevent serious damage to that person's health. Under the objectives of the Act, such a measure is to be considered a 'last resort' and only applicable if there is no less restrictive means reasonably available to ensure the person receives required treatment.^{1660 1661}

There are cases, however, where the person's drug dependence although serious, may not be of sufficient severity to give rise to action under the SSDTA. For example, the user's life or health may not be in immediate danger. The person may, however, be still manifesting chaotic and disturbing behaviour. For some family members who gave evidence to the 'forced' treatment it is viewed as the only way in which the user can get much needed assistance. For example, Kerryn Johnston the mother of a young woman with a serious methamphetamine dependency, told the Committee:

My biggest problem is that [my daughter] she does not think she needs help but if he [an arresting police officer] had been able to put her in a van, take her to the rehabilitation place and say, 'This is what you have to do,' it might have been an opening for her but she was let go, and I had to let her go and there is nothing you can do.¹⁶⁶²

Similarly, Darlene Sanders from Mildura told the Committee that she wished her son had been forcibly put into treatment by the magistrate who sentenced him for crimes associated with his ice use:

I would like to see the law changed that makes it up to them if they go to rehab. I have said to a magistrate, 'That should not be their choice', because it is not our choice to put up with their drug addict behaviour. For me, that law needs to be changed. If they have said, 'You're going to rehab', you need to go to rehab and that is it. You do not get a say in it.¹⁶⁶³

And Rob McGlashan from Project Ice in Mildura told the Committee that, 'A lot of family members are ringing us and saying, 'We need them [family members who use ice] to be picked up and taken to treatment against their will — yet there is no mechanism to do this at the moment'¹⁶⁶⁴

1659 See also, Pritchard et al. 2007 for a review and detailed description of compulsory treatment options across Australia.

1660 Section 8, SSDTA (Vic).

1661 See also discussion of this legislation in Chapter 18 of this Report.

1662 Ms Kerryn Johnston, Public Hearing, Wodonga, 24 February 2014.

1663 Ms Darlene Sanders, Indigenous Engagement Officer, Mallee Family Care, Public Hearing, Mildura, 5 December 2013.

Although outside the SSDTA it is not strictly possible to *force* a person into drug treatment even as a result of a court order, a judicial officer is certainly able to impose a condition of drug treatment as an alternative to a custodial sanction. In effect it could be argued this operates as a form of *de facto* forcible treatment. See discussion in Chapter 21 on criminal justice diversion options in this context.

1664 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

As discussed in Chapter 23, however, sometimes family members do not necessarily understand or they overestimate what can be done for their loved ones in treatment.

Other family members who gave evidence *in camera* made similar observations.¹⁶⁶⁵

While treatment status (either voluntary or mandatory) has been associated with treatment outcomes, particularly as a mediator of client motivation, a review of compulsory treatment showed that both custodial and non-custodial participants who have been mandated to treatment show good clinical and forensic outcomes (Crime and Misconduct Commission (Qld) 2008). In this study, the authors estimated that an average of 65% of both mandated and voluntary clients reported reducing their drug use or harms, suggesting mandated treatment is not a significant barrier to experiencing good outcomes.

Several witnesses to the Inquiry noted that while engaging people in treatment voluntarily is philosophically preferable, good outcomes are still possible with the right approach:

Ms Macdougall from Primary Care Connect noted in her testimony:

No matter how they walk through the door, whether it is pushed or whether they step in themselves, that gives us an opportunity, and all drug treatment service is an opportunity to start doing that connection. They might come in belligerent and angry, but it is certainly our job to make them feel that we are there to work for them, and that is what we do. I think we do it quite well, and I think most of the drug treatment communities over Victoria use that opportunity; they do not let that chance go by just because they are mandated.

Similarly, this testimony from Ms Melinda Grady, Youth Worker at Barwon Youth, suggests that although motivation can be lower among mandated clients when they come into treatment, AOD workers have specific strategies they can engage to increase motivation and keep this group in treatment:

Remembering these are mandated clients, not necessarily voluntary at this point. Our aim is to engage and continue treatment... Young people find it quite interesting themselves to discover where they are at emotionally, how the drug is impacting on their health, lifestyle and their mental health... We use strategies, such as motivational interviewing which is about working out where a person is at in regard to treatment, do they want to make change or not, and if not what we can provide for them.¹⁶⁶⁶

Whatever the merits or otherwise of a system of mandated treatment for drug dependence, including crystal methamphetamine, some witnesses have pointed out to the Committee that there are substantial obstacles involved in initiating the process. For example, as Kaz Gurney, from Goulburn Valley Community Legal Centre told the Committee not only are the grounds under the SSDTA limited and the procedure for invoking it difficult and time consuming, there are also few facilities or resources available for working with mandated clients. According to Ms Gurney, De Paul House at St Vincent's Hospital in Melbourne is at this stage the only secure facility to cater for the treatment of involuntarily committed drug dependent patients.¹⁶⁶⁷

¹⁶⁶⁵ The merits or otherwise of involuntary treatment of drug dependence was also mentioned in the evidence of many witnesses. People from the AOD sector were divided between those who thought involuntary treatment was limited in value as the client was not truly motivated in such circumstances, to those who, whilst acknowledging the initial reluctance of mandated clients to seek treatment, believed they gradually receive some benefit from an enforced stay.

See for example: Mr Alan Fisher, Clinical Leader, Drug and Alcohol Community Treatment Services, Albury Wodonga Health, Public Hearing, Wodonga, 24 February 2014; Ms Di Griffin, Aboriginal Drugs and Alcohol Counsellor, Albury-Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014; Mr Gino Vumbaca, Executive Director, Australian National Council on Drugs, Public Hearing, Canberra, 11 February 2014; Ms Melissa Lonsdale, Team Leader, Drug Treatment Services, Sunraysia Community Health Services, Public Hearing, Mildura, 5 December 2013; Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013; Dr Nic Reid, Emergency Staff Specialist, Emergency Department, Barwon Health, Public Hearing, Geelong, 28 October 2013; Mr Peter Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013; Ms Kerry Donaldson, Manager, Community Programs, Youth Support and Advocacy Service, Bendigo, Public Hearing, Bendigo, 25 October 2013; Ms Cayte Hoppner, Director of Mental Health, Latrobe Regional Hospital, Public Hearing, Traralgon, 28 January 2014; Ms Eden Foster, Drug and Alcohol Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

¹⁶⁶⁶ Ms Melinda Grady, Youth Worker, Barwon Youth, Public Hearing, Geelong, 28 October 2013.

¹⁶⁶⁷ Ms Kaz Gurney, Managing Lawyer, Goulburn Valley Community Legal Centre, Public Hearing, Shepparton, 25 February 2014.

Existing resources on treatment require review and dissemination

Throughout the Inquiry there have been calls for resources for professionals to support their work with methamphetamine users. There are numerous resources currently in existence for a range of professionals including tertiary treatment providers, police, ambulance and primary care professionals. As Mr Rob McGlashan told the Inquiry:

So the recommendation is to look at more governmental direction for clinical guidelines. I know we have drug and alcohol centres, but methamphetamine is quite different in the withdrawal and treatment. With Project Ice Mildura there is no package you can pick up and say, 'This has been tested and recommended from the best sources we have available to us from Victoria or Australia. Run with this; we know that the campaign has been trialled and tested'. We are making it up as we go, and we are learning a hell of a lot along the way as well.¹⁶⁶⁸

However, evidence provided to the Inquiry suggests that many treatment providers may be unaware of the resources available to them. In addition, a significant amount of research has been undertaken in the last decade and many of these existing resources require updating.¹⁶⁶⁹

Professor Paul Dietze from the Burnett Institute told the Inquiry that existing resources for people who use methamphetamine are similarly out of date or are not user-friendly.¹⁶⁷⁰

The following list summarises the Australian resources that are currently available and their publication dates. It is notable that none 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.¹⁶⁷¹

¹⁶⁶⁸ Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

¹⁶⁶⁹ See also Mr Alan Fisher, Clinical Leader, Drug and Alcohol Community Treatment Services, Albury Wodonga Health, Public Hearing, Wodonga, 24 February 2014.

¹⁶⁷⁰ 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.

¹⁶⁷¹ For further discussion see Chapter 25.

Table 27.2: Resources currently available on methamphetamine treatment

<p>Monograph <i>Models of intervention and care for psychostimulant users — 2nd edition. Monograph Series No 51.</i> Baker, A., Lee, N.K. & Jenner, L. (eds) (2004). Australian Government Department of Health and Ageing. (Update of 1998 Monograph).</p> <p>Clinical treatment guidelines <i>A brief cognitive behavioural intervention for regular amphetamine users: a treatment guide.</i> Baker, A., Kay-Lambkin, F., Lee, N.K., Claire, A. & Jenner, L. (2003). Australian Government Department of Health and Ageing. <i>Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine dependence and treatment.</i> Lee, N.K, Johns, L., Jenkinson, R., Johnston, J., Connolly, K., Hall, K. & Cash, R. (2007). Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc. <i>Psychotherapy for methamphetamine dependence: Treatment Manual.</i> Smout, M. and The Amphetamine Treatment Project (2008), Drug and Alcohol Services South Australia.</p> <p>Withdrawal guidelines <i>Alcohol and Other Drug Withdrawal Practice Guidelines (2nd edition).</i> Frei, M., Berends, L., Kenny, P., Swan, A., Jenner, L. et al (2012) Melbourne: Turning Point Alcohol and Drug Centre.</p> <p>Guidelines for frontline workers <i>Management of Patients with Psychostimulant Toxicity: Protocols for emergency departments.</i> Queensland Health (2008). Brisbane, Queensland: Queensland Government. <i>Guidelines for the medical management of patients with methamphetamine-induced psychosis.</i> Prepared by Cassandra McIver, Catherine McGregor, Michael Baigent. David Spain, David Newcombe and Robert Ali on behalf of the Guidelines Development Working Party (2006). <i>Management of Patients with Psychostimulant Toxicity: Guidelines for emergency departments.</i> Jenner, L., Spain, D., Whyte, I., Baker, A., Carr, V.J., Crilly J. (2006). Australian Government Department of Health and Ageing. <i>Treatment approaches for users of methamphetamine: a practical guide for frontline workers.</i> Jenner, L. and Lee, N. (2008). Australian Government Department of Health and Ageing, Canberra. <i>Responding to challenging situations related to the use of psychostimulants: a practical guide for frontline workers.</i> Jenner, L. and Lee, N. (2008). Australian Government Department of Health and Ageing, Canberra. <i>Management of Patients with Psychostimulant Toxicity: Guidelines for ambulance services.</i> Jenner, L., Spain, D., Whyte, I., Baker, A., Carr, V.J., & Crilly, J. (2004). Australian Government Department of Health and Ageing. <i>Management of patients with psychostimulant use problems — Guidelines for general practitioners.</i> Australian General Practice Network. (2007). Australian Government Department of Health and Ageing. (Update of 2006 guidelines). <i>Psychostimulants — Management of Acute Behavioural Disturbances: Guidelines for police services.</i> Jenner, L., Baker, A., Whyte, I., & Carr, V. Australian Government Department of Health and Ageing (2004). Australian Government Department of Health and Ageing.</p>
--

Resource implication of longer treatment engagement

Although brief interventions¹⁶⁷² are recommended for methamphetamine users (see Baker et al. 2005), the neurocognitive effects of methamphetamine result in a potentially longer period of recovery.¹⁶⁷³ It can take up to a year or more for the brain to regain pre-use level of functioning, and relapse rates are high in that time. Therefore, while brief interventions are effective in helping users reduce and quit their methamphetamine use, longer-term case management and follow-up including after-care programs are needed.¹⁶⁷⁴ This creates a situation for services where additional resources may be required to achieve good long-term outcomes for these clients.

For withdrawal services, time available for withdrawal is based on alcohol and heroin dependence and is generally too short for methamphetamine users, resulting in a high risk of relapse.

For example, Ms Stoneman from Latrobe Community Health Services noted:

1672 For a brief discussion of brief interventions see Chapter 28.

1673 See discussion of these issues in Chapter 28.

1674 See discussion of these issues in Chapter 28.

The current withdrawal stays are set up usually at five to 10 days, and often we do not see people completing the difficult stage of their ice withdrawal for a couple of weeks. So the current withdrawal programs do not quite meet that need of these people.

However, one of the barriers for services to extending the withdrawal period to 14 days is that it reduces bed availability for other clients, reducing turnover and therefore the number of episodes of care achievable in a funding period. Alternative funding models, including funding for extended stay, may be required to better accommodate methamphetamine users in treatment and withdrawal, to reduce the barriers for services providing quality care.

Conclusion

A number of barriers and challenges exist with regard to treatment for methamphetamine use problems. These apply to clients seeking or entering treatment and service providers offering treatment. Perceptions of both clients and staff, long waiting lists for treatment and withdrawal, a lack of knowledge about existing support resources and treatment options, the neurocognitive effects of methamphetamine itself which has an impact on how well clients can engage and be retained in usual treatment modalities, and the lack of an effective pharmacotherapy limit the options for treatment.

The resources to support practitioners in their work with service consumers require revision and updating to incorporate the significant amount of research that has been conducted over the past decade. The updated resources must be accompanied by a planned dissemination strategy that includes not only training for practitioners in their use, but support for ongoing workforce development activities.

28. Best Practice Treatment and Service Provision

Introduction

People who use methamphetamine are by no means a heterogeneous group. Their demographic characteristics vary widely, as do their reasons for using methamphetamine and the ways in which they use. Though there are risks associated with the use of any substance and the short-term risks associated with the use of methamphetamine are well documented (see discussion in Chapter 6), not every person who uses methamphetamine either needs or desires specialist drug treatment. For these reasons, people need attractive, effective and accessible options to manage the continuum of adverse effects of methamphetamine use, including options that can be offered by health care providers outside of the mainstream drug treatment sector.

This chapter examines a range of approaches that have been shown to be effective for people who use methamphetamine. These include brief interventions, cognitive behaviour therapy, Acceptance and Commitment Therapy, motivational enhancement, contingency management, and residential rehabilitation. Programs that have incorporated effective elements of therapy such as Matrix and the HOPE program are also described.

Characteristics of the general population of methamphetamine users

Data from the 2010 National Drug Strategy Household Survey showed that 2.3% of the general population in Victoria aged over 14 years had used methamphetamine in the previous year. Those included people who used regularly and those who may have used only once in the last year. Nationally in 2010, 0.2% of the population (or around 9.3% of those who had used methamphetamine in the past year) had used at least once in the week prior to the survey.

First results from the 2013 National Drug Household Strategy survey shows that there has been no overall increase in the use of methamphetamine nationally (state specific data are not yet available), but there has been an increase in the proportion of people who reported daily or weekly use of methamphetamine¹⁶⁷⁵ (from 9.3% to 15.5%). Among people who used crystalline methamphetamine specifically, daily or weekly use rose from 12.4% in 2010 to 25.3% in 2013.

While this is a substantial increase in regular methamphetamine use among some Australians, it is important to recognise that 84.5% of people who use methamphetamine do not use regularly, while nearly 75% of people who use crystalline methamphetamine also use less than weekly. This is a significant finding for specialist alcohol and other drug (AOD) treatment providers, as people who use irregularly are at less risk of developing dependence than regular users,^{1676, 1677} and are therefore less likely to require specialist treatment.

1675 Reported use of crystalline methamphetamine also increased from 22% in 2010 to 50% in 2013, while the use of methamphetamine powder decreased from 51% in 2010 to 29% in 2013.

1676 In estimating the number of people likely to be dependent on methamphetamine in Australia in 2005, only those who reported frequency of use as weekly or greater were considered at risk for dependence. See McKetin, R, McLaren, J, Kelly, E, Hall, W & Hickman, M 2005, 'Estimating the number of regular and dependent methamphetamine users in Australia'.

NDARC Technical Report No. 230, National Drug and Alcohol Research Centre, University of New South Wales, Sydney NSW

1677 The most recent Diagnostic and Statistical Manual (DSM-V) no longer discriminates between substance 'abuse' and 'dependence', rather it allows for an assessment of the severity of 'substance use disorder', using the following criteria: taking a substance in greater quantities or for a longer duration than intended; a desire to cut down or stop; extended time in obtaining, using or recovering from the substance; cravings to use; failure to fulfil major role obligations due to recurrent substance use; continuing to use despite social or interpersonal problems; withdrawal from social, occupational or recreational activities due to substance use; recurrent substance use in situations in which it is physically hazardous; continuing to use the substance despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by substance use.

However, compared to those in the 2010 survey who had not used methamphetamine in the last 12 months, recent users were twice as likely to report high or very high levels of psychological distress (20.8% compared with 9.6%), being diagnosed or treated for a mental illness in the previous 12 months (25.6% compared with 11.7%), and were more likely to be underweight (4.8% compared with 2.3%). They were less likely to have a range of health conditions such as diabetes, heart disease and cancer, and just as likely to report excellent or good health. These data suggest that there are some areas, probably directly related to the use of methamphetamine, in which recent methamphetamine users are at higher risk of problems than those that have not used in the past year.

These people are likely to seek and receive support from a wide range of health and welfare providers including general practitioners, and those that are considered 'hard to count' by researchers conducting the national review of AOD treatment services such as private providers, Employee Assistance Programs, complementary therapists, and those based in educational settings (Gomez & Ritter 2014). Although a recommendation was made to the Inquiry for the establishment of more specialist treatment centres and recovery centres,¹⁶⁷⁸ for example, many people, even those who experience problems, do not see a need for specialist drug treatment. This suggests that all services that are likely to come into contact with people who use methamphetamine need training and support to engage people when they present and provide assistance that is effective and appropriate for the setting.

While data shows that the recent use of methamphetamine by Victorians has remained relatively stable at 2-3% over the past decade, the use of the more potent form, crystalline methamphetamine, or 'Ice', by people who injected drugs and participated in the Illicit Drugs Reporting System (IDRS) increased from 36% in 2010 to 53% in 2011.¹⁶⁷⁹ This suggests that methamphetamine-related harms, including the potential for acute methamphetamine toxicity, may be more visible among existing users. The implications for the delivery of treatment may be an increase in the need for specialist methamphetamine treatment among this group and greater frequency of emergency care in both the pre-hospital and emergency department settings. For example, data published by Turning Point Alcohol and Drug Centre, Eastern Health, reported an increase of 109.9% in the number of ambulance callouts in metropolitan Melbourne related to the use of crystalline methamphetamine in 2011-2012 (592 callouts) compared to 2010-2011 (282 callouts) (Lloyd 2013).¹⁶⁸⁰ In addition, recent data from the Victorian Department of Health shows large increases in the number of people presenting for specialist treatment. Data show an increase from 5.8% in 2011/12 to 25.8% in calls to DirectLine about methamphetamine and a 5.7% increase in the number of presentations with methamphetamine as the drug of primary concern (from 16.3% in 2011/12 to 22% in 2012/13).

Patterns of methamphetamine use and models of care

Those requiring specialist drug treatment are an important group to focus on, yet overall data discussed in this section suggest that most users are not dependent and many do not require (or even want) treatment from specialist AOD treatment providers (see for example Quinn et al. 2013). However, many people who are not dependent experience issues with methamphetamine use such as mental health problems, sleep disturbance, nutritional deficits, and blood-borne viruses, all of which have implications for matching support and treatment with individual needs, ranging from emergency care and brief

¹⁶⁷⁸ See Ms Shelley Turner, Founding Partner of Rangatira Management Consultancy, Submission, 13 June 2014

¹⁶⁷⁹ The Victorian Drug Statistics Handbook: Patterns of drug use and related harm in Victoria for the period July 2010 to June 2011.

¹⁶⁸⁰ The highest number of ambulance callouts remains associated with alcohol however, with 8824 callouts in 2011-2012, an increase of 27% from those recorded during 2010-2011.

interventions, to intensive psychosocial treatment in either outpatient or residential settings and pharmacotherapy. Strategies to reduce harms from the use of methamphetamine are a routine part of care across the treatment spectrum, and are particularly important for people who use methamphetamine as the concomitant use of multiple substances including alcohol; for example, cannabis and sedatives is the norm.

As patterns of methamphetamine use vary from person to person, so do people's responses. Mr Stuart Fenton, a drug and alcohol counsellor who has used methamphetamine in the past, told the Committee:

I do not think everyone is tarred with the same brush with crystal meth. People I know can function on it for 10 or 15 years, smoking it on a daily basis in their job, but I have also fortunately witnessed the person in my mind, who is a solicitor, finally recovering and going onto a 12-step program. Unfortunately, what that 15 years of manageable using does is, it gives the impression that this is a drug that you can use and not be affected. I was at the other end of the continuum, where I started using the drug and got psychosis within the first six months of using it.¹⁶⁸¹

As described in Chapter 6, people who use methamphetamine, from occasional users to regular dependent users, are vulnerable to the short-term (or acute) risks associated with methamphetamine use, such as toxicity and psychosis; sexual risk-taking; harms from smoking, snorting or injecting; and adverse effects from using multiple drugs, to name just a few. The spectrum of appropriate responses for short-term risks and consequences include emergency medical care, education, brief interventions, and harm reduction strategies that were detailed in Chapter 26.

With greater frequency of methamphetamine use comes vulnerability to longer-term risks and harms such as dependence and withdrawal; depression and anxiety; sexually transmitted infections; chronic sleep disturbances; dental problems; weight loss and poor nutrition; social, occupational and family problems; and long-term neurocognitive changes. Specialist drug treatment is most appropriate for people who use methamphetamine regularly and for those who are dependent.

In examining the role of innovative responses for people who use methamphetamine, Australian clinical researcher Kay-Lambkin (2008) argued that:

Reducing the impact of methamphetamine use problems requires the simultaneous development of effective management strategies and methods to improve the uptake and accessibility of treatments for this population. This will require a focused effort on preventing the initiation of methamphetamine use, the reduction of associated harms of methamphetamine use and the co-ordination of interventions across a range of environments, using flexible, multi-component strategies. The spectrum of methamphetamine use will also need to be considered, incorporating non-hazardous use, hazardous/harmful (regular) use, through to methamphetamine use disorders (abuse, dependence) (Kay-Lambkin 2008, p.319).

Stepped-care — a useful treatment model

Support and treatment responses must be wide-ranging to be effective for the spectrum of people who use methamphetamine, most of whom are not dependent. A 'plurality' of services that can respond to an individual as well as their families, friends and communities is therefore required. One model that fits this approach well is 'stepped-care', which is

¹⁶⁸¹ Mr Stuart Fenton, Drug and Alcohol Counsellor, Public Hearing, Ballarat, 18 November 2013.

recommended for clients of AOD services in general¹⁶⁸² and for users of methamphetamine in particular (Kay-Lambkin, Baker et al. 2010).

According to Baker and colleagues (Baker, Kay-Lambkin et al. 2012), stepped-care comprises offering the least intensive intervention likely to be effective as a first step, and then moving on to more intensive interventions only when the lesser interventions have proven insufficient. It has great potential in the treatment of methamphetamine use because the flexibility inherent in the approach can accommodate the broad range of problems people can experience, particularly common mental health symptoms that often resolve with cessation of methamphetamine use. The model also allows for the integration of new evidence-based approaches as they become available.

Stepped-care can be applied in a wide range of treatment settings, from primary health care to specialist AOD drug treatment services. For example, in the primary care setting, the least intensive interventions that have been shown to be effective — screening and brief intervention — may be offered in the first instance, and should these prove insufficient to produce meaningful change a referral would be made to a specialist drug treatment service. The model provides a sound opportunity to manage existing treatment resources efficiently.

In specialist drug treatment services, practitioners would conduct a comprehensive assessment and possibly offer one session of structured cognitive behaviour therapy or acceptance and commitment therapy (both of which are examined later in this chapter) in the first instance, moving to three to four sessions, and additional sessions if treatment progress is not seen (Kay-Lambkin, Baker et al. 2010). Similarly, should mental health symptoms not resolve with less intensive therapies, care can be stepped-up to include the introduction of suitable medicines or referral for specialist mental health treatment. Kay-Lambkin and colleagues observe that in their research, most treatment gains were made by week five of treatment regardless of how many treatment sessions were provided; therefore they suggest a five-week cycle for stepping-up the intensity of treatment. In this model, careful monitoring of treatment progress is a crucial aspect of care.

As shown later in this chapter, there is evidence that structured brief therapy is effective for some people who use methamphetamine, including for some people who are dependent, therefore a stepped-care model that offers the least intensive (and least expensive) treatment first is sound. It may also help to address some of the barriers to treatment access and delivery as discussed in Chapter 27, such as lengthy waiting lists, and high treatment drop-out among people who use methamphetamine.

Stepped-care was the model used by specialist stimulant treatment clinics in NSW and Victoria, both of which demonstrated successful outcomes with clients, and the model warrants careful consideration by all health care providers.

Effective treatment and evidence-based practice

Evidence-based practice is a term that is referred to regularly in the health arena, including the specialist AOD treatment field. Evidence-based practice means that health care providers are aware of the research evidence for the effectiveness (or indeed non-effectiveness) of treatments, and actively apply that knowledge to how they conduct practice with people in their care. The increasing emphasis on quality improvement in all health care settings, coupled with the ethical

1682 For example, according to the 'Drug and alcohol psychosocial interventions: professional practice guidelines, NSW Health (2008):

'Stepped care allows for flexible treatment matching. The first step is the least intensive intervention that could be effective. Interventions are stepped up only if the client fails to gain benefit from the previous step. Considered a useful approach for AOD clients with depression and anxiety as these symptoms often abate with drug treatment alone'.

imperative to provide clients with treatments that have been shown to be effective and safe, demonstrate the growing importance of applying evidence-based practice.

Understanding the research evidence and applying it to day-to-day practice does not come naturally to many workers however, and some may be reluctant to move away from established models of care that have been in place for a long period of time in favour of newer therapies as evidence for their effectiveness emerge (Haug, Shopshire et al. 2008). The application of evidence-based practice therefore requires workforce development strategies including training, ongoing supervision and regular review of practices (Olmstead, Abraham et al. 2012).

The National Institute of Drug Abuse (NIDA) produced a guide, *The Principles of Drug Addiction Treatment*, that clearly describes the evidence base for a range of interventions for the AOD treatment field and lists 13 principles of effective treatment (National Institute of Drug Abuse (US) 2009). In summary, these are:

1. Substance dependence is a complex but treatable disease that affects brain function and behaviour.
2. No single treatment is appropriate for everyone.
3. Treatment needs to be readily available.
4. Effective treatment attends to multiple needs of the individual, not just his or her drug treatment.
5. Remaining in treatment for an adequate period of time is critical.
6. Behavioural therapies — including individual, family, or group counselling — are the most commonly used forms of treatment.
7. Pharmacotherapies are an important element of treatment for many people, especially when combined with counselling and other behavioural therapies.
8. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
9. Many people who are dependent on substances have other mental health disorders.
10. Medically assisted detoxification is only the first stage of treatment and by itself does little to change long-term outcomes.
11. Treatment does not need to be voluntary to be effective.
12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
13. Treatment programs must monitor clients for infectious diseases and provide targeted risk-reduction counselling, linking patients to treatment if necessary.

An Australian review of the evidence published by the Australian Psychological Society (APS) in 2010, *Evidence-based Psychological Interventions in the Treatment of Mental Disorders*, is a companion to that produced by NIDA and is consistent with its findings, with the strongest evidence found for cognitive behaviour therapy in the treatment of adults with substance use problems.

Emergency care for methamphetamine toxicity

The administration of methamphetamine triggers an acute release of the neurotransmitters dopamine, noradrenaline and serotonin, resulting in the person feeling alert, energetic and confident. Heart rate and blood pressure increase, appetite is reduced. Wakefulness may

continue for up to 12 hours. In higher doses, the person might experience anxiety, sweating, racing heart, jaw clenching or teeth grinding, confusion, irritability, and perceptual disturbances (Majumder & White 2012).

In overdose (methamphetamine toxicity), paranoia, panic and psychosis may result. Similarly, chest pain, shortness of breath; brain haemorrhage; severe headache, tremors, hot and cold flushes, dangerously high body temperature; seizures and cardiac arrest can also occur (Majumder & White 2012).

Naïve, intermittent and regular users of methamphetamine are all at risk of experiencing harms that might require emergency, short-term interventions. For new or irregular users, emergency care and follow-up may suffice, while more intensive and longer-term interventions will be required for people who are dependent on methamphetamine.

The Inquiry heard evidence from many professionals from emergency departments (ED) and ambulance services across Victoria concerning emergency care for people with suspected and confirmed stimulant toxicity and typical presentations were described.¹⁶⁸³ Ambulance officers and paramedics are often first responders to a scene that may involve the use of methamphetamine, but it is more likely that that information is not readily available at the outset. The range of management strategies employed in a pre-hospital setting was summarised by Mr Whelan from Ambulance Victoria in Shepparton:

Initially, if it is the violence or the aggression or the agitation is up, we use a verbal de-escalation strategy — so a calming response, trying to elicit some modification in their behaviour. If we are unable to do that or violence escalates, then we use a chemical sedation. Our chemical sedation is midazolam; we give that as an intramuscular, intravenous injection. What that does is it blunts the effect of the methamphetamine, so that if they are agitated, they can be quite calm and become cooperative to the point where they are falling asleep. The other side of it is that when they are unconscious and non-responsive these patients do not have control of their breathing or their airway, so they cannot cough and clear their throat. Anything that they vomit, breathe or have in their mouth will go into their lungs; they require an advanced airway procedure. We use drugs to sedate and paralyse them to place a breathing tube in and take control of the airway. It is a fairly labour-intensive and risky procedure to do in field, and it has ongoing health costs by presenting that type of patient to hospital with managing somebody who has to be on a ventilator for a period of time.¹⁶⁸⁴

Guidelines to assist ambulance services to respond to people suspected of intoxication with amphetamine were produced in 2006 (Jenner, Spain et al. 2006) and were later adapted in local areas by experts in various locations. Evidence provided to the Inquiry suggests that the use of established guidelines is usual practice. For example, Mr Mark Allen from Ambulance Victoria at Traralgon told the Inquiry:

I used the guideline myself probably four months ago. There was a young fellow found naked inside a house. Someone found him in the house, didn't know him from a bar of soap, and chased him and he leapt out of the window. The police had been called, obviously. They arrived at the scene and they had a naked 20-something-year-old, in the dark, standing behind a shed, trying to put a sock on. That was the best effort he could make at getting dressed. Now, clearly something was going on there, very likely psychostimulant abuse. He started to get really agitated with the police there and tried to

¹⁶⁸³ The following is just a sample of the many witnesses who had concerns on this issue. See, for example, Associate Professor Tony Walker, General Manager, Regional Services, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013; Mr Allan Eade, Intensive Care Paramedic, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013; Mr Kerry Strachan, Group Manager, Ambulance Victoria, Public Hearing, Bendigo, 25 October 2013; Mr Richard Marchingo, Ambulance Paramedic, Ambulance Victoria, Public Hearing, Bendigo, 25 October 2013; Mr Terry Marshall, MICA Paramedic and Group Manager, Ambulance Victoria, Barwon District, Public Hearing, Geelong, 28 October 2013; Dr David Edey, Director of Emergency Medicine, Barwon Health, Public Hearing, Geelong, 28 October 2013; Mr Grant Hocking, Clinical Support Manager, Grampians Region, Ambulance Victoria, Public Hearing, Ballarat, 18 November 2013; Mr Steven Fumberger, Group Manager, Sunraysia Region, Ambulance Victoria, Public Hearing, Mildura, 5 December 2013.

¹⁶⁸⁴ Mr Michael Whelan, MICA Team Manager, Ambulance Victoria, Public Hearing, Shepparton, 25 February 2014.

physically attack one of the police. The two of them there at the time jumped on and held him down to protect themselves, and him really, and then another couple of police members turned up and they were able to adequately hold him down.

He was agitated the whole time, he was eating mouthfuls of grass in the backyard, and that was a perfect application for that new guideline that we have, because we were able to settle him down, manage him, get a set of observations on him, get his blood pressure, check his heart rate, put the cardiac monitor on, none of which would have been possible in any meaningful way without the application of that guideline.

The other consequence sometimes of people using psychostimulants is that they will overheat and become hyperthermic — will have a very high body core temperature — and ambulance now has the capacity to do a number of things with patients in that category. We can provide active cooling with cool fluids if we are unable to, through more passive measures, reduce their core temperature, and there are also some really significantly advanced airway management issues if their conscious state has been affected to the point where they are deeply unconscious.¹⁶⁸⁵

The presentation of a person who requires treatment in an ED due to methamphetamine toxicity is complex and often involves management of significant mental health disturbances and potentially violent behaviour that usually results from methamphetamine-related psychosis. The following evidence was offered to the Inquiry and is illustrative of the challenges faced by ED staff:

As David has said, the numbers are not high but the impact on the emergency department is quite significant. As we have outlined, these patients can take up a large amount of resources in emergency. They can present for a number of reasons. They can present with physical complaints or psychological complaints or a combination of the two, but the chaos that often comes with ice, either intoxication or withdrawal in the emergency setting is quite high. They often require staff from a number of areas in the emergency department. It will often involve staff members from the mental health team, as well as security staff, and often require large numbers of staff and often for protracted periods of time.¹⁶⁸⁶

Managing methamphetamine related violence in the emergency department is a complex issue and requires an organisational approach to jointly introduce measures to minimise harm but also to reduce the use of restrictive interventions that have been shown to cause injury and, in some cases, death. Strict protocols for appropriate pharmacological approaches, along with verbal de-escalation skills, have been useful in some circumstances. However, the specific management is often related to individual presentations and circumstances, including the level of intoxication and comorbidities. Reducing the number of presentations to the emergency department through diversion to appropriate and accessible drug treatment services should be considered. Specialist addiction medicine services in emergency departments would also provide additional advice and treatment for management of all alcohol and drug presentations.¹⁶⁸⁷

Screening and brief interventions for people at risk of methamphetamine-related harms

For non-emergency presentations, screening and the provision of brief interventions are likely to be suitable for people who use methamphetamine intermittently and may be experiencing methamphetamine-related issues such as insomnia and mood disturbance. Screening is designed to detect the likely presence of an AOD use problem and helps with decision making about the next steps to take in response, such as providing brief interventions and advice, or offering referral for specialist treatment. In the case of methamphetamine use, screening with a set of formalised questions or screening tools identifies if a person is

¹⁶⁸⁵ 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.

¹⁶⁸⁶ Dr Nic Reid, Emergency Staff Specialist, Emergency Department, Barwon Health, Public Hearing, Geelong, 28 October 2013.

¹⁶⁸⁷ Dr Tony Chan, Emergency Department Director, Latrobe Regional Hospital, Public Hearing, Traralgon, 28 January 2014.

using methamphetamine and if he or she experiences adverse effects from such use (Ali, Meena & Gowing 2012). Screening can help health workers, especially those who are not drug treatment specialists, to decide if a detailed AOD assessment is required. Screening is the first step in a brief intervention, and is ideal for primary care and community health settings.

A useful screening tool is the Alcohol, Smoking and Substance Involvement Test (ASSIST), which was developed for the World Health Organization by an international group of substance abuse researchers to screen for problem or risky use of a variety of drugs in primary care settings. The ASSIST is also accompanied by a brief intervention that was associated with a reduction in self-reported stimulant use among study participants (including those recruited in Australia) at 3-months follow-up (Humeniuk, Dennington & Ali 2008).

Brief interventions are the least intensive of all interventions in the suite of available drug treatments. They comprise brief advice following screening to help the person reduce harms, the quantity and or frequency of substance use, or to cease use entirely. Duration of a brief intervention may range from 5–10 minutes with a general practitioner through to several sessions with an AOD worker. Brief interventions can be offered in a range of primary care settings such as general practice, EDs, pharmacies, needle-syringe programs (NSPs) and other front-line services.

Most of the research conducted into the effectiveness of brief interventions has focused on alcohol and tobacco; however one Australian pilot study conducted during 2004–2006 tested the effectiveness of a single-session motivational-style brief intervention for psychostimulant users — ‘The Psychostimulant Check-up’. The intervention comprised a brief assessment of drug use and the harms associated with such use. The Checkup took about 30 minutes to complete. Investigators reported a reduction in both self-reported stimulant use and the experience of stimulant-related harms among 49 of the 80 methamphetamine users, mostly young males, contactable at 3-month follow-up, 77.6% of whom had been using by injection on an average of 14–15 days in the month previous to the Checkup (Smout, Longo et al. 2010a). Of note is that only about half of the participants were actively ready to make a change in their methamphetamine use at the beginning of the intervention, suggesting that this approach was effective for those who were not seeking professional support.

While little is known about the effectiveness of brief interventions for drug use other than alcohol and tobacco in primary care, the limited evidence available is compelling, and coupled with promising Australian pilot research, provides a rationale for its application for users of methamphetamine (Saitz, Alford et al. 2010) and warrants further investigation.

Brief interventions in general practice

People who are dependent on methamphetamine do not always access specialist drug treatment services and those who use only irregularly do not usually need to do so. Research conducted with 126 people in Melbourne who used methamphetamine found that, on average, people waited five years from the onset of problems related to their use of methamphetamine before they sought specialist treatment (Lee, Harney & Pennay 2012). During this period, many people visit primary health care providers, including general practitioners, seeking assistance with adverse consequences of methamphetamine use such as insomnia or mental health concerns, presenting an excellent opportunity for detecting use and intervening early before problems progress in severity.

A number of models for brief interventions are suitable for the general practice setting including FRAMES (feedback on behaviour and consequences; responsibility to change; advice; menu of options to bring about change; empathy; and self-efficacy for change) (Levy, Vaughan et al. 2002), and SBIRT (Screening, Brief Intervention, and Referral to Treatment) (Babor, McRee et al. 2007).

In a written submission to the Inquiry, Bayside Medicare Local highlighted the importance of primary health care workers in responding to people who use methamphetamine:

There are a number of barriers to treatment that impact on service utilisation for methamphetamine users. Reasons for users delaying seeking treatment include denial that they have a problem; negative attitudes towards treatment; concerns about confidentiality and organisational barriers such as cost, opening times, waiting times and location. As a result of these concerns, crystal methamphetamine users are more likely to access primary health care providers than specialist services. This provides an opportunity for primary health care professionals outside the alcohol and other drug (AOD) sector to identify crystal methamphetamine use and provide early screening, brief intervention and referral to treatment (SBIRT). General Practitioners, practice nurses and Pharmacists are well placed to lead this type of intervention¹⁶⁸⁸.

National guidelines to support general practitioners in the identification, assessment and management of patients with problems related to amphetamine were developed in 2004 and were subsequently updated by clinicians in 2007; however the application of these guidelines by general practitioners is unknown.

Brief interventions in emergency departments

Brief interventions may also be delivered by practitioners in the ED, once the acute effects of methamphetamine have abated. The Inquiry heard evidence from many professionals from these practice areas across Victoria.¹⁶⁸⁹

Staff members in EDs respond to the emergency health needs of a range of people who use methamphetamine, including naïve and intermittent users who do not come to the attention of specialist AOD treatment services, thus professionals in the ED are well placed to deliver information and professional advice at a crucial time. Linking people with treatment can be challenging for service providers, as Dr Cath Peake from Barwon Health highlighted:

A lot of the people first coming into contact with mental health services at Barwon Health because of or related to ice use are seen in the emergency department, and the psychiatric triage team will often also see them. But in terms of then linking them to ongoing treatment — and we know there needs to be long-term support in the community in all sorts of ways to address this — it is not possible necessarily to make that linkage into treatment at the point where someone is acutely intoxicated or distressed or they walk out or can leave and think, ‘Well, I’m okay now’, and do not see the need for engaging in treatment. Engaging people in treatment in the community is a challenge, working with people to acknowledge that there is a problem with ice use.¹⁶⁹⁰

Some studies have shown an association between brief interventions for alcohol use in emergency care settings and the reduction of alcohol consumption, risky drinking, and injury frequency (Nilsen, Baird et al. 2008). However their effectiveness for illicit drug use in the context of emergency department settings are not as clear (Woodruff, Clapp et al. 2014), and research into ED-initiated brief interventions where the use of methamphetamine is suspected or confirmed is required.

Brief interventions in other service settings

1688 Sharon O'Reilly, Clinical Services Manager, Bayside Medicare Local, Submission, 21 October 2013.

1689 For example see Dr David Eddey, Director of Emergency Medicine, Barwon Health, Public Hearing, Geelong, 28 October 2013; Dr Tim Baker, Emergency Department Physician, South West Healthcare, Public Hearing, Warrnambool, 3 March 2014; Mr Daniel Eltringham, Drug and Alcohol Care Coordinator, Emergency Department, Bendigo Health, Public Hearing, Bendigo, 25 October 2013; Ms Carol-Anne Lever, Nurse Unit Manager, Emergency Department, Bendigo Health, Public Hearing, Bendigo, 25 October 2013; Dr Andrew Crellin, Director of Emergency, Ballarat Health Services, Public Hearing, Ballarat, 18 November 2013.

1690 Dr Cath Peake, Clinical Coordinator, Drugs and Alcohol Services, Barwon Health, Public Hearing, Geelong, 28 October 2013.

Evidence provided to the Inquiry reveals that some other front-line services are offering brief interventions:

As I have mentioned, we use brief interventions. Some of the youth workers have reported that a lot of our clients who might be using ice might only come for one session and then we might not see them again. So for us around that brief intervention, what can we get in in that one session that is going to be meaningful for that person to take away? It might be some education, it might be making them fully aware of what services are available to young people. A lot of young people do not know what is out there, so for us it is about how we use that brief intervention effectively to provide some good information or education for that person. We are finding that a lot of young people do not come back a second time, so it is really important. Obviously counselling and case management is really important. A lot of clients sort of flow through the service system. They might be with UnitingCare one day and Community Health the next week, and somewhere else the week after.¹⁶⁹¹

It was also suggested in evidence to the Inquiry that brief interventions linked with police cautioning programs be introduced:

I would like to see more research and more engagement with the police cautioning program. I think it is a tremendous teachable moment for people for whom ice has not yet become a problem. They have had one encounter with the police by definition. If they have had convictions they do not get cautioned; they get whatever else is coming to them. It is such a teachable moment, because these are mostly employed young men and women who have a lot to lose.¹⁶⁹²

Assessment

Assessment is the next step-up from screening and brief intervention, and is conducted to inform treatment planning. There is no 'one size fits all' when it comes to methamphetamine treatment, so a well-conducted assessment is crucial. Australian guidelines (Baker, Kay-Lambkin et al. 2003; Lee, Johns et al. 2007) recommend asking about the use of alcohol, tobacco and all other drugs because poly-drug use is common among methamphetamine users.¹⁶⁹³ As Dr Matthew Frei, Head of Clinical Services at Turning Point Alcohol and Drug Service told the Inquiry:

The other thing I think is very important — and this is the thing across the board with drug use presentations to clinical treatment services — is that multiple drug use is the norm. In my experience we do not really see people who only use methamphetamine. When we talk about drugs we divide them into drug types. I have to say that is becoming less and less relevant in the 21st century because the norm is for people to use multiple drugs. People use drugs, particularly sedating drugs, with methamphetamine like benzodiazepines, prescribed sedative-type drugs or alcohol or marijuana or GHB, which is an illicit sedative drug.¹⁶⁹⁴

Dr Roger Brough, a drug and alcohol physician based in Warrnambool, who also provides advice and secondary consultation to practitioners in Victoria through the Drug and Alcohol Consultations Service (DACAS) telephone help-line, described the evolution of the current pattern of poly-substance use:

The other comment I would make about the amphetamines in the current milieu of drug use is that poly substance use is the accepted norm now, whereas back in the 70s and 80s there were more people who were more alcohol, more opiate or even the hallucinogens, stimulants, and there is a much

1691 Mr Paul Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013.

1692 Dr R. Volk, Forensic and Other Drugs Counsellor, South East Alcohol and Drug Service, Public Hearing, Melbourne 3 February 2014.

1693 See also Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013.

1694 Dr Matthew Frei, Head of Clinical Services, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

more homogenous population now of poly substance users. 'I might use a bit of this, a bit of that', depending on what is available, what they can afford, and their preference for drug use.¹⁶⁹⁵

Careful questioning about the use of a range of drugs beyond a person's primary drug of concern may also reveal a number of important areas for treatment that may have otherwise gone unnoticed, presenting an important opportunity for earlier intervention. As Mr Eion May observed about the increase in presentations to his service in Gippsland in which methamphetamine use is involved:

There are a number of reasons why that might be, and certainly, as I mentioned, people are perhaps starting to use it more. But also I think as clinicians we are starting to perhaps make a point of trying to assess a little more accurately and are actually starting to ask those questions, because quite often clients are actually presenting with, like I said, problematic alcohol use. Then when we do an assessment, we might find that there is in fact some methamphetamine use.¹⁶⁹⁶

Other essential components of assessment include previous alcohol and other drug treatment; triggers for relapse; presence of mental health symptoms such as depression, anxiety and psychosis and previous mental health treatment; physical health problems including infectious diseases such as blood-borne viruses; risk for suicide and violence; and other social issues that impact on care such as finances, employment, housing, legal issues, and family and social relationships (Baker, Kay-Lambkin et al. 2003).

Initial goals for treatment, such as reducing use or becoming abstinent from methamphetamine, repairing relationships, regaining employment, the person's readiness and their ability to make the changes necessary to meet their treatment goals should also be carefully assessed. The complete set of findings from the assessment is used to develop an individualised treatment plan, which is reviewed and updated regularly as people may change their treatment goals over time (e.g. from wanting to reduce methamphetamine use at the outset of treatment to wanting to stop using completely as confidence and motivation increase), or as other needs emerge.

All workers in alcohol and other drug treatment settings in Victoria are required to hold, or be working towards, the minimum qualification of a Certificate IV in AOD work, and assessment is a core competency.

Methamphetamine withdrawal and management

The 'crash' period

People who are dependent on methamphetamine are likely to experience a withdrawal syndrome when they cease using the drug. However, there is frequently a pre-withdrawal period, commonly referred to as a 'crash'. This is a distinct physiological phenomenon to physical withdrawal.

The intensely stimulating effects of methamphetamine use, including periods of extended wakefulness and lack of appetite, often result in a short period of recovery following an episode of methamphetamine use that involves prolonged sleep and increased appetite during which people may feel 'flat' and generally out of sorts for a few days. The crash typically lasts for 2–3 days. Several witnesses described to the Inquiry how the crash period has necessitated a change in clinical practice:

With our withdrawal services, we notice that, as you would be well aware, when a person is coming off ice the first thing they want to do is sleep. People will sleep up to 18 hours or so a day. That has certainly changed the way that we have had to manage withdrawal, especially within the residential

¹⁶⁹⁵ Dr Rodger Brough, Drug and Alcohol Physician, South West Healthcare, Public Hearing, Warrnambool, 3 March 2014.

¹⁶⁹⁶ Mr Eion May, Alcohol and Drug Worker, Gippsland Lakes Community Health Centre, Public Hearing, Traralgon, 28 January 2014.

withdrawal service. We usually have a fairly structured program in looking at strategies for people, with coping mechanisms and the reduction of harms. There is an engaging education program for people when they come through the withdrawal unit. We have had to adjust that because people need the first two or three, even up to four, days just to rest to restore a little bit of a sleep cycle balance.¹⁶⁹⁷

We have found that amphetamine users definitely need 10 days, sometimes longer. Primarily for the first few days in the program and in withdrawal we have found that clients need to sleep and eat basically. People are agitated. When they do go to sleep they want to be left to sleep. We were finding that if they were rousing people to get up for the program or get up for particular things that is often when the challenging behaviour emerged. All they felt capable of doing at that point was sleeping and starting to get some nourishment, so the program was changed a bit. Obviously if people were well enough to participate from day one, they could, but there was some leniency in the first few days to allow people that time to sleep and start to get some nourishment.¹⁶⁹⁸

The withdrawal period

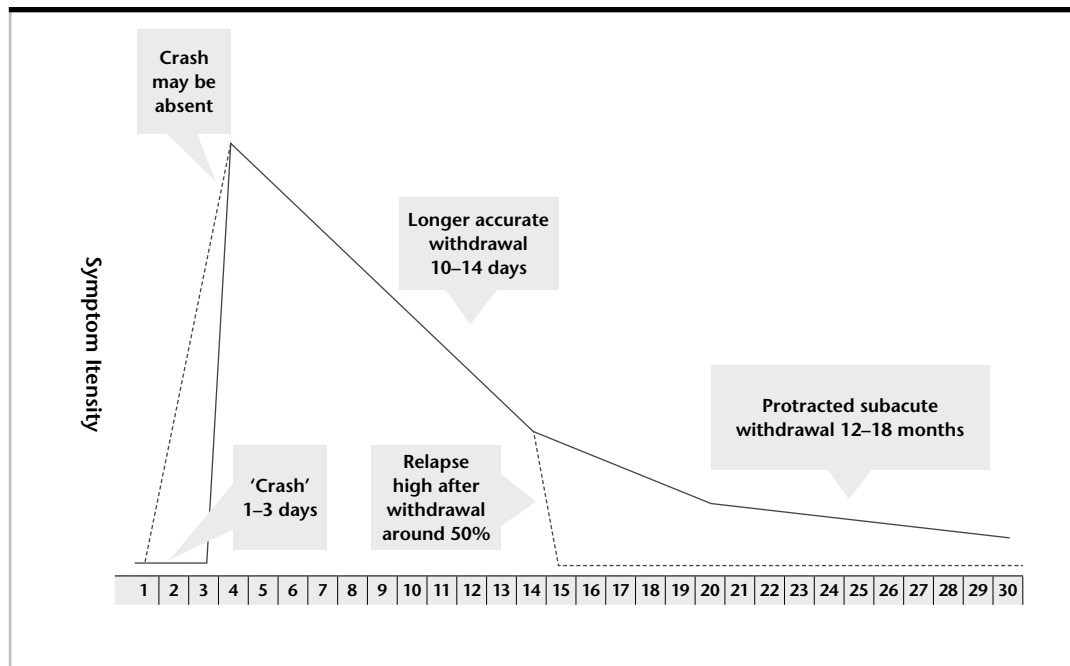
Research into the natural history of methamphetamine withdrawal shows that, depending on dosage and duration of use, it is characterised by depression of varying severity, agitation, anxiety, and intense craving to use. Symptoms of psychosis are sometimes present.

This acute phase may last for seven to ten days, with sub-acute symptoms lasting for at least a further two weeks during which time cravings often persist (McGregor, Srisurapanont et al. 2005; Zorick, Nestor et al. 2010). For some people, symptoms of depression and cognitive impairment may last for many months (see 'Neurocognitive effects of methamphetamine and implications for treatment' in this chapter). This clinical picture differs markedly from, for example, uncomplicated alcohol withdrawal that usually resolves within five days of onset. Figure 28.1 illustrates the typical course of methamphetamine withdrawal.

1697 Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013; Mr Christofer Beal, Coordinator, Tanderra AOD Services, Bairnsdale, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

1698 Ms Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013.

Figure 28.1: Typical course of methamphetamine withdrawal, and potential for enduring sub-acute symptoms¹⁶⁹⁹



The Committee heard from many witnesses that the current allowable duration of stay in supervised withdrawal units is insufficient to ensure that methamphetamine withdrawal is completed prior to discharge.¹⁷⁰⁰

Because we are still in the early days of understanding ice and people tend to fall back on their understanding of speed withdrawal, what we are finding is that the withdrawal for ice versus speed is just so much more intense and much longer. The current withdrawal stays are set up usually at five to 10 days, and often we do not see people completing the difficult stage of their ice withdrawal for a couple of weeks. So the current withdrawal programs do not quite meet that need of these people.¹⁷⁰¹

We have got a service system that was really set up around heroin and then adapted around alcohol when we started doing a lot more work with alcohol. For example, the average length of stay in a withdrawal unit is seven days, which is around heroin withdrawal. Over the last six months when we have been doing some investigations into the group of methamphetamine users we have found that they were doing very poorly in treatment. They do not seem to be able to be retained in withdrawal services. For this group, at the end of a seven-day admission they were demonstrating withdrawal symptoms sometimes as severe as at the beginning of their stay. People were being discharged at the end of treatment still experiencing withdrawal symptoms and therefore very likely to relapse. It seems

¹⁶⁹⁹ Based on studies describing the natural history of methamphetamine withdrawal and those concerning neurocognitive effects: Mancino, M.J., Gentry, B.W., Feldman, Z., Mendelson, J., Oliveto, A. (2011) Characterizing methamphetamine withdrawal in recently abstinent methamphetamine users: a pilot field study. *Am J Drug Alcohol Abuse*. Zorick, T., Nestor, L., Miotto, K., Sugar, C., Hellemann, G., Scanlon, G., Rawson, R., London, E.D. (2010) Withdrawal symptoms in abstinent methamphetamine-dependent subjects, *Addiction* 37(2):131-6; 2010 Oct;105(10):1809-18; McGregor, C., Srisurapanont, M., Jittiwutikarn, J., Laobhripatr, S., Wongtan, T., White, J.M. (2005) The nature, time course and severity of methamphetamine withdrawal, *Addiction* 100(9):1320-9; Cruickshank, C.C., Montebello, M.E., Dyer, K.R., Quigley, A., Blaszczyk, J., Tomkins, S., Shand, D. (2008) A placebo-controlled trial of mirtazapine for the management of methamphetamine withdrawal. *Drug and Alcohol Review*, 27(3):326-33; Lee, N.K., Harney, A., Johns, L., Pennay, A., Kenny, P. (2006) Psychostimulant withdrawal: natural history and options for intervention, *Acta Neuropsychiatrica* (18)6:260-261; Scott, J.C., Woods, S.P., Matt, G.E., Meyer, R.A., Heaton, R.K., Atkinson, J.H., Grant, I. (2007) Neurocognitive effects of methamphetamine: a critical review and meta-analysis. *Neuropsychol Rev*. 2007 Sep;17(3):275-97.

¹⁷⁰⁰ See also Ms Kit-e Kline, Drug and Alcohol Worker, Wathaurong Aboriginal Co-Operative, Public Hearing, Geelong, 28 October 2013; Mr Paul Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013.

¹⁷⁰¹ Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

that for methamphetamine the withdrawal period is longer, up to six weeks, with the intense period being the first two weeks, the first three days of which is a crash period.¹⁷⁰²

Similarly, an inadequate withdrawal period, based according to some witnesses inappropriately on a model for managing heroin withdrawal,¹⁷⁰³ can also result in insufficient time for recovery or lead to early relapse.¹⁷⁰⁴ For young people in particular this may be problematic. As a submission to the Inquiry from Mackillop Family Services noted:

Residential care staff noted that detox programs are not generally available to the young people they work with. Staff report that when a young person identifies that they wish to enter detox, it takes too long for a place to become available. Additionally, when detox is available, the length of stay (generally seven days) is inadequate for most ice users. There is often no follow up rehabilitation. This can increase the risk of overdose, if young people leave detox without adequate support and rehabilitation.¹⁷⁰⁵

In a written submission, UnitingCare ReGen described how staff became aware that the established withdrawal program was not meeting the needs of people who were withdrawing from methamphetamine due to their distinct presentation, and took steps to modify the program accordingly with favourable results, although seven days was found to be an inadequate time to ensure withdrawal symptoms had reduced prior to discharge:

Program changes that were implemented on 01/01/13 and monitored over a six-month period mainly concerned the lowering of program participation expectations (group participation) in the first 48 hours (up to 72 hours if clinically indicated) post admission and active support of the “crash” phase by allowing clients to rest in bed with close monitoring and support.

Evidence from a clinical practice audit at the end of the trial period showed that: program retention had increased from 48 to 60%; relationships between clients and staff were less hostile and stressful; and the number and severity of incidents declined in the final 3 months of the 6 month trial period.

The most unexpected finding of the clinical practice audit was that for the group of 24 methamphetamine users (for which complete data was available), withdrawal symptoms as measured by the Amphetamine Cessation Symptom Assessment (ACSA) tool had increased for 50% of the clients at the conclusion of the withdrawal episode (day 7 of the withdrawal).¹⁷⁰⁶

Setting

Withdrawal from methamphetamine during the acute stage is relatively safe and can often be undertaken in the community with specialist support and monitoring if the person’s home environment is conducive to promoting abstinence (e.g. supportive family/friends, no exposure to drugs). However, withdrawal can be complicated by poly-drug dependence and/or co-occurring mental health or medical conditions, particularly those which have not been diagnosed, so some people may require admission to a specialist setting in order to withdraw safely (Lee et al. 2007, p.6).

Self-detoxification by users is common and people may use benzodiazepines or other prescription drugs to self-manage their withdrawal symptoms (Lee et al. 2007; Kenny et al. 2011). A problem, however, with self-detoxification according to some AOD treatment agencies is that those going through withdrawal can access a mixture of licit and illicit drugs including alcohol, cannabis, antidepressants and antipsychotics to alleviate their symptoms. Use of this

1702 Ms Donna Ribton-Turner, Director, Clinical Services, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013.

1703 See Ms Sharon O’Reilly, Clinical Services Manager, Bayside Medicare Local, Submission, 21 October 2013.

1704 Cameron McGregor, a withdrawal nurse with Goulburn Valley Health in Shepparton, told the Committee that even after his clients go through a six-week withdrawal program at Odyssey House, Benalla, they are ‘still depressed, still in a low mood’ and consequently still at risk of relapse’. See Mr Cameron McGregor, Senior Withdrawal Nurse, Goulburn Valley Health, Shepparton, 25 February 2014.

1705 Ms Micaela Cronin, Chief Executive Officer, MacKillop Family Services, Submission, 21 October 2013.

1706 Mr Geoff Neideck, Head, Housing Homelessness and Drugs Group, Australian Institute of Health and Welfare, 22 April 2014.

mixture of 'uppers' and 'downers' can lead to potentially dangerous drug interactions and, in fact, exacerbate depression and psychosis.¹⁷⁰⁷ Given these risks, Kenny et al. have argued that:

Self-help materials to support and assist methamphetamine users through withdrawal may be useful in reducing the risks associated with self-withdrawal (including the concurrent use of other drugs) and could indicate the point at which users should consider seeking professional assistance if withdrawal becomes too difficult (2011, p.6).

Management

Management of the acute stages of withdrawal either through home detoxification or in hospital or a residential clinic¹⁷⁰⁸ involves: careful monitoring of the progress of withdrawal using a validated tool such as the Amphetamine Cessation Symptom Assessment; monitoring of mental health symptoms including the severity of depression; education about the progress of withdrawal; relapse prevention counselling including the management of cravings; and the supervised administration of medicines to manage withdrawal symptoms, particularly insomnia, agitation and anxiety on a case-by-case basis.¹⁷⁰⁹ Symptoms of psychosis, should they emerge, are treated symptomatically, though symptoms usually resolve with abstinence.

Pharmacotherapy for withdrawal management

The lack of approved pharmacotherapy for people who use methamphetamine was discussed in Chapter 27 and is touched on only briefly here. Unlike alcohol and heroin withdrawal, there are no validated and standardised protocols for the pharmacological management of methamphetamine withdrawal, which is viewed as problematic by some treatment providers who gave evidence to the Inquiry.¹⁷¹⁰

Despite a number of studies, some of which were conducted by Australian researchers (see for example, Lee et al. 2013; Cruickshank et al. 2008; Shearer et al. 2009; McGregor et al. 2008; Shearer et al. 2001),¹⁷¹¹ no pharmacotherapies have yet been approved for routine use in methamphetamine withdrawal,¹⁷¹² although several medicines show promise and warrant further investigation (Lee, Jenner & Nielsen, in press).

Dr Rebecca McKetin, an expert in methamphetamine research, told the Committee that pharmacotherapies for short-term withdrawal were equally as important as substitution therapies for addressing the long-term cessation of methamphetamine use:

What we really need as a first step are drugs that can manage the withdrawal symptoms. When people turn up at the emergency department they are very messy and ratty and they are very hard to engage with, even through the detox process.¹⁷¹³

1707 See Mrs Sue Medson, Chief Executive Officer, Gippsland Lakes Community Health, Submission, 21 October 2013.

1708 The problem with home detoxification particularly in environments such as group homes or out-of-home care according to some witnesses to the Inquiry is that it is too tempting for the person attempting to detoxify to be pressured by other drug users in the environment to relapse into continuing use.

See for example evidence of: Ms Tricia Quibell, Deputy Director, Hume region, Berry Street, Shepparton, 25 February 2014. Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Shepparton, 25 February 2014.

1709 A submission from Primary Care Connect states that they have a reasonable amount of success with their clients through the prescription of antidepressants in conjunction with counselling therapies to assist in the acute withdrawal stage. See Mr Hamish Fletcher, Chief Executive Officer, Primary Care Connect, Submission, 18 October 2013.

1710 For example, Mr Eion May, Alcohol and Drug Worker, Gippsland Lakes Community Health Centre, in a Public Hearing at Traralgon on 28 January 2014 indicated that protocols for alcohol withdrawal may be being used inappropriately for people withdrawing from methamphetamine.

1711 See for example, McGregor, Srisurapanont, Mitchell, Wickes & White 2008; Lee, N.K., Pennay, A., Hester, R., McKetin, R., Nielsen, S. & Ferris, J. 2013; Cruickshank, C.C., Montebello, M.E., Dyer, K.R., Quigley, A., Blaszczyk, J., Tomkins, S. & Shand, D. 2008.

1712 See also Chapter 30 for a discussion of the need for further research into methamphetamine use.

1713 Some studies have examined the benefit of some pharmacotherapeutic interventions for addressing withdrawal. For a technical review of these medications and their effectiveness see Shoptaw et al 2009; Srisurapanont, Jarusuraisin and Kittirattanapaiboon 2001a; Lee, N.K., Jenner, L. & Nielsen, S. (in press); and the section on pharmacotherapy in this chapter.

If they have been using ice heavily, they are craving the drug, they have no emotional regulation, they are very difficult to manage and they are very agitated. What the clinicians say is that it is very hard to engage them in any kind of longer term treatment using the psychological therapies, which are actually effective. What they ask for is some type of medication regime or something that can get those people through the first two to three weeks until they are settled and you can have a proper conversation with them and start to sort out their lives. I think that is where the pharmacotherapies have to focus.¹⁷¹⁴

Practice guidelines to assist alcohol and other drug workers in the management of a range of withdrawal states, including amphetamine-type-stimulants, were published in 2012 by Turning Point Alcohol and Drug Centre (Frei, Berends et al. 2012). The authors recognise the lack of a validated protocol for the management of withdrawal, however they state that in practice medicines for symptomatic relief are often used on a case-by-case basis. Figure 28.2 shows a suggested medicine support regime.

Figure 28.2: Potential symptomatic relief for symptoms of amphetamine withdrawal

Symptoms	Symptomatic medication
Pronounced agitation or insomnia	Benzodiazepines, preferably diazepam in tapering doses for short duration a b Other agents such as typical and atypical antipsychotics, mirtazapine and tricyclic antidepressants have been used (Tricyclic antidepressants are generally avoided due to toxicity)
Psychotic features (psychosis, thought disorder, such as paranoid ideation, or perceptual disturbances)	Typical antipsychotic medication including haloperidol, chlorpromazine or atypical agents such as olanzapine or risperidone. Note: If these symptoms are marked, assessment with an experienced mental health clinician (or psychiatrist) is recommended and involuntary treatment under jurisdictional mental health acts may be required b Antipsychotic medication is often continued for several weeks after an acute presentation with careful monitoring if medication is withdrawn a
Other symptoms	Non specific symptoms such as headache and nausea can be treated with symptomatic agents Psychomotor slowing a, particularly if part of a depressive disorder, may respond to selective serotonin reuptake inhibitors (SSRIs) b

a) NSW Department of Health (2008a)

b) Murray et al. (2002)

Source: Frei et al. 2012, *Alcohol and Other Drug Withdrawal Practice Guidelines*, 2nd edn, Turning Point Alcohol and Drug Centre.

Long-term rehabilitation is as necessary as supervised short-term withdrawal for people who are dependent on methamphetamine

Nearly every witness from a clinical, community health, alcohol and drug or welfare background who gave evidence to the Inquiry stressed the need for a ‘long haul’ approach to addressing cessation of methamphetamine use. Although evidence suggests that not all methamphetamine users require long-term interventions, those that do require anything between six months to one year to be effective.¹⁷¹⁵ Such witnesses endorse Lee and Jenner that ‘[w]ithdrawal in itself is of little long term value in treating amphetamine type stimulant use unless sufficient engagement in aftercare is provided’ (2012, p.195).

1714 Dr Rebecca McKetin, Fellow in Mental Health Research, College of Medicine, Biology and Environment, Australian National University (via teleconference), Canberra, 11 February 2014.

1715 See for example evidence from: Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS), Traralgon, 28 January 2014; Ms Donna Ribton-Turner, Director, Clinical Services, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013; Ms Robyn Reeves, Chief Executive Officer, Ballarat Community Health Centre, Public Hearing, Ballarat, 18 November 2013; Mr Paul Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013; Ms Di Griffin, Aboriginal Drugs and Alcohol Counsellor, Albury-Wodonga Aboriginal Health Service, Wodonga, 24 February 2014; Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Traralgon, 28 January 2014; Mr Bill Wilson, Youth Outreach, Alcohol, Tobacco and Other Drugs Team, Gateway Community Health, Wodonga, 24 February 2014.

As Herb Goonen, Drug and Alcohol Manager of the Alcohol and Drug Unit at the Rumbalara Aboriginal Co-operative told the Inquiry, 'detox is only one relatively small and insignificant part of the overall approach to addressing methamphetamine addiction'.¹⁷¹⁶ Long-term problems associated with a previous chaotic lifestyle, lack of employment, family breakdown or accommodation will not have gone away simply because an initial period of withdrawal or detoxification is completed.¹⁷¹⁷

The lack of effectiveness for withdrawal as a stand-alone intervention for people who are dependent on methamphetamine has been previously highlighted in the Methamphetamine Treatment Evaluation Study (MATES) by McKetin et al. The study, which included an assessment of community based treatment options, found that:

Detoxification conveyed no benefit in reducing methamphetamine use at any follow up relative to not receiving treatment. This is consistent with previous research and suggests that detoxification should not be provided as a standalone service. We found that most detoxification clients were highly motivated to reduce their methamphetamine use and sought abstinence indicating a need to educate detoxification clients that addressing physical withdrawal symptoms may not alleviate methamphetamine dependence in the longer term and that further treatment is needed to address broader psychosocial issues (eg coping and interpersonal skills) as well as ongoing craving for the drug and their role in precipitating relapse (2012b, pp. 2005-2006).

Witnesses to the Inquiry told the Committee that there was too much emphasis on the immediate withdrawal process at the expense of longer-term treatment interventions. For example, Dr Matthew Frei argued that:

The really hard work, the heavy lifting in this group for treatment, is not in the first few days as it is with most drugs; it is in the long term. In the management of methamphetamine users we focus on the maintenance of abstinence, the prevention of relapse, the reduction of use and reduction of harm after withdrawal or after detoxification. That is where the most important and critical interventions are. I guess the message I would have as a clinician is that that is where we really need to focus work in methamphetamine treatment — that is, focusing on people in the medium to long term in supporting and helping people to recover in that period of time.¹⁷¹⁸

Similarly, Cheryl Sobczyk from Bendigo Community Health Services told the Inquiry:

The significant issue for people going through withdrawal is that it is reasonably okay to have that initial stop where they actually cease using the drug, but the actual time it takes for them to recover is much more protracted than we have seen in relation to alcohol, cannabis, heroin or other drugs. We are talking about at least a six-month period before people start to restore some of their physical health and some of their feelings of wellbeing in relation to their emotional health. The actual time it takes them to recover is much, much more protracted.¹⁷¹⁹

Eion May from the Gippsland Lakes Community Health Centre made similar observations. He told the Inquiry:

The biggest challenge for me, I think, with methamphetamine is the protracted withdrawal process. What we do not see, like we might with alcohol or heroin, is an acute physical manifestation of withdrawal symptoms. Most users are able to actually stop from a physical perspective quite easily, but what we see is a really protracted withdrawal phase, where they are really incapable of feeling any type

1716 Mr Herb Goonen, Drug and Alcohol Worker, Rumbalara Aboriginal Cooperative, Shepparton, 25 February 2014. See also the similar comments from Ms Kaz Gurney, Managing Lawyer, Goulburn Valley Community Legal Centre, Shepparton, 25 February 2014.

1717 See comments of Mr Donald Currie, Team Manager Alcohol & Other Drugs, Gateway Community Health, Wodonga, 24 February 2014. See also Chapter 7 for a discussion of the social consequences of methamphetamine use.

1718 Dr Matthew Frei, Head of Clinical Services, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

1719 Ms Cheryl Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services, Public Hearing, Bendigo, 25 October 2013.

of pleasure or joy, which really then makes it very difficult to try and support people to maintain that abstinence and not relapse and go back to using, because often they are in a position where the only way for them to feel any kind of pleasure is to actually use that substance.¹⁷²⁰

A lack of access to treatment services or at least a waiting period can mean methamphetamine users may relapse after the initial period of detoxification.¹⁷²¹ As Don Currie, Manager of Gateway Community Health in Wodonga told the Inquiry:

We can support someone to go and do a detox and that will be totally unpleasant for them and they will come out at the other end they will feel that they have achieved enormous goals, but then being able to provide that constant support for them after that to ensure that they do not relapse and go back to using the ice is not easy because we do not have the clinicians on the ground, we do not have the bed availability in rehabilitation services, and those supports that these people really need are not there once they have finished their detox.¹⁷²²

A call for additional research into withdrawal

Numerous witnesses to the Inquiry have made a call for further research into withdrawal from methamphetamine, suggesting that existing research findings need to be more widely promoted. For example, Belinda McNair from the Salvation Army's Drug and Alcohol Unit in Geelong told the Committee:

We are of the view that there needs to be further research into withdrawal. There are some in the sector that would argue there is no clinical evidence to demonstrate a withdrawal syndrome for amphetamines. There perhaps needs to be some research there. Up until very recently there was still a couple of detox services not taking clients for amphetamine withdrawal because their view was there is no clinical evidence to demonstrate there is a withdrawal syndrome. We would certainly argue — and most people that I would speak to in the sector would argue — that there is definitely a withdrawal syndrome but it has not been clinically identified or researched.¹⁷²³

Similarly Sunraysia Community Health Services (SCHS) in Mildura note that many alcohol and drug agencies and individual workers do not have a full understanding of the stages of withdrawal (pre, acute, chronic stages) and therefore treatment interventions are not sufficiently tapered to those stages. More research on the complexities of the withdrawal process is therefore required.¹⁷²⁴

Psychosocial interventions

The main aims of psychosocial interventions for methamphetamine use are to:

- a) engage people in the treatment process;
- b) to keep people engaged and retained in treatment;
- c) encourage commitment to and compliance with treatment; and
- d) to support people in the prevention of relapse to methamphetamine use (Ciketic, Hayatbakhsh et al. 2012).

1720 Mr Eion May, Alcohol and Drug Worker, Gippsland Lakes Community Health Centre, Traralgon, 28 January 2014.

1721 See also comments of Mr Cameron McGregor, Senior Withdrawal Nurse, Goulburn Valley Health, Shepparton, 25 February 2014.

Almost all witnesses who work in metropolitan but particularly rural and regional drug and alcohol settings deplored the lack of detox, withdrawal and rehabilitation services for methamphetamine and other drug and alcohol clients in regional towns throughout Victoria. This issue is discussed in further detail in Chapter 29.

1722 Mr Donald Currie, Team Manager Alcohol & Other Drugs, Gateway Community Health, Wodonga, 24 February 2014.

1723 Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013.

1724 Observations of SCHS contained in Rob McGlashan, Executive Officer, Northern Mallee Primary Care Partnership, Submission, 21 October 2013.

Psychosocial interventions can be delivered in outpatient and residential settings; and to individuals, groups or a combination of the two. Counselling has been shown to be a cost-effective treatment option for Australians who are dependent on methamphetamine when compared to the option of no treatment (Ciketic, Hayatbakhsh et al. 2014).

A range of psychosocial interventions of varying duration have been shown to be effective in the treatment of AOD use disorders generally, and a considerable body of research evidence, primarily reported by investigators based in the United States, has demonstrated the effectiveness of psychosocial therapies for treating people 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.

CBT refers to a suite of psychological therapies that focus on the cognitive (thinking) and behavioural (doing) drivers of substance use. Relapse prevention falls under the umbrella of CBT and is a core competency of specialist AOD treatment services. CBT can also be used with good effect to target mental health symptoms such as depression and anxiety that commonly co-occur with methamphetamine use.

Motivational interviewing is a style of engaging people in a conversation about their substance use, with the aim of increasing a person's readiness to change. Using a set of skills and tools, practitioners help people prepare for change by eliciting the person's own ambivalence about their behaviour and helping them resolve the uncomfortable feelings that arise by making plans to change. A confrontational style is antithetical to motivational interviewing (Miller & Rollnick 2009). Motivational enhancement therapy is a brief therapy that incorporates a motivational style of treatment delivery, and has shown promise for people who are dependent on methamphetamine (Galloway, Polcin et al. 2007).

Narrative therapy, an approach that helps to facilitate change by encouraging people to tell and retell the 'story' of their lives, was used in one Australian study among people withdrawing from methamphetamine in the community (Cruickshank, Montebello et al. 2008); however as the focus was on pharmacotherapy (mirtazapine), no conclusions as to its benefit can be drawn.

In the absence of approved medicines to treat methamphetamine dependence, psychosocial interventions are currently the only evidence-based methamphetamine treatment available; however treatment drop-out remains a vexing issue.

Brief therapy

A study of brief (two or four session) therapy among 214 regular amphetamine users was conducted by Australian researchers in 2001-2002 (Baker, Lee et al. 2005), a time when the use of methamphetamine had just become well established in Australia. At baseline, there were high rates of methamphetamine dependence and considerable mental health comorbidity among study participants.

The therapy involved structured cognitive behaviour therapy combined with motivational interviewing and was delivered by trained psychologists. Topics included coping with cravings and lapses, controlling thoughts about using amphetamine, building motivation to change, and relapse prevention. The investigators reported that both two and four sessions were successful in increasing rates of abstinence from amphetamine for up to six months following the intervention. Four sessions also significantly reduced the severity of depression among those in the treatment condition in comparison to those who received an assessment and self-help booklet only. Despite a highly dependent and complex group participating in the study, treatment retention was reasonable, with 76% of people allocated

to two sessions completing both, and 68% of those allocated to four sessions completing three or four sessions.

The manual detailing the brief intervention remains available for download from the website of the Australian Government Department of Health, but due to the considerable time that has elapsed since its development; the resource may not be well known to the drug treatment sector in 2014.¹⁷²⁵

More intensive therapies

Acceptance and commitment therapy

Acceptance and Commitment Therapy (ACT) is a type of mindfulness-based behavioural therapy that belongs to the so-called 'third wave' of psychological therapies that followed behavioural (first wave) and cognitive (second wave) approaches (Hayes 2004). ACT differs from 'traditional' CBT by focusing on becoming aware of, and accepting without judgement, the process of thinking rather than disputing and modifying unhelpful thoughts. It also emphasises exploration and identification of personal values. According to Russ Harris who is a leading Australian therapist in this modality, the goal of ACT is to '...create a rich and meaningful life, while accepting the pain that inevitably goes with it' (Harris 2006).

ACT has been trialled with some success for smoking cessation (see Bricker et al. 2013; Brown, Palm et al. 2008), methadone detoxification (Stotts et al. 2012), and cannabis dependence (Twohig et al. 2007) among other conditions, making it a potentially good candidate for the treatment of methamphetamine use problems.

In a randomised controlled trial of ACT for treating methamphetamine use disorders, researchers in South Australia compared 12, one-hour weekly sessions of ACT with traditional CBT to treat methamphetamine abuse or dependence according to Diagnostic and Statistical Manual criteria (DSM-IV) among 104 treatment-seekers, most of whom were injecting methamphetamine. The ACT therapy used Baker and colleague's brief cognitive intervention as a foundation, and incorporated additional elements from ACT. Topics included building motivation, developing coping skills to manage high-risk situations for methamphetamine use, long-term relapse prevention skills training, and therapy for other areas of the person's life that influence drug use (Smout, Longo et al. 2010b).

Findings showed ACT to be as effective (but not more so) as traditional CBT in reducing methamphetamine use, severity of dependence and negative consequences of methamphetamine use (Smout, Longo et al. 2010b). About 61% of participants that began the intervention completed at least four of the 12 sessions, and 32.5% completed 12 sessions of ACT (the completion rate for CBT was similar), therefore the investigators concluded that future studies of ACT for this group should focus on fewer sessions to improve treatment completion. This study suggests that ACT is a viable and evidence-based treatment option for methamphetamine users.

Contingency management

Contingency management is an approach that uses tangible reinforcers such as vouchers, food or cash for desirable behaviours such as returning a urine drug screen that is free from methamphetamine metabolites (Lee & Rawson 2008). Most of the research on contingency management has been conducted in the United States and among users of a range of drugs, while several studies found favourable results for contingency management when used in the context of methamphetamine treatment including reduction in methamphetamine use and greater retention in care. However as Lee and Rawson point out, it is unclear whether the benefits are sustained in the longer-term when the incentives are no longer provided.

¹⁷²⁵ See Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

Contingency management is not used in methamphetamine treatment in Australia. As Dr Rebecca McKetin and Dr David Jacka told the Inquiry:

In the US they are big on it [positive contingency management programs]. Here it is not very popular for cultural and ethical reasons. In a very crude way, it is like paying people for drug-free urine, but it is a little more sophisticated than that, and it can be implemented in various regimes. The idea is to provide people with reinforcement for not using the drug, and that can be in a number of different ways. It usually has to be in some kind of cumulative reinforcing way. It is not just a flat reward but an escalating reward, so that the longer you stay off the drug, the more you get. That has been found to be quite effective in the US.¹⁷²⁶

In the US they use a lot more [positive contingency management programs] than we are able to do here. They offer financial rewards; they offer food vouchers; they offer a whole variety of positive rewards. We just offer gold stars.¹⁷²⁷

Matrix model

Matrix was developed in California during the 1980s in response to the prevalence of problems related to the wide-spread use of cocaine and crack cocaine (Rawson & McCann 2006). A detailed treatment manual was produced by the developers to guide the delivery of the intervention.

How does the program work?

Treatment was designed to be delivered in a 16-week, intensive outpatient group program based on cognitive-behavioural therapy and covering early recovery skills, relapse prevention, family education and social support. Family and client education groups were also central to the model, as was individual therapy and encouragement to attend 12-step meetings.

Participants attended the clinic 3-4 times per week and participated in structured individual, group and family sessions that taught people how to stop using drugs and how to prevent relapse. Participants in the evaluation had 36 sessions in total of cognitive behavioural therapy, 12 sessions of family education, and four social support group sessions.

Matrix used a positive reinforcement focus, meaning practitioners supported people by identifying treatment gains in a positive way, and avoided confrontational approaches. Regular urine drug screens were also performed to measure people's progress through treatment.

Results and impact

A number of early evaluations of the Matrix Model showing the intervention had significant promise (Rawson, Huber et al. 2001) collectively resulted in a larger-scale study conducted between 1999 and 2011 across eight sites in the United States to test which aspects of the Matrix model were more effective than standard drug treatment (referred to as 'treatment as usual'). A total of 978 people who were dependent on methamphetamine and seeking treatment participated in the study, with about half randomly assigned to receive the Matrix intervention and about half to the best available outpatient treatment as usual, which varied widely across sites, and ranged from eight to 16 weeks in duration (Rawson, Marinelli-Casey et al. 2004).

Findings showed that more clients in the Matrix treatment program returned methamphetamine-free urine drug screens during the program than those who

1726 Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

1727 Dr D. Jacka, Addiction Medicine Specialist, South East Alcohol and Drug Service, Public Hearing, Melbourne 3 February 2014.

received treatment as usual — in fact they were 31% more likely to have urine free from methamphetamine during treatment. At six-month follow-up, methamphetamine use remained reduced in both groups: 69% of those followed-up returned methamphetamine-free urine drug screens.

About 41% of people completed the Matrix treatment compared to 32% who received treatment that was not tailored to methamphetamine use. People who received Matrix were 27% more likely to complete treatment than those who received non-tailored treatment, and Matrix demonstrated better treatment effects overall than treatment as usual.

Witnesses to the Inquiry told the Committee that the Matrix model has recently been introduced by the South East Alcohol and Drug Service:

At South East Alcohol and Drug Service this year we have started an intensive group treatment program for drug court clients who are using methamphetamine. It is intensive as it is 16 weeks where they attend three times a week. The idea is, as Roger said, to provide a structured lifestyle to replace the lifestyle of substance using. This is a program that, as far as I know, has not been used in Australia. It was developed in the United States about 20-odd years ago to address the cocaine epidemic over there, and they have adapted it for methamphetamine users and other substance use. It has been researched and found that is actually quite effective with good attrition rates. Plus also in terms of substance use, compared to treatment as usual, they have found more negative urine samples amongst participants in the Matrix program compared to treatment as usual as well. So we thought it was about time we started something in our area, considering there is an increase in methamphetamine use but no methamphetamine-specific intervention, so it was well and truly needed.¹⁷²⁸

HOPE Intervention

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. The program is modelled after a successful court-based program of the same name initiated in 2004 by Judge Steven S. Alm of Hawaii's First Circuit Court (Department of Justice 2011) and emphasises swift and certain principles in response to violations of parole. Judge Alm estimated around 80% of probationers in the program abuse drugs and alcohol, which suggests a strong link between drug use and crime (PBS 2014). Due to the success of the program, in 2011 it was extended to four communities in the states of Oregon, Massachusetts, Arkansas and Texas and funded through the Second Chance Act (SCA) of 2007 (Department of Justice, 18 October 2011). Since then it has been expanded across the United States.

The SCA was passed by the United States Congress to help criminal offenders successfully return to the community after they are released from prison in response to wider concerns around recidivism rates and high incarceration rates. The United States with five percent of the world's population, accounts for 25 percent of the world's prisoners; as of 2013 there were two million people behind bars, with 4.5 million on probation or parole (equivalent to the population of New Zealand) (Kornell 2013). Through the SCA, the federal Bureau of Justice has awarded more than \$250 million in grants to government agencies and non-profit organisations. Increasingly re-entry programs in the United States are moving towards a rehabilitative philosophy, based on evidence based practices (Ritter 2013, p.37).

HOPE emphasises the delivery of 'swift and certain' punishment when a probationer violates conditions of their probation. Judge Alm based his ideas on how he disciplined

¹⁷²⁸ Ms Eden Foster, Drug and Alcohol Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne 3 February 2014.

his own children. He recognised that children who were punished under a system that was consistent and predictable and prompt were less likely to misbehave than those who faced delayed, arbitrary and unpredictable punishment (Kornell 2013). He observed that probationers would often violate their probation conditions, two, three or four times, and nothing would happen, and at the 20th infraction, they would then be slammed with several years in prison, which then creates its own set of problems (Walters 2014).

How does the program work?

HOPE starts with a formal warning issued in court that any violation of probation will lead to an immediate, but brief jail stay. The program requires probationers with drug conditions — who represent the majority of the caseload — to undergo random drug tests up to six times a month. They must call a hotline each weekday morning to learn whether or not they will be drug tested that day. If they fail a drug test they are arrested immediately, and put before a court within a few hours or a few days (Pearsell 2014, p.37).

The importance of random drug tests is particularly important because there is a strong incentive to lie about drug use, or prepare for scheduled drug tests in advance, given the consequences of a positive test. A study by Farabee and Fredlund in 1996 showed that of offenders that had tested positive for recent cocaine use, 43 percent of those had denied using in their self-report (Hawken 2010, p.1).

What makes HOPE different to other probation programs is that it focuses on reducing drug use rather than on imposing drug treatment on every participant. The program only mandates drug treatment if participants test positive for drug use a number of times, but it can also mandate residential treatment as an alternative to prison. This means that drug treatment is focussed on those who need it the most. It also allows the option for probationers who are in employment to serve their jail time during weekends, so as not to jeopardise their employment, which keeps them engaged in the community (National Institute of Justice 2012).

Results and impact

An evaluation study conducted in December 2009 showed promising results in terms of HOPE's aim to reduce crime and drug use. The one-year, randomised controlled sample showed HOPE probationers were 72 percent less likely to use drugs compared to those in the control sample, with only 13 percent of HOPE probationers using drugs, compared to 46 percent of those who were in the control sample. Only 21 percent of HOPE probationers were arrested, compared to 47 percent of those in the wider population (Pew 2010).

The HOPE program has been widely lauded in the United States. In 2013 it was included in the top 25 innovations in government at the Kennedy School of Government at Harvard University (Harvard University 2013). It has been extended across the United States, with more than a dozen states experimenting with programs based on HOPE. In June 2012 the state of Washington introduced legislation based on similar principles of swift, certain and proportionate punishment and have been implementing it across the board for 70 percent of the state's 15,000 offenders, and one year in it has been reported that jail stays are down by two-thirds state wide (Kornell 2013)¹⁷²⁹.

A specialist treatment service model from Victoria

Recognising a need for tailored treatment that would be attractive to people who use methamphetamine and potentially overcome many of the barriers to treatment-seeking identified in the literature, Turning Point Alcohol and Drug Centre in collaboration with Access Health established 'Access Point' specialist methamphetamine clinic in Melbourne

¹⁷²⁹ See Chapter 21 for other examples of offender-based intervention programs.

in 2007. Services were offered by a team from the professional disciplines of nursing, psychology, addiction medicine, general practice and psychiatry. Treatment included counselling (based on the Baker et al. brief intervention for regular amphetamine users) and pharmacotherapy, where appropriate, with an emphasis on mental health, and delivered with no waiting period in a physical space separated from other clients (Pennay, Ferris et al. 2010). As Dr Matthew Frei, Head of Clinical Services at Turning Point Alcohol and Drug Centre told the Inquiry:

It is predominantly males, and a lot of young males [coming in for treatment], but we get people into their late 40s... It is not just 20-somethings. There is a frequent pattern of use that is a bit different from, say, drugs like alcohol or heroin or other opioids in that it is often not constant use; it is broken up. There is a pattern of intense use for a period of time and then a crash or a come-down and a break from use for a few days. Some people use methamphetamine every day for long periods of time, but it is quite a common presentation that people have intense use followed by brief break cycles.¹⁷³⁰

The evaluation conducted by Pennay and colleagues reported that the clinic provided services to 82 people between 2008 and 2009. They found considerably longer retention in treatment (about 100 days) among clients and higher rates of repeat attendance at sessions than methamphetamine users receiving treatment from mainstream AOD services in Victoria (85% vs 25%). Half of Access Point's clients had not previously sought drug treatment; reported high levels of satisfaction with the service offered; and showed a reduction in methamphetamine use and severity of dependence as well as improved mental health over time.

Another two specialist services for methamphetamine users were established in New South Wales in 2006 and the evaluation found similarly promising results as those reported for Access Point. For example, people were retained in treatment for a median of 89 days (an average of six treatment sessions were provided) and the use of methamphetamine reduced from 79% past month use at the start of treatment to 53% at 3 months and 55% at 6 months follow-up. The mental health of clients also improved; specifically, symptoms of psychosis and hostility decreased over time (McKetin, Dunlop et al. 2013).

Residential rehabilitation

Residential rehabilitation is a longer-term option for treatment (up to one year or longer in some cases) that offers residents an opportunity to develop the skills necessary, in a supported and structured environment, to become abstinent from the use of illicit drugs and alcohol. Residential rehabilitation usually involves a structured program that guides day-to-day activities within the community, coupled with therapeutic groups.

Residential rehabilitation is not treatment as such; rather it is a setting for a range of approaches to promote abstinence such as a 'therapeutic community' in which the dynamics and setting of the community itself effect positive change in individual members. A therapeutic community is guided by a philosophy that problematic use of alcohol and other drugs must be explored in the context of a person's whole life, and that the community assists residents to make that change, traditionally towards abstinence-oriented recovery.¹⁷³¹ This approach is referred to as 'community-as-method' for change (De Leon 2000).

A recent review of 30 publications reporting on 16 studies found positive outcomes from therapeutic communities on a number of key indicators including reduced substance use

¹⁷³⁰ Dr Matthew Frei, Head of Clinical Services, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

¹⁷³¹ In recent year, some therapeutic communities in Australian have adopted a 'modified approach', and have relaxed the admission criteria to allow people on a range of prescribed medicines including those for mental health problems and opioid replacement pharmacotherapy, to enter and benefit from the community.

and criminal involvement, increased rates of employment and improved psychological functioning, particularly among people with longer duration of stay and those that engaged in aftercare. Family and social relations were found to be improved in two studies. Overall treatment retention, however, tended to be lower than comparison groups (primarily case management, standard drug treatment or probation), particularly in longer and more intensive programs (Vanderplasschen, Colpaert et al. 2013).

Australian research with 248 people who used methamphetamine and entered residential rehabilitation showed that residential rehabilitation was effective in assisting people to achieve abstinence from methamphetamine use, at least in the short-term (McKetin, Najman et al. 2012b). As Dr Rebecca McKetin, the chief investigator of the study told the Inquiry:

The residential rehab had an impact at about three months. If you took 100 people and put them into the residential rehab, what you saw was that 33 had stopped using at three months compared to if they had not received the treatment, and that dropped to 14 at one year and 6 at three years, so really high relapse rates. That is not to say it does not work for some people, but it could be better.¹⁷³²

The outcomes from this study highlight the importance of aftercare and opportunities for 'top-up' treatment to help prevent relapse in the longer-term.

A cognitive behavioural therapy/acceptance and commitment therapy-based protocol to guide workers in therapeutic communities to respond effectively with users of amphetamine-type stimulants was developed by Lynne Magor-Blatch and James Pitts from the Odyssey House McGrath Foundation in 2009, and is available for download from the Odyssey House website (Magor-Blatch & Pitts 2009). The protocol covers clinical assessment, building motivation for change, cravings management, managing cognitions and feelings, anxiety management, and relapse prevention. It also contains more than 20 worksheets that can be used by practitioners during treatment.

Testimony from many witnesses to the Inquiry suggests that there is a very strong focus by the drug treatment sector on the importance of residential rehabilitation in the treatment of people who use methamphetamine. Residential rehabilitation is indeed an important part of the suite of evidence-based treatments available. However, as noted in the background paper to the national Amphetamine-type Stimulants Strategy (Department of Health and Ageing 2007) it is an expensive option and most appropriately reserved for people with more severe problems. Research also shows that outpatient programs are not as effective for those who are most disadvantaged, those with complex health and welfare needs, including those whose living environment is not conducive to outpatient treatment, indicating that residential care is more appropriate than outpatient care for these groups (Ciketic, Hayatbakhsh et al. 2012). The Committee visited Odyssey House and Birribi Residential Rehabilitation (Youth Support + Advocacy Services) and was impressed with the work of both these centres.

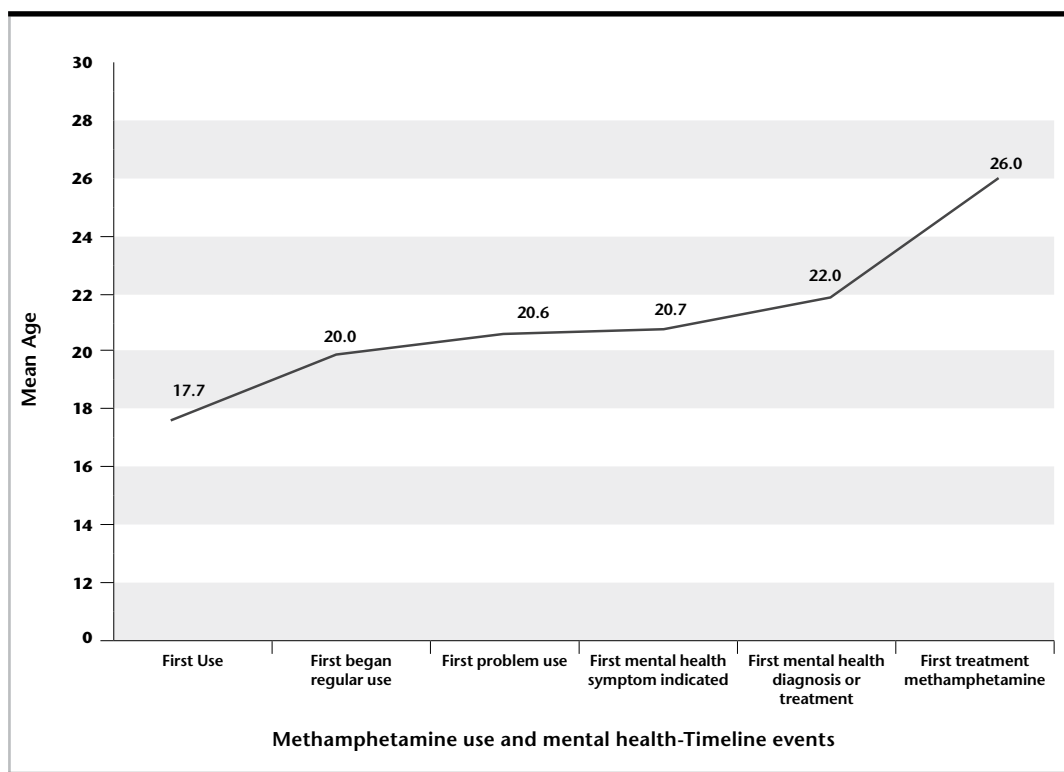
¹⁷³² Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

Management of mental health symptoms

Despite intensely euphoric effects of methamphetamine reported by users, the negative influence of methamphetamine on mental health is widely recognised and the impact of methamphetamine on people’s mental health was described by many witnesses to the Inquiry.¹⁷³³ Australian research found that around half of a sample of regular users of amphetamine 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 (Baker, Lee et al. 2004).

More recent Australian research by Lee and colleagues found that among 126 adults who used methamphetamine, 69% had been diagnosed or treated by a doctor for a mental health problem, most frequently depression (50%) and anxiety (29%). Participants reported a lag of about five years between first problematic use of methamphetamine to the time they first sought drug treatment (Lee, Harney et al. 2012). Figure 28.3 shows the temporal relationship between methamphetamine use and first drug treatment reported by participants in the study.

Figure 28.3: Temporal relationship between methamphetamine use and mental health symptoms



Source: Nicole K. Lee, Angela M. Harney, Amy E. Pennay 2012, ‘Examining the temporal relationship between methamphetamine use and mental health comorbidity’, *Advances in Dual Diagnosis*, vol. 5, Issue 1, pp.23–31.

1733 For example see Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014; Dr Cath Peake, Clinical Coordinator, Drugs and Alcohol Services, Barwon Health, Public Hearing, Geelong, 28 October 2013; Mr James Dale, Acquired Brain Injury and Alcohol and Other Drug Clinical Consultant, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014; Professor Steve Allsop, Director, National Drug Research Institute, Curtin University (via teleconference), Public Hearing, Canberra, 11 February 2014; Dr Matthew Frei, Head of Clinical Services, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013; Dr Anshuman Pant, Director of Psychiatry, South West Healthcare, Public Hearing, Warrnambool, 3 March 2014.

Depression and the potential for suicide

Methamphetamine use depletes neurotransmitters such as dopamine and to a lesser extent serotonin that are required for psychological wellbeing. Neurotransmitter stores may take days to replenish following short-term use, but brain structures that regulate the action of these neurotransmitters can be changed by long-term, regular use of methamphetamine (Sekine, Minabe et al. 2003). So for some people, recovery can take up to a year or more and depression, self-harm and thoughts of suicide may result. Mr Daniel Eltringham from Bendigo Health told the Committee:

The other issue that you do have with ice and something that I have seen a lot in my position is people who are experiencing suicidal and self-harm thoughts and their mood is just so low. The way that the ice affects the different chemicals like dopamine and that sort of stuff, they cannot feel pleasure in anything and they feel just completely worthless. With a lot of the people we are seeing, at one end you have a lot of agitation and aggression and that sort of stuff and at the other you are seeing a lot of people who have really depressed moods and self-harm-type behaviours¹⁷³⁴.

Depression and risk for suicide also pose significant problems for the Aboriginal community who are already vulnerable for a range of mental health issues. Dr Niall Quiry from the Victorian Aboriginal Health Service offered the following remarks:

I believe that when young people commit suicide or die under dubious circumstances that people will give reasons. I would suspect that a lot of the reason is in the nature of the drug. When people are coming down from ice, they get to a very depressed state, and often people have been taking a lot of other drugs with that. They take drugs to help with that process of coming down. I know that that is going to lead to depression and a detrimental mental state, so whatever your circumstances are, they are going to look a lot worse when you are coming off an amphetamine-type drug. The debts themselves are not necessary leading to suicides; it is the general sense of hopelessness and a depressed mental state. So I believe that supporting the withdrawal process is certainly going to reduce the frequency of suicide.¹⁷³⁵

As Mr David Kirby, the Director of Mental Health Services at Mildura Base Hospital reported in regard to people presenting with methamphetamine-related symptoms such as depression:

I suppose the difference for us is that we will not have people presenting to us for withdrawal from a substance. People will come to us for a mental health issue, be that psychosis and/or depression or suicidal thoughts — that type of presentation is what we will see. Then it is a matter of teasing out the reasons behind that, and quite often it is drug use, alcohol use et cetera, but we are seeing people coming in who have been using multiple substances in the past and then they have the addition of ice. For people who have been using some ice, because of the chemical changes associated with that, the down afterwards is extreme. Instead of seeing somebody with an acute depression over a number of months, they will come in after a number of days on ice — a few days after use.¹⁷³⁶

As stated in the 'assessment' section, because of the high frequency of mental health problems among users of methamphetamine, questioning about the presence and severity of symptoms, including the temporal relationship between methamphetamine use and mental health symptoms is required for appropriate treatment planning. Symptoms should be reassessed regularly as treatment progresses and care should be stepped up or down accordingly.

A careful risk assessment for self-harm and suicide should also be conducted, and monitoring of the person's mood should be a regular component of treatment. Escalation of risk for

1734 Mr Daniel Eltringham, Drug and Alcohol Care Coordinator, Emergency Department, Bendigo Health, Public Hearing, Bendigo, 25 October 2013.

1735 Dr Niall Quiry, Senior Medical Officer, Victorian Aboriginal Health Service, Public Hearing, Melbourne, 3 February 2014.

1736 Mr David Kirby, Director, Mental Health Services, Mildura Base Hospital, Public Hearing, Mildura, 5 December 2013. See also in this regard Dr Anshuman Pant, Director of Psychiatry, South West Healthcare, Public Hearing, Warrnambool, 3 March 2014.

self-harm is a trigger to conduct a comprehensive mental health assessment or link a person to an appropriate mental health professional service.

Three Australian studies found that treatment with CBT/ACT not only assisted people to reduce or stop methamphetamine use, but also had a positive effect on co-occurring symptoms of depression, at least in the short term (Baker, Lee et al. 2005; Kay-Lambkin, Baker et al. 2010; Smout, Longo et al. 2010b). Common to each of these studies and providing evidence for an effective approach were:

- ◆ attention to engagement and rapport;
- ◆ comprehensive assessment (including mental health) and regular review;
- ◆ motivational enhancement approach;
- ◆ skills building;
- ◆ identifying and managing high risk situations for relapse including cravings management;
- ◆ attention to other factors that could affect treatment gains; and
- ◆ applying the skills learned in therapy to 'real life' situations (homework).

Low mood, lack of motivation, poor concentration and reduced self-confidence may be potent triggers for people to use methamphetamine in an effort to counteract these typical symptoms of depression, therefore an important focus of treatment is to assist people to manage symptoms of depression during abstinence. A structured and detailed daily activity plan, cultivating healthy sleeping habits, a balanced diet, and setting small and achievable goals are useful strategies. The benefits of exercise in managing depression are also well-recognised (see for example Stathopoulou, Powers et al. 2006) and researchers are currently investigating the role of exercise in the treatment of stimulant use problems (see for example Stoutenberga, Rethorst et al. 2012).

Pharmacotherapy for symptoms of depression may be indicated for some people, particularly those with enduring or severe symptoms. However, the interaction between commonly prescribed medicines such as selective serotonin reuptake inhibitors (SSRIs) and methamphetamine is potentially dangerous (e.g. life threatening serotonin syndrome, in which the body becomes dangerously overheated resulting in the breakdown of muscle tissue, may result). People must be made aware of this risk and cautioned against concomitant use of medicines and methamphetamine (Juckes 2012).

Psychosis

The issue of psychosis in the context of regular or high dose methamphetamine use was raised as a significant issue by many witnesses to the Inquiry, and the Committee heard evidence about the complexity of managing people with methamphetamine-related psychotic symptoms.¹⁷³⁷ The term psychosis describes a range of conditions that affect a person's perception of reality and may manifest in alterations to mood, behaviour, thinking processes and beliefs. People may experience 'delusions' which are fixed, false beliefs that are incongruent with the person's culture or religion.

¹⁷³⁷ See Dr Tony Chan, Emergency Department Director, Latrobe Regional Hospital, Public Hearing, Traralgon, 28 January 2014; Mr Imran Mansoor, Manager, Primary Health Care, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013; Mr David Kirby, Director, Mental Health Services, Mildura Base Hospital, Public Hearing, Mildura, 5 December 2013; Ms Heather Pickard, Chief Executive Officer, Self Help Addiction Resource Centre, Public Hearing, Melbourne, 14 October 2013; Ms Kerry Donaldson, Manager, Community Programs, Youth Support and Advocacy Service, Bendigo, Public Hearing, Bendigo, 25 October 2013.

Most people who use methamphetamine regularly experience low grade (sub-clinical) symptoms of psychosis from time to time that might involve visual illusions or odd thoughts and behaviours. People who experience sub-clinical symptoms are often aware that their experience is related to methamphetamine use, and the symptoms usually abate with sleep and a break from methamphetamine use.

In contrast, methamphetamine use can also trigger an acute episode of psychosis that is extremely hard to distinguish from other mental health disorders such as schizophrenia (Ali, Marsden et al. 2010), and teasing out whether a person's presentation is methamphetamine-related or due to an existing psychotic disorder is extremely difficult. The following examples are illustrative of the challenges experienced by treatment specialists:

It is well established that methamphetamine use can cause mood and anxiety disorders during intoxication and withdrawal states and has its own diagnostic category in DSM-IV. It is also recognised that methamphetamine use can cause an acute psychosis which is self-limiting or could trigger a psychotic state in someone with a previous diagnosis or predisposition. The challenge for treatment and rehabilitation, therefore, is to establish whether there is any underlying mental health disorder which would require long-term mental health treatment in addition to the drug rehabilitation.¹⁷³⁸

I guess I would like to just go back a little bit to the people we have coming into the mental health ward. No doubt this committee has heard a lot about the ice masking or mimicking the mental health symptoms or even exacerbating them, but the clinical picture is very blurred and very difficult. On top of that there is often the reason people do not want to tell us or reveal to us what they have been taking. I think that is something we probably have not thought about and discussed — that people are not always identifying what they have been using, and they may or may not have known what they were using. They can be out and using substances and not really knowing exactly what they have used, and there could be numerous different substances. I guess that clinical picture is always very blurred when you have people coming in or accessing our service.¹⁷³⁹

Early laboratory studies demonstrated that the acute administration of amphetamine can trigger a psychotic episode, even in otherwise healthy people with no history of psychosis (Bell 1973). Research shows that the prevalence of psychosis among people who use methamphetamine regularly is around 11 times that of the general population (McKetin, McLaren et al. 2006).

Methamphetamine psychosis is characterised by delusions of persecution, auditory and sometimes visual hallucinations, strange or unusual beliefs and bizarre behaviour. The following case, as described by Mr David Rice from Ambulance Victoria in Traralgon, is illustrative of such behaviour:

One was a 21-year-old female who four of us actually went to, and she was quite irrational, at home with her parents. It took 35 minutes just to calm her down and actually get her to come into an ambulance. Even then her behaviour was quite irrational. The normal things you do with patients who are just intoxicated through alcohol is to get eye contact and slowly get a bit of rapport going. That was not working with this girl, so we had to continually get her focused. She was biting her arm, scratching incessantly, picking things up — would lose focus in about three seconds — so it was really hard to actually get any level of trust and rapport going and get some information. She could barely speak¹⁷⁴⁰

People are often extremely agitated, highly suspicious or paranoid, leading some to engage in self-protective behaviour that can, in some cases, escalate to violence (McIver, McGregor et al. 2006). The issue of methamphetamine-related violence — both with and without

1738 Dr Tony Chan, Emergency Department Director, Latrobe Regional Hospital, Public Hearing, Traralgon, 28 January 2014.

1739 Ms Jill Gleeson, Dual Diagnosis Consultant, Mildura Base Hospital, Public Hearing, Mildura, 5 December 2013.

1740 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.

psychosis — was a common theme in much of the testimony given to the Committee.¹⁷⁴¹ Great care must be taken to de-escalate potentially volatile situations, including calm and clear communication and the reduction of environmental stimuli until appropriate treatment is initiated.

Due to the physiological effects of methamphetamine, de-escalation of over-arousal with calming communication may not always be effective, however, even when highly experienced mental health practitioners are involved:

We have been talking about the hospital to date, but I will quickly follow on in terms of managing these people presenting acutely ice intoxicated in the psychiatric unit of the Geelong Hospital. The presentation has increased markedly over the last couple of years, the ones who do go into the mental health inpatient unit, whereas the mental health clinicians in the hospital, in the psych unit, are very skilled and experienced in talking down people having a psychotic episode related to schizophrenia, say, they find it is not possible to talk someone down really that is having an ice induced psychosis. They have to use the rapid sedation pharmacological and the use of seclusion more which is distressing for everyone. The point I would like to make is we do not yet know what the cumulative effects for staff are on having to deal with these much more distressing, violent [patients], and greater use of seclusion and restraint. That impacts on staff as well, of course, as the person themselves. That is something to keep in mind certainly in the emergency department.¹⁷⁴²

Australian guidelines for responding to challenging situations related to the use of psychostimulants recommends specific communication strategies, and appropriate actions should attempts at de-escalation be ineffective, usually involving ensuring the safety of the person, staff and bystanders and calling for urgent police assistance (Jenner & Lee 2008).

Methamphetamine psychosis usually resolves rapidly when the effects of methamphetamine have worn off. Psychosis that persists for over one month following abstinence is likely to be the result of a pre-existing vulnerability or pre-existing psychotic illness such as schizophrenia and is treated with antipsychotic medicines, for example olanzapine or haloperidol (Ali, Marsden et al. 2010) and psychosocial care.

As the Director of Psychiatry at South West Healthcare Dr Anshuman Pant told the Committee:

The issues that we see in the mental health team, one is of intoxication, patients that come to ED with amphetamine intoxication. If the symptoms are not resolving they will probably pass them on to us, to the mental health unit. The second is amphetamine induced psychosis. There is some data which I can share about the global prevalence of amphetamine induced psychosis which is around eight percent to 46 percent in regular users. There are several studies which are quite robust in this area. Eight percent to 46 percent of regular users have a risk of developing a psychotic episode. Most of the psychotic episodes are self-limiting or they limit within two weeks of treatment. However, about five to 10 percent, maybe 15 percent can get chronic and then it is difficult to tease out what is going on, whether it is an amphetamine induced psychosis or a functional psychosis like schizophrenia. We do have a few clients in the early intervention teams where it is very difficult to tease out what is going on. In fact some of them have not been abstinent enough for a month for us to tease out what is going on. It (methamphetamine use) is a comorbid condition, is something which I am seeing in our mental health settings.¹⁷⁴³

1741 For examples, see Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014; Mr Wayne Daly, Nurse Unit Manager, Alexander Bayne Centre, Psychiatric Services, Bendigo Health, Public Hearing, Bendigo, 25 October 2013; Dr Tony Chan, Emergency Department Director, Latrobe Regional Hospital, Public Hearing, Traralgon, 28 January 2014; Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates Court, Public Hearing, Traralgon, 28 January 2014; Ms Jan Rowe, Chief Executive Officer, Mirabel Foundation, Public Hearing, Melbourne, 17 February 2014; Dr Roger Volk, Forensic and Other Drugs Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014; Mr Les Twentyman, OAM, 20th Man Fund; Mr Paul Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013.

1742 Dr Cath Peake, Clinical Coordinator, Drugs and Alcohol Services, Barwon Health, Public Hearing, Geelong, 28 October 2013.

1743 Dr Anshuman Pant, Director of Psychiatry, South West Healthcare, Public Hearing, Warrnambool, 3 March 2014.

People who have experienced psychosis in the context of methamphetamine use, or who have an existing psychotic disorder, are extremely vulnerable to the acute effects of methamphetamine administration¹⁷⁴⁴ such as rapidly increased levels of dopamine, and should be cautioned against continued use as risk for relapse of psychosis is high. Methamphetamine may also interact with antipsychotic medicines rendering them less effective, therefore close monitoring of symptoms and medicine compliance should be conducted.

The prevalence and potential severity of mental health symptoms among users of methamphetamine suggests that staff in AOD treatment services must be sufficiently trained in, and have capacity for, recognition, assessment, treatment planning and follow-up. However; staff may not be currently receiving the support required. As Mr Jon Borkowski, Coordinator AOD Services in Morwell told the Inquiry:

The other one is the area of dual diagnosis. I think that a few years ago training in dual diagnosis was quite big. There was a lot going on. Unfortunately, over a period of time that has declined. Within our field we have a very high turnover of staff. If we are getting new staff coming in that have not been trained in dual diagnosis — because we know that there is a link between drug use and mental health issues — we struggle. So training is extremely important to be maintained within our sector, especially looking at new drugs coming in, because ice is relatively new. We know how to deal with amphetamines. Ice has a different aspect to it.¹⁷⁴⁵

Alternatives to face-to-face treatment: The case for online self-help and treatment opportunities

As noted, many people who use methamphetamine are reluctant to seek assistance from specialist services, particularly when adverse effects are not yet severe, and many prefer to self-manage symptoms such as disturbed sleep and mild psychological distress. Coupled with the characteristics of methamphetamine users, that is, their relatively young age and patterns of use, these findings have led to a growing interest among clinical researchers in developing internet-based options to promote the availability of credible and evidence-based early intervention, self-help, and structured treatment opportunities. As Mr Simon Ruth, from the Victorian AIDS Council observed:

There could be options for exploring online modules, particularly for naive users. If you know you are going to be using amphetamines, you might go and Google them if you do not have the friends to talk to. So they could be an area that we could move into.¹⁷⁴⁶

In 2012-13, about 83% of Australians had access to the internet at home (including 79% of households outside of capital cities) and most accessed the internet every day.¹⁷⁴⁷ About 75% of people are estimated to look online for health information. There is a growing body of research evidence for the benefits of online therapy in the treatment of, for example, anxiety (Klein, Meyer et al. 2011) and alcohol use problems (White, Kavanagh et al. 2010). The Australian National University now has a centre for research and development into online therapies.

The importance of ensuring access to these technologies for people who use methamphetamine was also raised by Ms Debbie Stoneman from Latrobe Community Health Services:

1744 This is known as 'amphetamine sensitization' and involves dysregulation of the dopamine signalling system in the brain. It may also play a role in drug-seeking behaviour. See O'Daly OG, Joyce D, Tracy DK, Azim A, Stephan KE, et al. (2014) Amphetamine Sensitization Alters Reward Processing in the Human Striatum and Amygdala. *PLoS ONE* 9(4): e93955. doi:10.1371/journal.pone.0093955.

1745 Mr Jon Borkowski, Coordinator Alcohol and Other Drug (AOD) Services Morwell, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

1746 Mr Simon Ruth, Director of Services, Victorian AIDS Council, Public Hearing, Melbourne, 14 October 2013.

1747 Australian Bureau of Statistics, Household Use of Information Technology, Australia, 2012-13.

We need ice specific, 24-hour online and anonymous counselling, which I guess leads into that fear of the legal ramifications — telephone counselling, with the ability to refer to local service providers. The community is becoming so much more technologically savvy and counselling at that level is showing itself to be very effective.¹⁷⁴⁸

Real-time online counselling

CounsellingOnline, run by Turning Point Alcohol and Drug Centre's Healthlink, delivers 24/7 online, text-based counselling for people with alcohol and other concerns, and is accessible via an Internet website, www.CounsellingOnline.org.au. An evaluation conducted in 2007 showed the service had provided 2,004 sessions of online counselling in its first 13 months of operation, representing twice as many episodes of care delivered by one of Victoria's largest AOD treatment agencies (Swan & Tyssen 2009). Nearly two-thirds of all sessions were provided outside of regular business hours. A significant number of contacts were with women, young people aged 24 years and under, students, and those in the workforce — groups that specialist drug treatment services typically find difficult to reach. Around 35% of sessions involved stimulants as the primary drug of concern, and for 39% of clients it was their first contact with an AOD treatment service.

Websites

An online survey of about 1,200 drug and alcohol website users conducted by Australian researchers found that information-seeking was the most common reason for accessing the websites. Participants valued a good design and ease of navigation; open access; and content that was reliable, valid and trustworthy. Screening tools, self-help treatment programs; and downloadable factsheets were also considered important features. Participants preferred online treatment with the option of email support by a therapist (Klein, White et al. 2010).

Two Victorian, online resources for people who use meth/amphetamine are currently available. The first, meth.org.au is a self-help website developed for users of methamphetamine and family members in 2008 by Turning Point Alcohol and Drug Centre with funding from the Amphetamine-Type Stimulants (ATS) Grants Program. It contains self-assessment, worksheets, and a brief self-help intervention based on the Baker and colleagues CBT manual. However, the site is heavily text-based and has not been updated for a number of years.

The second online resource is bluebelly.org.au, which is a collaborative, harm reduction-focused website that offers information and a forum about ATS. It was developed in 2008 by UnitingCare ReGen also with funding from the ATS Grants Program. The site has not been updated in recent years.

Structured online treatment for methamphetamine use

Psychosocial treatment such as CBT is most commonly delivered face-to-face. However, research conducted in Australia showed that among 25 people with problematic methamphetamine use and concurrent depression who received nine sessions of CBT via computer, reduced methamphetamine use at the same rate as those who received treatment delivered by a practitioner (Kay-Lambkin 2008). Severity of depression also improved following the online intervention, and treatment gains were maintained at 6-months follow-up.

In 2012, Australian researchers published a protocol to conduct a randomised-controlled trial of a brief online CBT intervention for ATS use, comprising three modules and an expected completion time of 90 minutes. Outcome measures will include ATS use at the beginning of therapy, at three months and again at six months; 'readiness to change'; quality

1748 Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

of life; psychological distress; days out of role; poly-drug use; help-seeking intention and help-seeking behaviour (Tait, McKetin et al. 2012).

Further investigation of the role of computer-delivered treatment is warranted in an effort to reach a wider group of non-treatment seeking methamphetamine users.

Need for follow-up and aftercare services

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. For example, people are likely to make more than 10 attempts to quit smoking before they are successful (Center for Tobacco Research and Intervention 2003). Relapse rates among people with alcohol and drug dependence are similar to those of other chronic medical illnesses such as diabetes, hypertension and asthma, which are also influenced by behavioural and physiological factors (see National Institute on Drug Abuse (US) 2009). In this context, calls for results-based accountability for drug treatment service providers¹⁷⁴⁹ must not rely on abstinence as a key outcome indicator; however, ongoing measurement of progress is a crucial element of treatment and must be conducted regularly and routinely.

Craving to use alcohol or other drugs is a hallmark of dependence and is a known trigger for relapse. Due to the action of methamphetamine on the central nervous system and its immediate and highly reinforcing effects, cravings to use can be intense. Similarly, for many regular users and those with dependence, the recovery period is lengthy. It is not surprising therefore that among people who reduce or stop using methamphetamine, risk for relapse is high, as demonstrated by research conducted by Dr Rebecca McKetin and colleagues (McKetin, Najman et al. 2012).

Follow-up for missed appointments for all clients of AOD treatment services is ideally a routine part of clinical practice. 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 (see also 'Neurocognitive effects of methamphetamine and impact on treatment' in this chapter).

Mr John Insana, General Manager, Community Correctional Services, South-east Metropolitan Region stressed the importance of follow-up when he told the Inquiry:

We have also had a number of self-reports from staff that indicate a number of offenders, in particular young offenders, are contravening their orders earlier on. They are forgetting appointments or they might be hard to track down. In terms of our case-management plan, it is imperative for us to get on the front foot and ensure there is timely follow-up. When they miss appointments we try to follow up in a timely manner.

People who use methamphetamine and have been engaged with treatment in either residential or outpatient settings need opportunities for follow-up and aftercare to prevent relapse. The importance of aftercare was emphasised by several witnesses to the Inquiry. For example, in discussing the needs of new mothers, Dr Ellen Bowman from the Royal Women's Hospital Alcohol and Drug Service stated:

We know that pregnancy is a time when women are often motivated to make change for the better in their lives. This is a window of opportunity to do this, but we need to support and get these services on board. I would personally make a plea from the baby's perspective that a well mum helps to have a better baby. We know that there are risks of women falling back into their old behaviours. Stats are

¹⁷⁴⁹ See Ms Shelley Turner, Founding Partner of Rangatira Management Consultancy, Submission, 13 June 2014.

high that this has a tendency to occur at six to eight months post-partum, and we just need to make sure that the services do not withdraw too soon.¹⁷⁵⁰

Similarly, the importance of follow-up and aftercare for those who return to regional Victoria following residential treatment was stressed by some witness.¹⁷⁵¹ For example, Dr Paul MacCartney, a Medical Practitioner with Primary Care Connect in Shepparton stated:

They go into a place for 3 months, or even 12 months or two years in some cases, and they learn some connection. The reason it works is that they develop therapeutic communities. They develop a source of identity and meaning with the people they are with, but then it finishes and they are plonked back into their community. Again they are struggling for those sources of identity and meaning. I agree with you, Tim, that post-rehab is absolutely vital. Building connections within the community is essential.¹⁷⁵²

It is important to recognise that treatment gains can be retained long-term though, as demonstrated in a follow-up study of a convenience sample of over 100 people from two to five years following treatment for methamphetamine dependence with the Matrix model (Rawson, Huber et al. 2002). Rawson and colleagues found 82.5% were no longer using methamphetamine, 11% reported 'some use' and 6% reported daily use. Urine drug screens were conducted on half of the group and confirmed self-report.

A report of findings for the effectiveness of telephone follow-up to prevent relapse among people who had completed treatment for stimulant use problems was recently published. Investigators found that those who received telephone follow-up had reduced problems with substance use at three months, while those who were simply passively referred to an after-care program and received no telephone follow-up had increased problems with substance use (Farabee, Cousins et al. 2013).

It is clear that AOD treatment services need to be adequately resourced to provide meaningful after-care for people at high risk for relapse to methamphetamine use.

Adjusting treatment to better suit the needs of methamphetamine users

Until recent years, the most common problems encountered in specialist drug treatment services were those associated with the use of alcohol or heroin, and workers are highly experienced in providing effective responses for these substances. However, as the statistics from the Australian Government Institute of Health and Welfare show, people are presenting to specialist services seeking treatment for methamphetamine use in increasingly greater numbers. Due to the particular effects of methamphetamine and the often small window of opportunity available to respond when someone is ready to engage in treatment, services and systems require adjustment to meet the specific needs of people who use methamphetamine.

One such adjustment that has been shown to be effective with depressed people who use methamphetamine is a stepped-care approach to treatment, as discussed elsewhere in this chapter. Using a stepped-care approach can build on brief therapies that are known to be effective for some users of methamphetamine, yet deliver the additional treatment and support to those who require it.

The need to re-orient treatment and service provision and the steps being taken in Victoria were described to the Inquiry by witnesses:

1750 Dr Ellen Bowman, Paediatrician, Royal Women's Hospital Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

1751 See also Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Public Hearing, Shepparton, 25 February 2014; Mr Paul Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013.

1752 Dr Paul MacCartney, Medical Practitioner, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014.

We know that brief interventions and cognitive behavioural therapy can be effective and again we are working to try to really understand the types of people coming to our service for ice use and to be specifically tailoring treatment. A one size fits all, the same approach we might take for someone who is only alcohol dependent, cannot be the same.¹⁷⁵³

Treatment services generally need to make small changes to accommodate the needs of amphetamine users. These changes are especially important early on in treatment, where disrupted sleep patterns, anxiety and agitation require greater flexibility in treatment expectations, routines, use of medication and a longer period of withdrawal than for other drugs¹⁷⁵⁴.

Before we get into treatment, I just want to say that 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, but the impact on them during that time makes the treatment look very different. You are replacing hours and hours and a lifestyle of use, which is different from an alcohol user or a marijuana user, which is how the Matrix program is probably going to be effective.¹⁷⁵⁵

It is difficult to ascertain how effective treatment provided by DAS has been to date for crystal methamphetamine users. Data specifically relating to outcomes and re-presentations for this specific population has not yet been collated. However, it appears that a “one size fits all” approach to community based clinical treatment is not sufficient and a greater degree of specificity with regard to treatment for different types of substances (and poly-substance use) would be beneficial. The DAS Addiction Psychiatrist and Clinical Coordinator are currently in discussion about developing more specialised and targeted interventions (including perhaps a specialist sub-team) that will be specific to adult crystal methamphetamine users.¹⁷⁵⁶

Similarly, the clinical picture of a person experiencing withdrawal from methamphetamine is substantially different to that of a person withdrawing from alcohol or heroin as detailed in the ‘withdrawal’ section. UnitingCare ReGen, a service that provides supervised withdrawal from methamphetamine has recently altered how that support is delivered. Ms Donna Ribton-Turner told the Inquiry:

We have changed the program so that people can crash for that first few days, and we have gone right back to basic nursing care — giving people fluids and food and keeping them in a low-stimulus environment for the first three days, and then gradually introducing a much lower stimulus program. We are offering 10-day admissions, but even something like that has the capacity to reduce our throughput by about 200 episodes a year, and we are trialling a step-up, step-down approach, where someone can step down to non-residential withdrawal support, which needs to be for at least four to six weeks after, because they are still experiencing withdrawal systems in that period.¹⁷⁵⁷

However, the need to reorient services may place strain on some specialist services, particularly those located in rural and regional Victoria. As Ms Claire Ryan from Ballarat Community Health told the Inquiry:

Current AoD treatment services and treatment facilities are not set up to respond to the needs of methamphetamine users. The process for withdrawal is longer and treatment needs to be more intensive and timely. Long waiting times are an issue as clients tend to relapse and disengage before resources become available. This is particularly true of smaller, already under-resourced rural services which have to transport clients long distances to access detox and rehabilitation facilities.¹⁷⁵⁸

Family-centred practice

1753 Dr Cath Peake, Clinical Coordinator, Drugs and Alcohol Services, Barwon Health, Public Hearing, Geelong, 28 October 2013.

1754 Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria, Submission, 21 October 2013.

1755 Dr Roger Volk, Forensic and Other Drugs Counsellor, Monash Health, South East Alcohol and Drug Service, Public Hearing, Melbourne, 3 February 2014.

1756 Dr David Eddy, 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.

1757 Ms Donna Ribton-Turner, Director, Clinical Services, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013.

1758 Ms Claire Ryan, Alcohol & Other Drug Services Team Leader, Ballarat Community Health, Submission, 12 November 2013.

General issues for families

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.¹⁷⁵⁹ As the mother of a 24-year-old user of methamphetamine told the Inquiry:

I have even thought of going and sitting in a shed somewhere with her, because I do not know where to go. If she does not want help, how am I going to deal with that?¹⁷⁶⁰

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.¹⁷⁶¹ Grandparents are also sometimes forced into a full-time caring role when their children are unable to provide care for their own offspring. Even though there may be much love in homes such as these, the impact on everyone concerned is enormous. As one full-time carer of three very young grandchildren in this situation recently wrote '[n]ot only do we have to deal with the loss of our daughter, but the loss of our future. All of our dreams have been destroyed'.¹⁷⁶²

Families have needs for information and effective support in their own right, and evidence was provided about the increasing demand for both:

At any one time our family services programs across our agency in all divisions see about 1000 families, so it would be 10 to 40 percent of those families where ice use is a factor, either current use or past use.¹⁷⁶³

What we have noticed is a 63 percent increase in the presentation and contacts with families, various components of families, whether it be parents, brothers, sisters, husbands, wives, and from the community point of view it is from welfare agencies and the workplace in particular.¹⁷⁶⁴

Over the years since I have been with Mirabel there has been an increasing number of families that when we first speak to the carer who makes contact with us, they mention that their son, daughter, sister, cousin or whoever is the parent of the child has been using ice and has been using ice for quite some time and the impact on the children.¹⁷⁶⁵

Challenges for providing assistance to families

Maintaining the confidentiality of a client while providing effective support for families can be challenging for treatment providers, but much can be done while observing a client's privacy or consent may be gained from the client to share information. In many cases, the family member is the client, particularly when the person who is using methamphetamine

1759 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.

1760 Ms Kerryn Johnston, Public Hearing, Wodonga, 24 February 2014.

1761 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.

1762 'Susan MacFarlane' (2012), living with amphetamine problems — a family's story (page 133), in Allsop, S & Lee, N 2012, Perspectives on amphetamine-type stimulants. IP Communications, East Hawthorn.

1763 Mr David Giles, General Manager, Family and Community Services, Anglicare Victoria, Public Hearing, Melbourne, 3 February 2014.

1764 Ms Bev McIlroy, Manager, Glenelg Southern Grampians Drug Treatment Service (QUAMBY), Public Hearing, Warrnambool, 3 March 2014.

1765 Ms Elizabeth McCrea, Advocacy and Family Support, Mirabel Foundation, Public Hearing, Melbourne, 17 February 2014.

is not seeking treatment themselves, in which case the needs of the family member are central to therapy.

Families have also reported various unhelpful experiences when attempting to seek help such as being ignored, dismissed or having their concerns trivialised by service providers.¹⁷⁶⁶ Families may also be unaware of how to access support and have difficulty navigating a potentially complex treatment system.

Although family support and education is important, services may not be adequately resourced to provide these, as reported in a submission to the Inquiry:

Working with families is core business within the drug treatment services; however it is not recognised or compensated appropriately through the funding stream. A predominant increase in family inclusive treatment is evident with an ice user, straining the service sector in treatment capacity.¹⁷⁶⁷

However, evidence provided to the Inquiry by the Department of Health suggests this may be addressed by the current reforms to AOD treatment services:

One of the features of the reforms that we are pushing forward at the moment is a new stream of funding which we would call Care and Recovery Coordination. This is targeted at an estimated 20 to 30 percent of clients who have more complex care needs. That will really allow care to be carried through and structured in a more flexible way over a period of up to six months, or even longer than that if it is warranted. That is very much where some of those interactions with services that connect with other parts of the community services systems can be followed through in more detail.¹⁷⁶⁸

What can be done to assist families?

According to Jenner and Lee (2008), useful approaches to assist families include helping families to clarify issues; explaining patterns of drug use including dependence, the effects of methamphetamine use including the 'crash' period and effects on mental health, and the concept of 'readiness to change'. They also include helping families to recognise escalating symptoms of psychosis or loss of emotional control and to develop a crisis plan for action; assist the family to set and maintain boundaries; encourage self-care, and provide information about family support groups and specialist family therapists.

When witnesses were asked by the Committee to describe what support was available for families, they offered the following examples of what is available:

We have many programs and we work with many other community organisations in delivering programs. What we find is that it is not that different to any other drug in the kinds of needs of the family. What we have found is that we need to teach families how to practise defusing techniques and how to be much more protective and aware of their own safety and the requirements of the rest of the family. We have found that families need — and I will reinforce this probably many times — to heal themselves in the initial stages. We have found that community supports such as support groups, especially in the rural areas, are a critical part of their process in coming to terms with the issue.¹⁷⁶⁹

We have single sessions, we have family counselling and we have partnerships with Family Drug Help, so we do a six-week education program for family members, and that is booked out months ahead. Then we have a family and friends support group. So we are doing a lot of work with families to try to support them.¹⁷⁷⁰

1766 Sharon O'Reilly, Clinical Services Manager, Bayside Medicare Local, Submission, 21 October 2013.

1767 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013.

1768 Mr Martin Turnbull, Manager, Service System Development and Reform, Community Programs and Prevention Branch, Mental Health, Drugs and Regions Division, Department of Health, Public Hearing, Melbourne, 31 March 2014.

1769 Ms Heather Pickard, Chief Executive Officer, Self Help Addiction Resource Centre, Public Hearing, Melbourne, 14 October 2013.

1770 Ms Donna Ribton-Turner, Director, Clinical Services, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013.

What needs to be done?

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.

As Mr Mark Powell from Headspace in Warrnambool told the Inquiry:

One of the things — and I probably did not say it clear enough at the start, but the actual engagement into the system is problematic and we are not getting people early enough. Often the families, are picking up the concerns early on. We need to make a system that responds to those family needs, and engage the family and work with the family around bringing the young person into treatment.¹⁷⁷¹

Conclusion

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.

Some interventions have been shown to be effective for some people who use methamphetamine, including brief interventions, cognitive behaviour therapy, Acceptance and Commitment Therapy, motivational enhancement, contingency management, and residential rehabilitation. Programs such as Matrix and HOPE are also promising, and services should be using these evidence-based approaches as first-line options for treatment. For novel and innovative interventions that build on the evidence base, services need to be adequately funded to undertake formal evaluations of programs, which should be built in to service agreements. Similarly, services need to be adequately resourced to offer the range of interventions that are required by a diverse group, including options for extended withdrawal treatment, outpatient and residential care, and assertive follow-up and aftercare.

More research is required into treatment options for specific groups of people who use methamphetamine, including young people and Aboriginal people, as well as for those with various patterns of methamphetamine use.¹⁷⁷² Online CBT-based self-help and formalised treatment, both with and without the option of therapist support are worthy of focused investigation to reach a broader base of people and to encourage earlier intervention to prevent the onset of more severe problems.

Although quite a number of resources are available to guide treatment practices, they are dated and are largely unknown to current service providers. Resources to support workers in their roles, as well as resources written for consumers, require review and wide dissemination that includes training and ongoing supervision for health providers and ease of access for consumers.

¹⁷⁷¹ Mr Mark Powell, Dual Diagnosis Senior Clinician, Headspace, Public Hearing, Warrnambool, 3 March 2014.

¹⁷⁷² See discussion in Chapter 29.

Furthermore, the families of people who use methamphetamine have clear and established needs for information and support in their own right and service providers need to be adequately trained and resourced to provide effective family-sensitive practice as a matter of course.

Recommendation 16

The Committee recommends that the Victorian Government:

- a) *Ensure that the available guidelines on methamphetamine are updated and disseminated widely to practitioners and services*
- b) *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*
- c) *Ensure all workers in alcohol and other drug treatment settings have available to them appropriate and regular professional supervision*
- d) *Ensure that agencies have policy and procedures in place to support the implementation of methamphetamine-specific treatment.*

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.*

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.*

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 27)

29. Treatment Needs of Specific Populations

Introduction

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. This chapter examines these specific groups and the barriers and facilitators to treatment that they may face.

Treatment and service provision in rural and regional communities

Whilst there are many barriers and challenges facing treatment providers in addressing the needs of clients who use ice, that will be the same in both Melbourne and regional Victoria; for example, the inadequacy of the amount of time allocated for withdrawal, or the long waiting periods to ascertain treatment. There are, however, some issues that may be particularly applicable in rural settings, such as issues pertaining to accessing services, the difficulty of maintaining anonymity in rural settings, and insufficient alcohol and other drug (AOD) specialists working in country areas.

Another possible problem facing rural drug treatment providers is that some small rural communities in Victoria may not have previously experienced a significant problem with 'hard' drug use and are therefore not sufficiently equipped to address it. As discussed in Chapter 11, many witnesses to the Inquiry have commented that crystal methamphetamine use in regional Victoria needs to be considered in relation to the misuse of other drugs. Alcohol in particular is considered to be the biggest 'drug problem' in rural and regional Victoria.¹⁷⁷³

This Inquiry has received evidence from countless witnesses that the major problem regarding methamphetamine use in rural and regional communities is the lack of treatment facilities including detoxification and rehabilitation centres in *local* proximity.¹⁷⁷⁴ It is not unusual for a person in a region such as Mildura or Gippsland to have to seek treatment

1773 See discussion in Chapter 11, although as mentioned in that chapter other witnesses have commented that a problem with methamphetamine, although arguably to a lesser degree than present, was noticeable in regional Victoria as long ago as the early 2000s.

1774 The number of witnesses who made this observation is far too numerous to record here in their entirety. Some of the more comprehensive accounts of problems associated with rural service delivery include:

Mr Laurence Alvis, Chief Executive Officer, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013; Ms Cayte Hoppner, Director of Mental Health, Latrobe Regional Hospital, Public Hearing, Traralgon, 28 January 2014; Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014; Mr Donald Currie, Team Manager Alcohol & Other Drugs, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014; Ms Fiona Harley, Deputy Executive Director, Mallee Family Care, Public Hearing, Mildura, 5 December 2013.

in a city such as Adelaide or Melbourne some distance away — the ‘tyranny of distance’ as some rural service providers have called it.¹⁷⁷⁵

For example Bev McIlroy, Manager of the Glenelg Southern Grampians Drug Treatment Service, told the Committee that that this problem of distance is exacerbated by poor public transport in rural areas, particularly when many users may not have their own cars:

Then we have the obvious things like distance, lack of transport... How do we get our clients over here? The bus leaves Portland at 3 o'clock in the morning and gets back at 6 o'clock at night. That is a typical thing.¹⁷⁷⁶

The lack of local treatment facilities can result in problems associated with sending a person away from their local support networks, a particular issue discussed earlier in Chapter 12. In addition, it is not uncommon for waiting lists to access such metropolitan facilities to be long and for no appointments to be available at the stage in the person's life when he or she wants to access treatment. As Mr Francis Broeckman told the Committee:

There can be a couple of months waiting period to access [AOD treatment] services. That is a long time if someone wants to seek a service to try and hold them in that ‘still want to change’ phase before that is lost... When people are willing to change, that you have the ability to work quickly and as seamlessly as you can to get those services is really important, when the time is right.¹⁷⁷⁷

An added complication may be that in small rural hospitals where resources are limited, methamphetamine patients suffering from withdrawal may be ‘extremely difficult to manage’ placing both patients and staff at risk (Armstrong & Guthrie 2012, p.150).

Challenges for providing treatment in rural and regional areas

There are a range of challenges associated with methamphetamine use and service provision in rural and regional areas of the state. For example, Ms Cath Murphy told the Inquiry that in the Mildura Rural City Council precinct there is a 12-bed mental health inpatient unit, no residential withdrawal beds, no headspace early intervention service for young people and no prevention and recovery care (PARC) unit.¹⁷⁷⁸

Similarly, a submission from Ballarat Community Health stated:

Current AoD treatment services and treatment facilities are not set up to respond to the needs of methamphetamine users. The process for withdrawal is longer and treatment needs to be more intensive and timely. Long waiting times are an issue as clients tend to relapse and disengage before resources become available. This is particularly true of smaller, already under-resourced rural services which have to transport clients long distances to access detox and rehabilitation facilities.¹⁷⁷⁹

The need for *local* treatment facilities was also stressed in a submission from the Northern Mallee Community Partnership in the context of service provision for Mildura and surrounding districts:

1775 See for example, Detective Senior Sergeant Chris Pegg, Divisional Crime Adviser, Division 6, Eastern Region, Victoria Police, Public Hearing, Traralgon, 28 January 2014; Ms Bev McIlroy, Manager, Glenelg Southern Grampians Drug Treatment Service (QUAMBY), Public Hearing, Warrnambool, 3 March 2014.

In regard to distance problems, Mr Geoff Soma from The Western Region Alcohol and Drug Centre (WRAD) in Warrnambool believes there should be a rural funding loading for drug and alcohol services in the country. See Mr Geoff Soma, Chief Executive Officer, WRAD, Public Hearing, Warrnambool, 3 March 2014 and the discussion in Chapter 11.

1776 Ms Bev McIlroy, Manager, Glenelg Southern Grampians Drug Treatment Service (QUAMBY), Public Hearing, Warrnambool, 3 March 2014.

1777 Mr Francis Broeckman, Chief Executive Officer, Brophy Family and Youth Services, Public Hearing, Warrnambool, 3 March 2014.

1778 Ms Cath Murphy, Director of Disability and Mental Health Services, Mallee Family Care, Public Hearing, Mildura, 5 December 2013.

1779 Ms Claire Ryan, Alcohol & Other Drug Services Team Leader, Ballarat Community Health, Submission, 12 November 2013.

According to Sunraysia Community Health Service, Drug and Alcohol Team, treatment for withdrawal needs to be more tailored towards methamphetamine users, although there is no set pharmacotherapy regime for methamphetamine.

The current set up in residential withdrawal units located *away from the region* is not conducive to the needs of the client, especially in the first few days to a week, where clients undergo a crash period... increased possibility of suicidal ideation and possible attempted/completed suicides.¹⁷⁸⁰

The issue of adequately addressing withdrawal from methamphetamine is a serious concern confronting rural service providers. This was commented upon by Laurence Alvis, CEO of Uniting Care ReGen when he gave evidence to the Committee:

One of the questions I think is worthwhile commenting on is in relation to...rural issues and enthusiasm in the rural areas to actually deal with some of these issues around methamphetamine. One of the notes of caution around this — certainly we have found — is that this is probably the most complex withdrawal process we currently have... I think one of the issues you may well have in the country is that you do not have that level of resources to actually do some of these withdrawals.¹⁷⁸¹

This was also mentioned by James Dale and Debbie Stoneman from LaTrobe Community Health Services in Gippsland:

One of our biggest challenges is that there is no inpatient withdrawal unit or residential rehab facility in Gippsland. Again, the access to these facilities is problematic due to the distance and the wait lists associated with receiving this kind of treatment. Due to the delay in treatment, clients can disengage with services and often relapse.¹⁷⁸²

What we are finding is that the withdrawal for ice versus speed is just so much more intense and much longer. The current withdrawal stays are set up usually at five to 10 days, and often we do not see people completing the difficult stage of their ice withdrawal for a couple of weeks. So the current withdrawal programs do not quite meet that need of these people.

When we look at hospital admissions for withdrawal, we are limited in this region to be able to admit a person to a local hospital primarily for a withdrawal, and of course beds are at such a premium that often we cannot keep people in hospital long enough anyway to get through a withdrawal.¹⁷⁸³

A number of witnesses located in regional Victoria stated it was simply wrong to expect a client to go to Melbourne to access treatment, effectively exiling themselves from family and community supports. For example, Melanie Vidler from the Bridge Youth Service in Shepparton told the Committee:

Young people have identified [to us] that they will just detox themselves at home — go through hell for a month — to get through whatever kind of withdrawal, whether it is ice or marijuana, because they do not want to go to Melbourne. That is a massive thing at the moment — young people are not wanting to travel for treatment. Their treatment for one to two weeks is funded, and then they come back to the same situation, the same people, the same friends and no support — they are falling back into the same circles. That is identified across the board in the youth sector here in Shepparton. That is a major issue for young people in our area and in rural Victoria in general, I guess, because you do

1780 Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013.

For other accounts of the need for more specific treatment facilities in rural and regional Victoria, see Mr Rudolf Kirby, Chief Executive Officer, Mildura District Aboriginal Services, Submission, 21 October 2013; Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013; Ms Karen Gurney, Managing Lawyer, Goulburn Valley Community Legal Centre, and Mr Peter Noble, Coordinator, Loddon Campaspe Community Legal Centre, Submission, 31 October 2013; Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol & Drug Association VAADA, Submission, 11 November 2013; Mr Zach Mason, Youth Worker, Junction Support Services, Public Hearing, Wodonga, 24 February 2014;

1781 Mr Laurence Alvis, Chief Executive Officer, UnitingCare ReGen, Public Hearing, Melbourne, 30 September 2013

1782 Mr James Dale, Acquired Brain Injury and Alcohol and Other Drug Clinical Consultant, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

1783 Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

need to go to the larger cities to seek that treatment, and then after they have returned — I think the maximum they can stay is for two weeks — ice may have just got out of their system and they are back with the same friends and the dealer across the road.¹⁷⁸⁴

Craig McGregor a Senior Withdrawal Nurse from Goulburn Valley Health made a similar criticism:

The demand for beds in rehabs has been well documented in Shepparton for many years... We do not have the same staff coming through [rural] areas, and when they do leave for Melbourne there are huge gaps and huge holes and we have to rebuild.

The current process to accessing beds is a real issue for rural clients. Requiring them to have face-to-face interviews in Melbourne is completely inappropriate when they have to get onto trains teeming with drug users. They use more drugs, make new networks. It is just horrible for some of these clients.¹⁷⁸⁵

Anonymity and confidentiality issues

Another significant issue is people's desire for privacy and anonymity when treatment seeking in a small community, and fears concerning loss of confidentiality may be a barrier to disclosing substance use (Wallace, Galloway et al. 2009). The social dynamics particular to smaller communities, while often positive, can also be an obstacle in accessing services. As the 2001 'Rural and Regional Alcohol and Other Drugs Consultation Forums' noted:

People in rural and regional areas tend to be reluctant to disclose their drug use... for fear of identification and stigmatisation (Australian National Council on Drugs 2001, p.7).

Although these comments were made over a decade ago, arguably they are as true today, as reflected in the following evidence from Bev McIlroy, Manager of the Glenelg Southern Grampians Drug Treatment Service:

Lack of anonymity in a small rural community is not to be overlooked in any circumstance when you are trying to get people to engage in drug treatment, particularly in this because it is such a fearful drug. It is such a dangerous drug...Confidentiality and the lack of anonymity [are barriers to treatment]. They stop people from doing so much. It stops people from going to casualty because someone that they know will be working there. It stops people from going to the police. It stops people from going to their doctor's. It is as simple as that.¹⁷⁸⁶

A possible way of addressing issues pertaining to anonymity, or lack thereof, is to create 'one stop shops':

I think there is a lot to be said for co-location with other services — perhaps even a one-stop shop where a range of services are provided as well as other things — like there might be a cafe in there, and things like that. That would make it not so obvious that you are going in there to get something dealt with. There have certainly been some services structured like that.¹⁷⁸⁷

Outreach models where the worker meets the client on their own 'territory' may also be a positive way of protecting a client's confidentiality. Another witness who gave evidence to both this current Inquiry and the earlier *Inquiry into Amphetamine and Party Drug Use*, Dr Brough, former Director of the Australian Rural Centre for Addictive Behaviours (ARCAB), offered these ideas to address the issue of anonymity:

Again, why we think an organisation like ARCAB is important relates to being able to extract the particular rural issues and look at rural solutions for them in a particular way — for example, one of the

1784 Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Public Hearing, Shepparton, 25 February 2014.

1785 Mr Cameron McGregor, Senior Withdrawal Nurse, Goulburn Valley Health, Public Hearing, Shepparton, 25 February 2014.

1786 Ms Bev McIlroy, Manager, Glenelg Southern Grampians Drug Treatment Service (QUAMBY), Public Hearing, Warrnambool, 3 March 2014.

1787 Ms Deb Heery, Upper Hume Community Health Service, evidence given to the Drugs and Crime Prevention Committee, Inquiry into Amphetamine and 'Party Drug' Use in Victoria, Public Hearing (Benalla), 22 October 2003.

things that we are very keen to pilot is a self-help service run through a telephone conferencing system. The need for something like that grows out of the issues that are associated with rural communities, and this gets back to the sort of things you are talking about with rural young people where anonymity is a real issue. If they attend a self-help meeting even in a city the size of Warrnambool the next-door neighbour, their mum and everybody else is going to find out about it even if they have left home and are living independently. Trying to establish self-help groups for people, particularly with illicit drug problems, is a problem partly because of the issues of anonymity but it is also an issue in terms of not being able to have enough people with enough time to be role models, to be the infrastructure supporting the group. So we see a real place for self-help groups in supporting people in their efforts to give up drugs, but they are the sort of services that are basically denied people in rural communities by virtue of the anonymity issue and the lack of numbers in any one geographical location.

They are the sorts of proposals and innovative ideas that we think are going to come from people in the bush because we live with the problems day and night, we are thinking about them and trying to solve them on an individual patient and client basis day in, day out.¹⁷⁸⁸

What is working well in regional communities?

Evidence provided to the Inquiry by a number of witnesses based in rural regional Victoria indicates that a number of coordinated, local responses to methamphetamine use are showing promise:

We had a forum in country Victoria a couple of weeks ago in Swan Hill. The enormous enthusiasm by the service providers there to actually share their resources to proactively deal with this issue was very encouraging. Part of the requirement of this problem, I think, is that people at the local level need to be taking ownership of it. That is local service providers, but also the local community. They were certainly talking about enhancing their referral pathways. There are effective ways of treating the problem, both from health professionals, drug treatment professionals and medicos treating methamphetamine use and also a role for building the capacity of the community to deal with it. That was certainly the very encouraging signal from the Swan Hill community. They have a problem — I think alcohol is probably the biggest problem, but methamphetamine certainly is a problem. In that community it reaches across the demographics as well. It is particularly significant for the Aboriginal community but more broadly for young people. I think that is really the way forward in relation to this, which is about increasing community control and community empowerment.¹⁷⁸⁹

Project Ice Mildura is very much a preventive model. That is our main area; our biggest weapon that we have got at our disposal is education to the community. It is a proactive response. It is organised, and it aims to try to reduce the demands and the supply in our region. It is important that we educate the community, and most important that we allow families and friends to have that difficult conversation with their loved ones and so forth that this is an issue locally and we need to start talking about it to address it. Out of that comes information from the community, which is leading to enforcement agencies on the issue. We want to try and promote local access to drug and alcohol services, and also to advocate for further services down the track.¹⁷⁹⁰

As discussed in Chapters 11 and 24 similar regional projects based on a partnership approach to addressing ice are located in Geelong and Horsham.

What needs to be done?

Evidence provided to the Inquiry indicates that methamphetamine use is of considerable concern to many rural and regional communities in Victoria, and those working with methamphetamine users and their families require support to do so effectively. It is clear

1788 Dr Rodger Brough, ARCAB, evidence given to the Drugs and Crime Prevention Committee, Inquiry into Amphetamine and 'Party Drug' Use in Victoria, Public Hearing (Melbourne), 6 October 2003.

1789 Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

1790 See Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

that many areas require additional resources locally. There are also several strategies that may be of use for treatment providers such as accessing secondary consultation from specialists in metropolitan areas including use of the Drug and Alcohol Clinical Advisory Service (DACAS) specialist telephone consultancy service. Other important recommendations were made by Ms Cayte Hoppner, Director of Mental Health, Latrobe Regional Hospital:

There is a lot of evidence around clinical models, but for rural and remote services we would need a model that would fit the region in terms of accessibility, so in terms of having telemedicine, telepsychiatry, virtual clinics where people can actually access day programs and treatment services but not necessarily be in a residential facility. They may come through a day program but also a virtual program so that services are accessible in their local region. I guess that is the pattern of thinking.¹⁷⁹¹

The variability and complexities of methamphetamine use throughout rural and regional Victorian communities clearly requires acknowledgment, further research and prevention and treatment strategies that are informed by people with appropriate training and knowledge of drug use, and the diverse cultural and environmental contexts in which they are used. Rural clinicians and treatment providers need to have access to training opportunities on treatment modalities and best proactive interventions without spending valuable time away from the field. The Committee believes that methamphetamine use and its associated harms need to be more comprehensively addressed in rural and regional Victoria. One way of achieving this is to ensure that the issues pertaining to methamphetamine use in rural and regional areas of the state and the specific needs of rural communities and their residents are specifically targeted in the Methamphetamine Action Plan proposed in Recommendation 3.

Treatment needs for Aboriginal people

General issues in treatment for Aboriginal people

Treatment for AOD problems among Aboriginal Australians is usually delivered by mainstream services, Aboriginal and Torres Strait Islander primary health care services, Aboriginal-specific substance use services and general practitioners.

In 2008-2009, a total of 17,043 closed treatment episodes were provided to Aboriginal people nationally by mainstream AOD treatment services, representing about 12% of all closed treatment (completed) episodes (Australian Institute of Health and Welfare 2011). Aboriginal people receiving treatment tended to be younger than other Australians (e.g. 19% were aged 10–19 years compared with 11% of other Australians in the same age group). About 7.5% of Aboriginal people reported amphetamine as their primary drug of concern, which is slightly lower than non-Aboriginal people (9.6%).¹⁷⁹²

Challenges for providing treatment to Aboriginal people

Removing Aboriginal people from their communities for withdrawal and treatment

As Teasdale et al. have observed there has been little research on the acceptability of drug service provision and mainstream treatment services for Aboriginal people. For example, has the importance of family and community in Aboriginal life been taken into consideration when providing these services. The settings in which they operate may also be overly impersonal and clinical (Teasdale et al. 2008). Removing an Aboriginal person from their community, isolating them from family and kin to receive treatment in a mainstream

¹⁷⁹¹ Ms Cayte Hoppner, Director of Mental Health, Latrobe Regional Hospital, Public Hearing, Traralgon, 28 January 2014.

¹⁷⁹² Principal drugs of concern reported by Aboriginal people were the same as non-Aboriginal people: alcohol, cannabis, opioids and amphetamine.

service, sometimes a long distance away, can be a major barrier to successfully overcoming their substance abuse problems (Dawe 2006).¹⁷⁹³ As Ms Karen Heap told the Committee:

I just think that if you are sending the kids, or anyone, away for detox or rehabilitation — it just makes it harder... When they come back, they are engaging straightaway with the issues that they left. If you keep them in the community where the issues are, as far as connection to their family, connection to the co-op, connection to various other things that they are connected to, then you are treating it as a normality, if you like. It is not about taking you away and isolating you from all those semi-supports that you actually get. It is actually keeping you within the bounds of those supports. It is also being able to develop a pathway for [rehabilitation].¹⁷⁹⁴

This removal may be particularly problematic for someone from rural Victoria who has to be sent to Melbourne for detoxification or treatment, an experience Magistrate Clive Alsop from Gippsland says is ‘terrifying’ for many members of the Koori community and another reason why local detoxification units are required.¹⁷⁹⁵

On the other hand, the Committee received evidence that in some circumstances, it may be best to remove a person with crystal methamphetamine use away from the ‘contamination effect’ of their local community, even if this results in that person ‘grieving’ for their loss of social connectivity, ‘culture’ of use and friendship networks.¹⁷⁹⁶ As Mr Imran Mansoor from Mildura told the Committee: ‘Sometimes the best treatment is to send them far from their circle of friends. If they go somewhere else, there might be a chance they can stop using the drug.’¹⁷⁹⁷ Moreover, removing the ‘addicted’ person has the double advantage of giving the family a period of respite from what is often a very emotionally draining time dealing with their loved one’s condition.¹⁷⁹⁸

The issue as to whether it is appropriate to send a person with a crystal methamphetamine ‘habit’ away from their community for treatment or even just ‘time out’ was raised by many witnesses.¹⁷⁹⁹ The consensus seemed to be that there were valid arguments on both sides but that in an ideal world, local facilities that could give professional assistance to address a person’s drug use but still be close enough to the supports offered by the local community were best.¹⁸⁰⁰ Similarly, there may be little value taking a person out of their community if the circumstances that may have contributed to a person’s drug use have not changed when he

1793 Interestingly there may even be cases where an Aboriginal person is placed in a culturally appropriate healing centre or other Indigenous treatment service, but because it is at a great distance from his or her own community, the person leaves and returns to his or her region long before the recommended duration of the therapeutic stay. For example, Magistrate Peter Mellas at the Warrnambool Magistrates’ Court has seen a number of cases where local people from the south-west are transferred to Wulgunggo Ngalu in Gippsland. ‘People go out there, do not stay very long, end up coming back here. That link with family, link with their region is a very important one’. This is one of the reasons according to Mr Mellas that a similar type of culturally appropriate treatment centre should serve the west side of Victoria.

See Mr Peter Mellas, Warrnambool Magistrates’ Court, Public Hearing, Warrnambool, 3 March 2014, and the discussion in Chapter 12.

Similar comments were made by Joey Chatfield also from Warrnambool. See Mr Joey Chatfield, Aboriginal Community Liaison Officer, Victoria Police, Public Hearing, Warrnambool, 3 March 2014.

1794 Ms Karen Heap, Chief Executive Officer, Ballarat and District Aboriginal Co-operative, Public Hearing, Ballarat, 18 November 2013.

1795 See Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates Court, Public Hearing, Traralgon, 28 January 2014 and the discussion in Chapter 27.

1796 Mr Donald Currie, Team Manager Alcohol & Other Drugs, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014.

1797 Mr Imran Mansoor, Manager, Primary Health Care, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013.

1798 See Dr Niall Quiry, Senior Medical Officer, Victorian Aboriginal Health Service, Public Hearing, Melbourne, 3 February 2014.

1799 See for example Mr Christofer Beal, Coordinator, Tanderra AOD Services, Bairnsdale, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014; Mr Donald Currie, Team Manager Alcohol & Other Drugs, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014; Mr Bill Wilson, Youth Outreach, Alcohol, Tobacco and Other Drugs Team, Gateway Community Health, Public Hearing, Wodonga, 24 February 2014; Ms Di Griffin, Aboriginal Drugs and Alcohol Counsellor, Albury-Wodonga Aboriginal Health Service, Public Hearing, Wodonga, 24 February 2014.

1800 See the discussion on barriers to treatment in Chapter 27 for further discussion of the need for treatment services in local areas.

or she returns to that community, as highlighted by Mr Wayne Muir, CEO of the Aboriginal Legal Service:

Each person is an individual. You need to think about how you approach the individuals in terms of being able to create strength and resilience not only in them — even if you move people out of the community, you have got to make sure that your approaches do something about family and community resilience. If you merely take them out, it is like taking them to prison and then releasing them back into the same environment. If you have done nothing in the environment, you are not changing any circumstances, or they are going back into the same sorts of challenges. Regardless of whether they are in the community or outside the community, my point is simply that not only do programs need to be adequate for the individual but they also need to be adequate for the environment to which they may return. If we do nothing about that and we simply put them back into those same environments, the same challenges that got them into strife in the first place will still be there and prevalent.¹⁸⁰¹

Whatever the appropriate intervention is in such cases, culturally appropriate prevention, treatment and other services should be integrated in a holistic way with mainstream services rather than being considered an ‘add on’ (Dawe et al. 2006).¹⁸⁰² As one witness told the Committee, culturally appropriate services need to go beyond a Koori flag in the window and a couple of posters on the wall.¹⁸⁰³

The need to offer 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.¹⁸⁰⁴ 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.¹⁸⁰⁵

The views of Mr Wayne Muir are representative of the opinions of many witnesses who gave evidence to the Inquiry on the ‘mainstreaming’ of drug and alcohol services:

I do not think a lot of non-Aboriginal services per se understand the issue of intergenerational trauma and grief as it pertains to Aboriginal people and the potential for post-traumatic stress disorder. As a result they are not necessarily providing what we might call culturally safe service delivery. We believe that where possible those service responses need to be delivered by Aboriginal organisations or at the very least in strong partnership with Aboriginal organisations to ensure that there is an element of cultural safety in what they do and how they do it. We would like to think that prior to them accessing or treating clients there is something done around cultural safety from that practice agency.¹⁸⁰⁶

Ms Lisa Briggs, CEO of The National Aboriginal Community Controlled Health Organisations (NAACHO) told the Committee that mainstream services and supports for addressing substance abuse and health issues for Aboriginal people have been largely

1801 Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Public Hearing, Melbourne, 17 February 2014.

1802 Key respondents to the Australian National Council on Drugs (ANCD) report into injecting drug use by Aboriginal people stated there were a number of ways in which such cultural appropriateness could be integrated into service provision including:

- Establishment of healing centres and other Aboriginal run, managed and staffed prevention and treatment facilities;
- If this was not possible at least the employment of Aboriginal people in mainstream services;
- Compulsory cultural awareness training in mainstream services on Aboriginal issues (ANCD 2011, p.89).

For further discussion on prevention and treatment services for Aboriginal people, see Chapter 12.

1803 Ms Lisa Briggs, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (via teleconference), Public Hearing, Canberra, 11 February 2014.

1804 See Dr Karen Adams, Researcher, Victorian Aboriginal Community Controlled Health Organisation, Submission, 18 October 2013; Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Submission, 17 October 2013.

1805 See Australian National Council on Drugs (ANCD) 2011, p.75 and the discussion in Chapter 26.

1806 Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Public Hearing, Melbourne, 17 February 2014.

ineffective.¹⁸⁰⁷ Mainstream services may be especially inappropriate when the user has to be sent away from their local community to access such services.

The National Indigenous Drug and Alcohol Committee (NIDAC) stresses that workers in mainstream services must deliver treatment within a framework of *cultural competence*, in which respect for Aboriginal people's culture is recognised, respected, and safeguarded; *cultural safety*, that ensures an environment for Aboriginal people that is free from 'assault, challenge, or denial of a person's identity'; and *cultural security*, in which cultural values are actively incorporated into the planning, delivery and evaluation of their practice (National Indigenous Drug and Alcohol Committee 2014, p.11).

What works in treatment?

Like the broader population, Aboriginal people require effective interventions for methamphetamine use; however, the suitability of evidence-based methamphetamine-specific psychosocial treatment for Aboriginal people has not been established. What is known from the treatment literature more broadly is that effective elements of interventions for Aboriginal people include involvement of trained Aboriginal workers; culturally appropriate engagement, screening and assessment practices; culturally appropriate strategies for information sharing and gathering that is suitable for all levels of literacy; an emphasis on lifestyle factors and wellbeing; and active family and community involvement (Proude, Lopatko et al. 2009; National Indigenous Drug and Alcohol Committee 2014).

The NIDAC emphasises the importance of providing care that has a sound evidence base for its effectiveness (e.g. brief interventions, counselling, and pharmacotherapy, as discussed in Chapter 28) but also points out that these interventions must be adapted to ensure their cultural appropriateness for Aboriginal people. NIDAC offers the following suggestions for cultural adaptations:

- Workers and services need to be flexible, open and culturally sensitive to the needs of people seeking treatment. For example, Aboriginal and Torres Strait Islander people often find it difficult disclosing information in group settings, so provision of one-to-one counselling options may be more effective. Likewise, aftercare is often best provided face to face with the person rather than over the phone. People should be offered the most effective approach for their circumstances.
- Interventions need to be delivered in culturally meaningful ways.
- Traditional healing practices should be utilised.
- Respect cultural differences.
- Involve family.
- Use cultural traditions that are relevant to the person receiving treatment (e.g. returning to country).
- Use storytelling to share information (NIDAC 2014, pp.9-10).

Aboriginal and Torres Strait Islander specific substance use services funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) provided care to 17,721 Aboriginal people during 2008-9, including residential drug treatment to 2,700 (about 15% of all Aboriginal clients receiving care). The services utilised a range of treatment approaches, with an emphasis on culture. Other aspects of care included family and community involvement, social and emotional wellbeing, cognitive behaviour therapy and Alcoholics or Narcotics Anonymous (Australian Institute of Health and Welfare 2011).

Mr Jon Borkowski from the Gippsland Aboriginal Cooperative spoke to the importance of Aboriginal workers when he described the successful outcomes from treatment delivered

1807 Ms Lisa Briggs, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (via teleconference), Public Hearing, Canberra, 11 February 2014.

by his university-trained Aboriginal team of workers.¹⁸⁰⁸ Similarly, involving families in the care of Aboriginal people who use methamphetamine was a common theme in testimony given to the Inquiry¹⁸⁰⁹. As Mr Herb Goonen from Rumbalara Aboriginal Cooperative stated:

Like I said, when I was in the AFDM program¹⁸¹⁰ I tapped into a lot of families there over the course of two years. I was doing that program for just under two years, and 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. If you are drawing on all these family members that have just as many issues as the main person you are focusing on, it just seems that they are not getting a stronghold with which to fight their addictions or anything else.¹⁸¹¹

One program reported to be working well was the 'Bumps to babes and beyond' model, as Mr Rudolph Kirby, CEO of the Mallee District Aboriginal Services (MDAS) stated:

I have a good answer for you: we have this model called bumps to babes and beyond. It is an intense case management model, and it works on a wraparound service. At MDAS we have a one-stop shop. We provide everything from housing to health to family services, child protection — you name it, we do it. What we provide in that bumps to babes and beyond, is intense support. We were working with 10 families in particular. Only the high-risk ones, and if you take into consideration all the other vulnerable factors in the Koori community, we work with 10 of the most high-risk mums and dads. Not one child was removed under this program in the two years it has been running.¹⁸¹²

Establishing partnerships between mainstream alcohol and drug treatment services and Aboriginal health services is considered an important step in improving access to services and for enhancing the credibility of mainstream services among Aboriginal people.¹⁸¹³ An example of this type of approach was described in a document provided to the Inquiry by UnitingCare ReGen:

In another significant program change, the treatment needs of Aboriginal clients (for methamphetamine and other drug use) were given priority. ReGen has recently provided priority assessment access, two dedicated withdrawal beds and additional support in collaboration with the Victorian Aboriginal Health Service.¹⁸¹⁴

What needs to be done to improve treatment for Aboriginal people who use methamphetamine?

Research into methamphetamine-specific treatment for Aboriginal people is required in an effort to develop an evidence base and guide clinical practice. In the meantime, existing treatment guidelines¹⁸¹⁵ should be adapted to ensure their cultural appropriateness for Aboriginal clients.

1808 Mr Jon Borkowski, Coordinator Alcohol and Other Drug (AOD) Services Morwell, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

1809 See testimony from Mr Norm Stanley, Youth Justice Worker, Wathaurong Aboriginal Co-Operative, Public Hearing, Geelong, 28 October 2013; and submission by Dr Karen Adams, Researcher, Victorian Aboriginal Community Controlled Health Organisation, Submission, 18 October 2013.

1810 Aboriginal and Torres Strait Islanders Family Decision Making (AFDM) program.

1811 Mr Herb Goonen, Drug and Alcohol Worker, Rumbalara Aboriginal Cooperative, Public Hearing, Shepparton, 25 February 2014.

1812 Mr Rudolph Kirby, Chief Executive Officer, Mallee District Aboriginal Services, Public Hearing, Mildura, 5 December 2013.

1813 NIDAC, 2014,; *Aboriginal and Torres Strait Islander Healing Foundation: Healing Centres, Final Report* 21 December 2012.

1814 UnitingCare ReGen, *Methamphetamine treatment: Building on successful strategies to enhance outcomes*, May 13 2014.

1815 For example the Baker et al. 2003, 'Brief CBT intervention for regular amphetamine users', or the Smout et al. 2008, 'Psychotherapy for methamphetamine dependence intervention' might lend themselves well to adaptation.

The case for healing centres

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’ (Australian National Council on Drugs (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 (MCDS) 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. As Ms Kit-e Kline from Wathaurong Aboriginal Co-Operative told the Committee:

A healing centre after rehabilitation or detox would be an advantage to the community and to those people that are affected. Because ice causes so much grief in a family, causes domestic violence, causes all kinds of issues within the family, I think there is so much healing that needs to be done with these characters and I think some sort of centre would be beneficial to them.¹⁸¹⁶

According to the Aboriginal and Torres Strait Islander Healing Foundation established by the Australian government in 2009 (Aboriginal and Torres Strait Islander Healing Foundation 2012a), healing centres provide a dedicated space to support healing work for Aboriginal and Torres Strait Islander people, and though operations may differ across communities, they all share the following design principles:

- Are physically, socially and culturally safe and meaningful spaces for Aboriginal and Torres Strait Islander people, and for the community which they serve in particular.
- Are founded from an Aboriginal and Torres Strait Islander worldview, and strengthen connections between families, communities, land and culture.
- Are developed, led and primarily staffed by Aboriginal and Torres Strait Islander people, but also draw on complementary skills from mainstream partners and professions.
- Are operated with and for their own communities, and work to empower individuals and communities to overcome the causes and symptoms of trauma.
- Facilitate healing through an experimental approach and emphasis on ‘what works’, drawing on both traditional and modern healing practices (Aboriginal and Torres Strait Islander Healing Foundation 2012a, p.4).

Healing centre programs encompass ‘mental health, social and emotional well-being, family violence, child protection, addictive behaviour (alcohol, drugs, gambling etc), sexual abuse, youth development, justice and corrections’ (Aboriginal and Torres Strait Islander Healing Foundation 2012b, p.5). Tools and strategies from mainstream programs, such as counselling, may also be utilised.

The importance of culture and cultural identity, connection with country and ongoing support in the context of drug treatment was emphasised by most witnesses to the Inquiry,¹⁸¹⁷ and healing centres appear to be an excellent model for ensuring these elements are present. Outreach is also another important aspect of care for Aboriginal people, which may also be provided through such centres.¹⁸¹⁸

1816 Ms Kit-e Kline, Drug and Alcohol Worker, Wathaurong Aboriginal Co-Operative, Public Hearing, Geelong, 28 October 2013.

1817 See for example Mr Gilbert Freeman, Counsellor, Ngwala Willumbong Co-operative Ltd, Public Hearing, Melbourne, 24 March 2014; Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service, Submission, 17 October 2013.

1818 As James Dale stated: ‘For Indigenous people, as we said, and their reluctance to seek treatment due to the difference in cultural needs, we discussed that there need to be more opportunities to provide services and education in an outreach capacity rather than waiting for the clients, particularly in that cohort, to come to us. We need to be out there actively in the community, and there also needs to be genuine collaboration with community elders, similar to the Koori Court system.’

Mr James Dale, Acquired Brain Injury and Alcohol and Other Drug Clinical Consultant, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

There is a growing body of literature from Canada, in particular, and to a lesser extent in Australia that attests to the value and effectiveness of healing centres (see for example, Caruana 2010). Since its inception, the Aboriginal and Torres Strait Islander Healing Foundation has invested in over 20 programs including several in Victoria.¹⁸¹⁹ In February 2014, Victorian Aboriginal Child Care Agency (VACCA) released a discussion paper to investigate options for healing centres in Victoria; however no funding had been secured at the time of its release.¹⁸²⁰

Treatment for young people

General issues in treatment for young people

It is important to recognise that not all young people who use methamphetamine will experience problems that require the intervention of specialist drug treatment services. As Dr Amy Pennay from Turning Point Alcohol and Drug Centre told the Inquiry:

I have been involved in a lot of research with recreational drug use, so that is young people who are going out and using methamphetamine in the context of the night-time economy with alcohol, cocaine and other stimulants. It is important to note that most methamphetamine users do not transition to regular use or dependence.¹⁸²¹

This point was further reinforced by Dr Andrew Groves who found in a recent study that many of the young people in his cohort were engaged in ‘risk management strategies’ when using methamphetamine and viewed excessive use by other young people in a negative light.¹⁸²² However; young people who do use methamphetamine regularly are particularly vulnerable to the risks of such use as the brain does not fully develop until at least 25 years of age, and adolescence/early adulthood is the life period in which mental health disorders most frequently emerge. When young people access treatment, their presentations are often complex. As Richard Michell from Youth Projects told the Inquiry:

The other thing that we see is that people are accessing treatment earlier. If we looked at heroin, traditionally over a period — somewhere between 12 months and 2 years — people might start to access it for the first time because of associated issues. What we are seeing with methamphetamine is that people are contacting our services either because of justice or criminality — based on whether it is driving or assaults et cetera — so they are coming in a lot earlier. Quite often when they come in, they are coming in as fairly complex as well — usually with a range of medical issues, mental health issues et cetera. I guess the question then is: how do we work with people with methamphetamine?¹⁸²³

During 2011-2012, slightly more than one in 10 closed treatment episodes provided by AOD treatment agencies in Australia were for young people aged 10–19 years (17,084 of 146,948 episodes, 11.6%), while those aged 20–29 years accounted for about 28% of all episodes of care (41,142 episodes) (Australian Institute of Health and Welfare 2013c). In Victoria, young people aged 10–19 years accounted for about 13% of all closed treatment episodes (6,585 of 50,004), while about 28.7% of episodes were provided to those aged 20–29 years (14,342 episodes).

Most episodes of care in which amphetamine was a drug of concern were provided to people aged 20–29 years (73%), while about 10% were provided to those aged 10–19 years.

1819 Healing Journeys through Ceremony, Gippsland and East Gippsland Aboriginal Cooperative; Kooramook Biganga Ngootyoong; Possum Skin Cloak Healing, Banmirra Arts Incorporated; Traditional Healing Centre, Rumbalara Aboriginal Co-operative.

1820 VACCA Healing Centres Design Project Discussion Paper, February 2014.

1821 Dr Amy Pennay, Senior Research Fellow, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

1822 Dr Andrew Groves, Research Officer, Flinders Law School, Flinders University, Public Hearing (via video conference), Canberra, 11 February 2014.

1823 Mr Richard Michell, Manager, Youth Outreach, Youth Projects, Public Hearing, Melbourne, 3 February 2014.

Evidence was provided to the Inquiry of increased treatment seeking by young people who use methamphetamine in Victoria.¹⁸²⁴ For example, the Youth Support + Advocacy Service (YSAS) reported in a written submission that since 2009, methamphetamine has increased fivefold as the primary drug of concern for young people in its care.¹⁸²⁵

Challenges for providing treatment to young people

As Bruun and colleagues have observed, ‘young methamphetamine users are themselves a heterogeneous population with diverse interests and needs. The usage pattern of different groups can reflect nuanced identities, expressing ethnicity and particular forms of masculinity, femininity or sexual preference’ (Bruun, Ennis et al. 2012, p.278). Adolescence and young adulthood also encompass various developmental stages; therefore treatment must be matched carefully with the needs and presentation of each individual young person and must be delivered flexibly as their needs may change rapidly.

Research suggests that having mental health problems, using other drugs, sexual risk taking and having a family history of drug use increase the risk of methamphetamine use by young people (Russell, Dryden et al. 2008), potentially adding to the challenges of providing treatment to a group with complex needs.

Attracting young people into substance use treatment can also be challenging for service providers, as a key milestone for adolescence is the development of autonomy resulting in a successful transition from dependence to independence (Stubbs, Hides et al. 2004).

Services can improve their attractiveness for young people by simplifying intake procedures; providing opportunities to drop-in; ensuring staff members are knowledgeable and relate well to young people; responding to a young person’s issues as they arise; and providing young person friendly environments that are safe, welcoming and not overly clinical (Bruun, Ennis et al. 2012). It is essential that the first contact a young person has with a treatment service is positive and conducive to the development of strong rapport that is necessary for future therapeutic alliance.

Approaches to overcoming barriers to engagement were described by Ms Kerry Donaldson from the Community Programs, YSAS in Bendigo, and Mr Anthony Grimm from the Chatterbox Street Outreach Program:¹⁸²⁶

We are a bit sneaky with people’s drug use. It is functional; we respect that. It is the young person’s life, and they are choosing to do it, so we try to beef up the other parts of their lives. We try to improve their health, get them linked into a mental health plan and get them to work on their mental health, get them into stable housing, maybe try and link them back into education or a meaningful activity that makes them feel good about themselves so they are not using all the time. In that way we try to beef up their capacity for resilience so the drug might not take on that much of a meaning for them, and they might be able to look a little bit further than where they are and see the drug as a barrier to getting where they might want to go. Then they might want to look at their drug use. Certainly young people are reluctant to give up their drugs, because it is working for them. It does not work for us, looking at them, so we work across the spectrum of a young person’s life, and often they are the systems that have collapsed. A lot of young people we work with have not been at school since grade 5

1824 Also see evidence of Mr Francis Broeckman, Chief Executive Officer, Brophy Family and Youth Services, Public Hearing, Warrnambool, 3 March 2014; Ms Cathy Bligh, Youth Worker and AOD Counsellor, The Western Region Alcohol and Drug Centre (WRAD), Public Hearing, Warrnambool, 3 March 2014.

1825 Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS, Submission, 21 October 2013.

1826 See also Ms Jan Berriman, Chief Executive Officer, YMCA Victoria, Public Hearing, Melbourne, 24 March 2014.

or year 7, and their systems have collapsed — 80 percent of them have mental health issues that have not been diagnosed. It is significant to try to beef up those things.¹⁸²⁷

We work, I guess, in a non-coercive manner and we encourage young people to seek help. We do not force them to seek help. The vast majority of young people would come to the bus. The biggest role we do is trust building, is rapport building, hopefully then with a view that through that trust and that development of trust we can encourage them to seek help, whether it be financial, whether it be drug and alcohol treatment.¹⁸²⁸

Another important challenge for treatment delivery is the significant potential for relapse among adolescents that are dependent on alcohol and other drugs, which must be addressed through robust follow-up and after-care (Van der Westhuizen, Alpaslan et al. 2013).

What works in methamphetamine treatment for young people?

Young-people-specific AOD treatment is a relatively recent area of investigation, and research findings on methamphetamine use interventions specifically for young people are rare. However, research from the broader AOD treatment literature suggests that young people respond to the same types of interventions that have been shown to be effective for adults such as cognitive and behavioural therapies, motivational enhancement therapies, and relapse prevention, in both outpatient and residential settings (National Treatment Agency for Substance Misuse 2009).

Assertive after-care to prevent relapse and promote continued treatment gains is also considered an essential component of treatment for young people. Research suggests that young people want after-care that helps them to change old habits associated with drug use; solve problems; regulate emotions; manage finances; rebuild relationships; and gain employment (Van der Westhuizen, Alpaslan et al. 2013). A recent pilot study among 80 young people aged 12–24 years who had recently completed outpatient and residential drug treatment in the United States found that after-care via telephone text messaging was associated with reduced risk for relapse, less substance use problem severity and increased participation in recovery-oriented activities (Gonzales, Ang et al. 2014).

Family therapy is another important element of drug treatment for young people and should be a routine part of treatment when it is appropriate and achievable. As Bruun and colleagues observe, family-focused interventions may also be used in the context of a community reinforcement approach (CRA) to build a family's skills in providing appropriate support, encouragement and reinforcement for behaviour change among young people.

Research with current and recently abstinent young Thai people who used methamphetamine showed that a number of factors were involved in prompting them to stop. These included awareness of the negative effects of use on themselves and others; the influence of family and friends; and community stigma of methamphetamine use (German, Sherman et al. 2006). Strategies that raise awareness of the negative consequences of use without being proscriptive, such as motivational enhancement, would therefore be useful.

Clinical researchers suggest conducting a comprehensive assessment, starting with identifying the young person's chief concern (Stubbs, Hides et al. 2004). Assessment of drug use covering past treatment history including severity of the drug problem; exploration of leisure and social functioning including relationships with peers and family and education/vocation; assessment of physical and mental health; history of offending; experience of trauma; and sexual practices, should be conducted and all should be monitored over time.

1827 Ms Kerry Donaldson, Manager, Community Programs, Youth Support and Advocacy Service, Bendigo, Public Hearing, Bendigo, 25 October 2013.

1828 Mr Anthony Grimm, Co-ordinator The Chatterbox Street Outreach Program, White Lion, Public Hearing, Melbourne, 24 March 2014.

Although young people are less likely than older people to require medically supervised withdrawal due to a (potentially) shorter duration of methamphetamine use and physical resilience, when withdrawal is required the young person is likely to require a high degree of support and careful monitoring (Stubbs, Hides et al. 2004).

In a written submission to the Inquiry, YSAS recommended:

- Maximizing the possibility of engagement through providing an option for young people to “drop in”, and creating safe, supportive, welcoming environments that are not overly clinical and impersonal.
- Having the capacity to respond to crisis particularly when young people are agitated, confused and possibly paranoid
- Limiting complex intake processes
- Responding to the most pressing issue for the young person
- Having the flexibility for assertive follow up and to be able to take services to young people
- Having available a stable, drug free residential setting that is capable of supporting withdrawal from methamphetamine and other substances while addressing a range of psycho-social problems
- Being prepared to work among networks of young people who use methamphetamine
- Involving the family in treatment where possible
- Using evidence based approaches such as cognitive behavior therapy and the community reinforcement approach.¹⁸²⁹

What needs to be done?

Research evidence to guide clinical responses to young people with methamphetamine use problems is required. In the short term, mainstream services should ensure they provide evidence-based drug treatment in a manner that is ‘young-person friendly’ and strengthen links and partnerships with other areas of the health and welfare sector so the multiple needs of young people can be met promptly and effectively.

Evidence for the effectiveness of after-care for young people following drug treatment is compelling, therefore services should ensure that adequate after-care is integral to the continuum of treatment provided.

It is also necessary to encourage participation of young people themselves in all aspects of designing, delivering and evaluating the effectiveness of treatment provided.

Treatment needs of other specific populations

This section briefly examines the needs of several other specific groups of people who use methamphetamine.

Same-sex attracted and GLBTI communities

General issues in treatment

Use of methamphetamine in same-sex attracted (SSA) and gay, lesbian, bisexual, transgender and intergender (GLBTI) communities is higher than in the general population. For example, the Sydney Gay Community Periodic Survey found that around 13 percent of participants had recently used methamphetamine, and the WA Lesbian and Bisexual Women’s Health and Wellbeing Survey found that about 17 percent had recently used methamphetamine (Howard et al. 2012).

¹⁸²⁹ Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS, Submission, 21 October 2013.

Reasons for use of methamphetamine among the SSA community are reported to include enhancement of sociability and sexuality, improvement of body image, and greater peer acceptance of substance use (Halkitis, Fischgrund & Parsons 2005; Howard et al. 2012).

Like the general population, many SSA people use methamphetamine in a recreational context and do not go on to problematic use. Those that do, however, face the same risks as other regular users of methamphetamine, while males are at increased risk for sexually transmitted infections including HIV associated with sexual risk taking (Leonard, Dowsett et al. 2008). People from the SSA community may also be more vulnerable to the development of depression and suicidal ideation.

The Inquiry heard evidence from two witnesses who referred to the use of methamphetamine by SSA men in Victoria:

One of our board members wrote a very controversial piece in this edition of Whack! that I just mentioned about gay men and methamphetamine, and his article also deals with the widespread prevalence of ice use and just how widespread it has become. He also dealt with the secrecy surrounding the injecting of meth within the gay community. His article provoked a huge response, and many have concurred with his observations.¹⁸³⁰

It particularly affects the gay communities, so men who have sex with men. That group seems to be affected by methamphetamine use, and we currently have a project between Access Point and the Victorian AIDS Council.¹⁸³¹

Challenges to providing treatment

Howard and colleagues (2012) point to a number of challenges in delivering treatment for the SSA, including barriers to treatment-seeking. Fear of, or actual experience of discrimination or homophobia by other clients or staff; fears regarding lack of personal safety or experience of violence related to sexual orientation; and discomfort about disclosing sexual orientation may also stop people from seeking treatment. People in the SSA community may also be reluctant to set abstinence from methamphetamine as a treatment goal. Mainstream services may fail to attract SSA people into treatment if the environment appears oppressive, homophobic, or heterosexist.

What works in treatment?

Whilst clinical researchers suggest that people from the SSA community do not necessarily need treatment that is different from interventions shown to be effective with the wider community of methamphetamine users (Howard et al. 2012), interventions that have been culturally adapted for the SSA community have been investigated. For example, Reback and Shoptaw (2014) trialed a gay men-specific, cognitive behavioural therapy combined with a low-cost contingency management intervention and found that both methamphetamine use and sexual risk-taking reduced, and reductions were maintained at 6-months follow-up (Reback & Shoptaw 2014).

Other evidence-based approaches are tailored harm reduction strategies (Carrico, Flentje et al. 2014) and contingency management (Strona, McCright et al. 2006). Research also suggests that opportunities for earlier intervention and opportunistic intervention for those people not in treatment are required. One such model described by Zule and colleagues comprised a single-session brief motivational intervention that resulted in self-reported reduced methamphetamine use and reduced unprotected sexual activity at 2-months follow-up (Zule, Poulton et al. 2012).

1830 Ms Jenny Kelsall, Executive Officer, Harm Reduction Victoria, Public Hearing, Melbourne, 30 September 2013.

1831 Dr Matthew Frei, Head of Clinical Services, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

Peninsula Health has developed a resource for the SSA community, which they described in a written submission to the Inquiry:

The second was a DVD tackling ATS use amongst the GLBTI communities following evidence that this population was at high risk of ATS harms and a lack of suitable resources:

- 3000 copies of the DVD were distributed at Melbourne’s Midsumma Carnival.
- An additional 2500 copies have been distributed via General Practices, AOD services and GLBTI venues.
- The film was launched to more 200 people at the ACMI in Federation Square and was shown at the International Harm Reduction Film Festival in Liverpool, UK. The Ontario Alcohol and Drug Film Festival has requested to show the film.
- A captioned version of the DVD has been printed following a request by Vicdeaf.
- Peninsula Health established a GLBTI Community Advisory Group that further improved services for this community.¹⁸³²

What needs to be done?

Treatment providers must ensure that services are inviting and welcoming. Staff must be adequately trained and resourced to deliver culturally sensitive practice to people from the SSA community. If group interventions are offered, the safety of SSA clients must be guaranteed. Specialist services must include harm reduction strategies in the repertoire of support options for SSA people. Mainstream AOD treatment services should also work closely with specialist services that support the SSA community in an effort to attract people into treatment who need it.

Offenders

Considerations for people in the justice setting were examined in detail in Chapter 21, and are therefore only briefly referred to here.

General issues in treatment

Data from the Drug Use Monitoring in Australia (DUMA) program showed a notable increase in the use of methamphetamine among police detainees in Australia during the first three quarters of 2011, with 21% testing positive (Macgregor & Payne 2011). The 2009-2010 DUMA data showed that females (21%) were more likely than males (16%) to test positive to amphetamine. Those aged 31 to 35 years were most likely to return a positive urine drug screen for amphetamine (23%), followed by those aged 26 to 30 years (19%), 21 to 25 years (17%) and 36 plus years (16%) (Sweeney & Payne 2012). The study referred to in testimony given by Professor Paul Dietze found that among people in Melbourne who used methamphetamine, 38% had been in prison at some time, and 41% had been arrested within the previous 12 months (Quinn, Stoové et al. 2013).

Evidence provided to the Inquiry by Ms Jan Shuard, Commissioner of Corrections Victoria, confirms these data.¹⁸³³

Just reflecting on what we know about ice in the CCS offender population, this is drawing from data that is provided to us by ACSO COATS. On slide 13 you can see that ACSO COATS conducted over 6900 individual offender assessments last financial year. In terms of what they were able to report back around a principal drug of concern, we can see that 12.9 percent were reported in the last quarter

1832 Dr Sherene Devanesen, Chief Executive, Peninsula Health, Submission, 21 October 2013.

1833 See also Mr Luke Tucker, Acting General Manager, Community Correctional Services, Gippsland region, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014; Mr John Insana, General Manager, Community Correctional Services, South-east Metropolitan Region, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014; Mr Clive Alsop, Regional Coordinating Magistrate, Latrobe Valley Magistrates Court, Public Hearing, Traralgon, 28 January 2014.

of the last financial year as having had ice or methamphetamine as their principal drug of concern. Putting that in context, we can see that has now surpassed heroin in terms of a principal drug of concern, and while we understand it is growing, there is still an obvious issue with alcohol in terms of the impact that alcohol is having on people's offending behaviour.¹⁸³⁴

What works in treatment?

It is important to recognise that the outcomes for people who are mandated to treatment can be as good as those who seek treatment voluntarily, and effective engagement is an important first step in developing a comprehensive treatment plan. As Caraniche, a psychological consulting firm that provides drug and alcohol treatment to prisoners and to offenders in the community, noted in its submission to the Inquiry:

Treatment for methamphetamine using offenders cannot examine their methamphetamine use in isolation but must look at the totality of their lifestyle, poor decisions and their consequences and the impact of both their drug use and their offending on themselves, their family and other relationships. Critical to successful reintegration are family and social relationships and for many methamphetamine users significant repair work with the family is required before the family feels able to support the user. In addition, pre-existing psychological issues and the problems and deficits that have developed as a result of methamphetamine use would also need to be addressed with clients supported to develop alternate coping strategies.¹⁸³⁵

Ms Shuard described the framework under which Corrections Victoria operates as one that is evidence-based and focused on providing the supports people need to reduce the risk of re-offending. One important arm of Corrections Victoria is Drug Courts. Another is the use of CISP; both described in detail in Chapter 21.

A novel approach to delivering treatment to people who have offended and also used methamphetamine was described by Mr John Insana, General Manager, Community Correctional Services, South-east Metropolitan Region. This is the Matrix Program discussed in Chapter 28.

We have a local alcohol and drug provider who will be attending one of our next management meetings to start to talk about the progress of Matrix, which is a pilot cognitive behavioural therapy program, and again that is in its infancy stages. This is with offenders or participants who are using ice. It is at the Drug Court of Victoria. We have initiated collaborative meetings between our staff and some of the youth services, such as YSAS in Dandenong and Frankston, and we have invited YSAS to spend a day or two working at the location trying to look at opportunities to work better with those offenders, in this case particularly young offenders. We have also instigated regular meetings with Victoria Police senior management to try to gather more intel around the manufacturing of amphetamines.¹⁸³⁶

Another program that has been trialled in the United States of America — Hawaii's Operation Probation with Enforcement (HOPE) — was highlighted in correspondence received from Associate Professor Peter Miller from Deakin University and is under investigation for its application in Victoria. HOPE is also described in Chapter 28.

High risk occupational groups

General issues in treatment

Some people use methamphetamine to enhance work performance and the prevalence of use may be higher in some industries than others. A reanalysis of data collected for the 2004 National Drug Household Survey conducted by researchers at the National Centre for

1834 Ms Jan Shuard, Commissioner, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014.

1835 Ms Jacinta Pollard, Managing Director, Caraniche, Submission, 21 October 2013.

1836 Mr John Insana, General Manager, Community Correctional Services, South-east Metropolitan Region, Corrections Victoria, Public Hearing, Melbourne, 17 February 2014.

Education and Training on Addiction (NCETA) identified hospitality, construction, transport and trades as the occupational groups with the highest rates of recent methamphetamine use at that time (Roche, Pidd et al. 2008). To gain a more current perspective requires repeating the analysis using the 2013 National Drug Household Survey data when it becomes available.

Alcohol and other drug use in the workplace is associated with workplace accidents and injuries and decreased productivity, both on-the-job and as a result of absenteeism (Pidd & Roche 2009). Workers who use methamphetamine are also more likely to be drug-affected at work, as well as drive a car, operate heavy machinery or abuse someone while under the influence, when compared to users of other illicit drugs (Roche, Pidd et al. 2008).

Witnesses to the Inquiry described a variety of issues pertaining to methamphetamine use by employed treatment-seekers:

The other thing about this group is that they are often treatment naive, and this is part of the reason why Access Point was set up. Very often they do not have an experience of drug culture and drug treatment. They are often people from working backgrounds. They may be tradies or, very commonly, people in the hospitality industry — restaurateurs, waiters and so forth — and management and that sort of thing. There is maybe a slightly different demographic to the standard illicit drug user.¹⁸³⁷

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, I think it is seen as a supplement to their workforce.¹⁸³⁸

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 and the desalination plants.¹⁸³⁹

The people that we are seeing that are truck drivers often are coming in having already recognised that they cannot continue to work under the influence of these drugs and they are wanting to get treatment to be able to return to driving. Most of them are reporting to me that the increased checking of blood alcohol levels and drug-testing is quite a deterrent, so it is quite different perhaps to what is actually happening there versus the people that are presenting to us. People come to us wanting assistance — voluntary clients who are acknowledging it — and the truck drivers themselves tend to not be driving. Other drivers of course are a different cohort.¹⁸⁴⁰

Challenges for providing treatment

Challenges include workplace environments that may exacerbate AOD use, including those in which people are engaged in shift-work, work in isolation, travel frequently, or have low levels of on-the-job supervision. Employed people may also be reluctant to seek treatment due to privacy concerns and fear of workplace repercussion. Similarly, workers may have difficulty in keeping appointments with mainstream services that operate only within business hours.

What works in treatment?

1837 Dr Matthew Frei, head of clinical services, Turning Point Alcohol and Drug Centre, Public Hearing, Melbourne, 30 September 2013.

1838 Mr R. Michell, Manager, Youth Outreach, Public Hearing, Melbourne, 3 February 2014.

1839 Mr James Dale, Acquired Brain Injury and Alcohol and Other Drug Clinical Consultant, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

1840 Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014.

Workplace interventions target alcohol, tobacco and all other drugs, rather than a single substance such as methamphetamine, and much of the work conducted focuses on alcohol prevention due to the high prevalence and impact of use. Extrapolating from the alcohol literature (for example Lee, Roche et al. 2014), effective elements for workplace interventions include:

- ◆ Workplace policies on drug use
- ◆ Opportunities for screening for risky use
- ◆ Peer based workplace interventions aimed at changing attitudes to drinking and drug use
- ◆ Secondary prevention counselling for people with methamphetamine-related problems
- ◆ Employee Assistance Program (EAP) services.

Similarly, Pidd and Roche (2008) emphasise the importance of adopting a broader prevention of workplace harms approach that shifts away from the traditional, more narrow problem-management approach. In their view, education and training regarding harm in the workplace and opportunities for treatment is an important element of workplace interventions, as is evaluating their effectiveness.

What should be done?

Workplaces are a logical dissemination point for information about the risks and harms of methamphetamine use at work and should actively link employees with treatment services when appropriate to do so, as Mr. John Ryan from Anex told the Inquiry:

It is about employers and employees, I think, stepping up to the plate in terms of having a sensible drug policy within their organisation, which includes prevention of drug use but also includes managing how drug use actually might occur and how to deal with that sensibly if that is the case. Importantly, I think education in the workplace is very important around drug use issues. It is not only colleagues' drug use that might be a problem but customers' drug use.¹⁸⁴¹

VicHealth has funded a pilot-project in Victoria to reduce alcohol-related harms in the workplace that is in its second year of a three-year trial.¹⁸⁴² Results of the study could inform future practice in industries in which methamphetamine use is high.

Conclusion

Methamphetamine use patterns are as wide and varied as the people who use it, and each will have different needs for support and treatment. Service providers must consider each person's presentation carefully and match their approach with individual needs, keeping in mind broader issues for these specific groups.

As Degenhardt and her colleagues observed, insufficient attention may have been paid to the specific requirements of particular sub-groups of people who use methamphetamine in the past (Degenhardt, Roxburgh et al. 2008). In particular, young people and high-risk occupational groups present an opportunity to utilise effective earlier intervention and secondary prevention strategies to prevent harms and reduce demand.

In addition, marginalised and disadvantaged groups — Aboriginal people, offenders, people in regional and rural areas, for example — require specific strategies and approaches to ensure that interventions are implemented effectively.

¹⁸⁴¹ Mr John Ryan, Chief Executive Officer, Anex, Public Hearing, Melbourne, 30 September 2013.

¹⁸⁴² This is a joint project between the National Centre for Education and Training on Addictions (NCETA) in Adelaide and LeeJenn Health Consultants in Victoria, in partnership with VicHealth.

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.*

See also recommendations in chapter 12.

Section Three

— The Way Forward

PART I

Future Directions

30. The Supply and Use of Methamphetamine: A Call for Further Research and Evaluation

Introduction

Research plays a crucial and central role in shaping the direction of drug policy, programs and initiatives in Australia and internationally. Australia has an international reputation for the quality of its research on the prevention and treatment of drug abuse.

There are many national, state and territory research centres in this country, focusing on all aspects of drug and alcohol research, producing excellent work that informs evidenced based strategies to address drug supply and use. Notwithstanding the important work being done by these bodies, throughout this Report the Committee has identified a number of areas in which further research and evaluation of policy initiatives is still required. Some relate to new avenues of data collection and monitoring of official statistics, while others entail the conduct of new surveys and other forms of research amongst drug users and offenders. Still other areas require ongoing evaluation of the various crime control and treatment measures that have been introduced, or the use of experimental or demonstration studies to assess the effectiveness of new approaches.

The Committee has focused its attention on those research areas most likely to elicit information that can lead directly to the improvement of current drug control and treatment programs.

The current framework for research into drug issues

The National Drug Strategy

Under the National Drug Strategy (NDS), the Australian Government provides core funding to three National Drug Research Centres of Excellence (the Centres). These are the National Drug and Alcohol Research Centre (NDARC), the National Drug Research Institute (NDRI) and the National Centre for Education and Training on Addiction (NCETA):

Core funding enables the Centres to build the capacity of the sector by undertaking drug and alcohol research, through the training of young researchers, the planning and execution of key original research studies, providing advice to the Intergovernmental Committee on Drugs, and collaboration with key community, clinical and research groups, broad stakeholders, family and consumer groups. These efforts inform national substance misuse prevention, early intervention, treatment and service improvement efforts.¹⁸⁴³

The functions of the Centres are to facilitate evidence-based policy development and community awareness with the overarching aim of reducing the harms associated with alcohol, tobacco and other drug misuse.

¹⁸⁴³ See Intergovernmental Committee on Drugs Annual Report 2012-13 at [http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/7FDE1A1621748A0ACA2571630008405F/\\$File/IGCD%20Annual%20Report%202011-12.pdf](http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/7FDE1A1621748A0ACA2571630008405F/$File/IGCD%20Annual%20Report%202011-12.pdf)

National Drug Law Enforcement Research Fund

The National Drug Law Enforcement Research Fund (NDLERF) was established in 1999 by the Ministerial Council on Drug Strategy to promote quality evidence-based practice in drug law enforcement to prevent and reduce the harmful effects of licit and illicit drug use in Australian society. The Commonwealth Department of Health and Ageing funds the NDLERF as part of its commitment to the National Drug Strategy. NDLERF supports the implementation of the NDS by:

- creating research which leads to quality evidence-based practice in drug law enforcement;
- facilitating experimentation and innovation; and
- enhancing strategic alliances and linkages between law enforcement personnel, human service providers, and research agencies, for the purpose of preventing and reducing the harmful effects of licit and illicit drug use in Australian society.¹⁸⁴⁴

Intergovernmental Committee on Drugs

To drive the current agenda on drugs research the Intergovernmental Committee on Drugs (IGCD) has established a working group drawing in experts from these national research centres¹⁸⁴⁵ and other institutions to develop a national drug research and data strategy. Subsequent to the findings of this group, in 2012, the Australian Government established the Collaborative Network of the National Drug Research Centres of Excellence with the Commonwealth Department of Health and Ageing. NDARC is leading the Collaborative Network which will provide a forum for regular discussions on the latest drug and alcohol research with the aim of improving the interface between policy and research.¹⁸⁴⁶

The IGCD Cost Shared Funding Model (CSFM) also funds projects of national significance in the drug and alcohol field. Each State and Territory, as well as the Australian and New Zealand Governments, participate in the IGCD CSFM, contributing a proportion of funding based upon the latest Australian Bureau of Statistics population figures. These approaches aim to ensure a systematic approach to drug research by:

- identifying priority areas for new research and areas where evidence needs updating and/or validating
- coordinating research efforts
- facilitating the identification of emerging issues for research
- encouraging the testing and validation of new interventions
- guiding the dissemination of findings; and
- assisting the translation of those findings into practical policies and programs (Ministerial Council on Drugs 2011, p.22).

The need for further research on methamphetamine

A common theme that has arisen throughout the Inquiry is the paucity of appropriately targeted research being undertaken into the area of methamphetamine.¹⁸⁴⁷ Allsop and Lee have stated in this regard that:

1844 See Intergovernmental Committee on Drugs Annual Report 2012-2013 at [http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/7FDE1A1621748A0ACA2571630008405F/\\$File/IGCD%20Annual%20Report%202011-12.pdf](http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/7FDE1A1621748A0ACA2571630008405F/$File/IGCD%20Annual%20Report%202011-12.pdf).

1845 National Drug and Alcohol Research Centre (NDARC), National Drug Research Institute (NDRI) and National Centre for Education and Training on Addiction (NCETA).

1846 See Intergovernmental Committee on Drugs Annual Report 2012-2013 at [http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/7FDE1A1621748A0ACA2571630008405F/\\$File/IGCD%20Annual%20Report%202011-12.pdf](http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/7FDE1A1621748A0ACA2571630008405F/$File/IGCD%20Annual%20Report%202011-12.pdf).

1847 Submissions and oral evidence to the Inquiry that generally noted the need for better targeted research on methamphetamine included:

Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership, Submission, 21 October 2013; Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services, Public Hearing, Traralgon, 28 January 2014; Mr Peter Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat, Public Hearing, Ballarat, 18 November 2013; Dr David Edey, Director of Emergency Medicine, Barwon Health, Public Hearing, Geelong, 28 October 2013.

While we have developed a range of prevention and treatment responses to a diverse range of drug problems, the research regarding amphetamine type stimulants has lagged behind that for other drugs such as alcohol and heroin. In particular we have been less successful in engaging and retaining people affected by ATS [amphetamine type stimulant] problems in treatment and we have a relatively limited evidence base about effective treatment (Allsop & Lee 2012, pp.1-2).

This lack of focused research applies not only to medical research relating to treatment but also to more general quantitative and epidemiological studies, qualitative and ethnographic research projects. Such a lack of inquiry and consequent policy development is felt not only in Australia but also at an international level

This need for further and better research on drug issues including methamphetamine was recognised by the *National Drug Strategy 2010–2015*:

The National Drug Strategy 2010–2015 will continue to support the development of a strong evidence base including clinical, epidemiological, criminological and policy research. In areas where the evidence base requires further development, a systematic approach is necessary (Ministerial Council on Drug Strategy 2011, p.22).

The value of research for the alcohol and drug sector

Research, particularly applied research, is not just an exercise in theoretical inquiry for its own sake. It can be of great value to assist policymakers and practitioners alike in addressing the harms of drugs such as methamphetamine. This approach to applied research is exemplified in the following quote from Professor Sir Bruce Keogh, Medical Director of the British National Health Service. He stated:

Good ideas for improving health services aren't in the heads of people sitting in darkened rooms in a back office. They come from people on the shop-room floor. But they have to be given permission to flag ideas and make service improvement part of their job.¹⁸⁴⁸

Similarly, Professor Anthony Shakeshaft, Deputy Director of the National Drug and Alcohol Research Centre has argued that (drug and alcohol) researchers need to work in partnerships with alcohol and other drug (AOD) workers to achieve best outcomes for their clients in particular. In an address to the Network of Alcohol and other Drug Agencies (NADA) conference in 2014 he stated:

What research can contribute [to AOD practice] is:

- Knowledge to help clarify harms (their extent, nature, etc), and the likely consequences of different choices:
- Create new, or improve existing, measures
- Describe the extent of problems, who is impacted, inequalities, etc. (eg. smoking rates in low SES communities [25%] is double that for high SES communities[13%];
- Quantify the impact of interventions. Could be improved treatment outcomes (eg. Is treating D&A and MH problems simultaneously more effective than treating them separately?) OR improved economic efficiency (eg. If treating D&A and MH problems simultaneously is no more effective for patients, is it cheaper?)
- Reviews of current evidence (eg. do ED interventions for alcohol work?).¹⁸⁴⁹

1848 Professor Sir Bruce Keogh, Medical Director, National Health Service England 2014, 'Using performance management to drive health systems change', Address given to the Hospital Alliance for Research Collaboration forum, Sydney, 12 May. Online at: <https://www.saxinstitute.org.au/events/harc-forum-taking-action-on-performance-measurement/>

1849 Professor Anthony Shakeshaft 2014, Creating service providers and research partnerships: Do we need them and how do we make them routine. Keynote presentation at 2014 NADA Conference: 'Diversity Driving Innovation', p.8, Sydney, 12–13 May.

Little research, however, has been conducted in Australia on how to apply and disseminate effective research interventions for drug users generally or methamphetamine users *specifically*. In public health generally, more than 75 percent of the research published is descriptive, with only around 15–20 percent intervention research and virtually no dissemination research to identify most effective dissemination methods (Shakeshaft 2014).

Shakeshaft argues that service providers such as AOD workers are critical to the conduct of high quality, applied research that can effectively and efficiently improve client outcomes, and that more effective partnerships are needed to improve client outcomes and the quantity and quality of applied research outputs. In particular, researchers need to develop their research questions and priorities in partnership with service providers. At the same time service providers might more effectively engage with researchers to develop more evidence based programs and evaluate the impact of their services. Shakeshaft suggests a new framework may be required to create more routine partnerships that simultaneously benefit service providers, researchers and clients (2014).

Professor Shakeshaft expanded upon the implications of a more integrated research model that promotes partnerships between researchers and practitioner in his paper to the NADA conference. He stated that:

- i. Both researchers and practitioners have input [into delivering positive outcomes], and there are benefits for both
- ii. Researchers can no longer *only* do what they want to do
- iii. Practitioners have to agree to trial new ways of doing things and to work in partnership with other agencies (& researchers) as part of their organisational culture
- iv. New ways of funding need to be identified (minimise costs by delivering services differently — not doing more?)
 - ♦ Partnership grants (eg. NHMRC, ARC)
 - ♦ NGO's pool funds for research [although] they may lose some control over what they use research/evaluation funds for
 - ♦ If we can show benefits can lobby governments to fund routinely
- v. [There is an] opportunity to reduce the evidence/practice gap
- vi. Over time we deliver better quality care and services become dynamic, adapting organisms.¹⁸⁵⁰

Gaps in the research on methamphetamine

Whilst there *is* certainly research being undertaken in the area of methamphetamine, the evidence given to the Committee suggests there are still gaps in knowledge about the drug and its effects including some that were identified 20 years ago (Hando & Hall 1993).

Notwithstanding a range of state, federal and university funded projects over the 20 years since these comments were made, it could still be argued that Hall and Hando's comments are as applicable today. The following discussion looks at research gaps and research needs in a variety of areas including:

- ♦ Prevalence and the extent of harm
- ♦ Production and supply
- ♦ Organised crime

¹⁸⁵⁰ Professor Anthony Shakeshaft 2014, Creating service providers and research partnerships: Do we need them and how do we make them routine. Keynote presentation at 2014 NADA Conference: 'Diversity Driving Innovation', p.8, Sydney, 12–13 May.

- ◆ Clinical and treatment
- ◆ Use by specific populations
- ◆ Other areas of research
- ◆ Evaluation of strategies, programs and interventions.

Prevalence and the extent of harm

A number of national and state monitoring systems exist with regard to both licit and illicit drugs. Some of the main ones include:

- ◆ National Drug Strategy Household Survey (Australian Institute of Health and Welfare (AIHW))
- ◆ Alcohol and Other Drug Treatment Services National Minimum Data Set (AIHW)
- ◆ Australian School Students' Alcohol and Drugs Survey (ASSADS)
- ◆ Clients of Treatment Service Agencies census (COTSA) (NDARC)
- ◆ Illicit Drug Reporting System (IDRS)
- ◆ Ecstasy and Related Drugs Reporting System (ERDS)
- ◆ Drug use Monitoring in Australia program (DUMA).

While the data collected from these sources are undoubtedly valuable, a constant refrain that the Committee has heard during the course of this Inquiry is that there is a lack of co-ordinated data with regard to methamphetamine usage, and the data that do exist are not readily disseminated at local level.

Another concern voiced is that even when (limited) data are available they are not sufficiently disaggregated into discrete drug categories. In other words, some health and drug datasets are classified into broad categories such as 'ATS' or 'amphetamine' which give very little indication as to what actual drug, or form of drug, has been taken under that broad category. Although the Committee has examined extensive statistical information on the prevalence of illicit drug usage in Australia and in Victoria, some datasets are often not able to be disaggregated to a sufficient degree to enable trends to be identified in the use of methamphetamine, and crystal methamphetamine, with respect to a number of variables of interest.

As a result, the Australian Nursing and Midwifery Federation suggested that data collection regarding the specific prevalence and demographics of methamphetamine users be improved to enable more detailed and targeted research to be conducted into this population group. It was suggested that research be conducted that distinguishes the impact of the different forms of methamphetamine including 'ice' that are currently being used in the community.¹⁸⁵¹

Current data collection methods may also be ill-equipped to pick up on some 'hidden populations'. School population surveys, for example, may fail to capture young people who are not attending school, whilst general population surveys may not sample young people living in out-of-home care or those who are homeless. People with insufficient literacy or from CALD communities where English is insufficiently spoken or understood are also not likely to fill out large surveys. Data collection methods, therefore, need to be extended to ensure that these people are not overlooked. Given that many people who use methamphetamine do not present for formal treatment such as detoxification or rehabilitation, it is unlikely that their use can be captured in clinical treatment data sets.

¹⁸⁵¹ Australian Nursing and Midwifery Federation, Submission, October 2013.

A further difficulty with developing policy through the use of statistical evidence is the timeframe in which data are made publicly available. Although this problem confronts all empirical research, the need for current statistics on illicit drug use is of great importance. This is in order for the most recent trend information to be made available to law enforcement and to enable the development of legislative and policy responses in a timely way. The use of regular online data collection could be one way of achieving this, although comprehensive, national data collections do, of necessity, take time to develop.

When Dr Rebecca McKetin gave evidence to the Committee she stated there were real problems in getting an accurate sense of the prevalence of methamphetamine use and the harms associated with it because the data was relatively dated and did not really reflect the levels of usage in *real time*:

Firstly, you have indicator data, such as your emergency presentations, which are a reflection of problems from the drug and then you have the number of people using, and they do not always correlate. Then also those data sources are old. Anecdotally I have heard there have been increases and I have seen some data that suggests that that is the case, particularly with ice, in the same way that you are saying is the case in Victoria. However, in terms of prevalence, there is not any data at the moment. That was my first comment. The last data that we have on the prevalence of methamphetamine use in Australia is from the national drug strategy household survey. It was, I think, 2.2 percent in people aged 14 or older. That is much higher in the 20-to-29-year bracket, where you get most drug use. It was 6 percent in the past year and that has been declining steadily since 1998. Now I expect it will go up again, but they conduct the survey only every three years, so the last data we have is for 2010.¹⁸⁵²

She also pointed out how difficult it was to get a true picture of methamphetamine use in 'real time' given the lag in providing accurate statistics:

There is a difference in the timing of the indicators. When someone starts using the drug they might try it for the first time when they are 18 or 20 years old. It might be two or three years, say, before they start getting into problems with the drug if they keep using it and they become dependent. It might be another three to five years before they start seeking help or start having serious problems and turning up in the hospital system, in the emergency departments, at their GP or wherever else. Often what you see is that the problems come after the increase in use. What you are seeing now in terms of increasing problems may have actually been provoked partly by increases in availability of methamphetamine some time back.¹⁸⁵³

There are also difficulties associated with understanding the complexities of poly-drug use through current data collection systems. The Committee was made aware of a number of research studies indicating 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 (eg. Degenhardt & Topp 2003; McKetin, McLaren & Kelly 2005; Kinner & Degenhardt 2008). 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. The Committee believes that all drug use monitoring systems in Australia should be expanded to capture information on the extent of poly-drug use within each jurisdiction that includes the different forms of methamphetamine. At present the data are inadequate in enabling prevalence to be determined through the use of monitoring programs owing to the inability to classify different types of methamphetamine, in comparison with other types of drug.

1852 Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

1853 Dr Rebecca McKetin, Fellow, College of Medicine, Biology and Environment, Australian National University, Public Hearing, Canberra, 11 February 2014.

Reinstatement of Victorian Data Collection Initiatives

An additional impediment to understanding the prevalence of the problem has been the unfortunate cessation of a number of important data collection initiatives in Victoria. There have also been concerns expressed that data with regard to methamphetamine use by those in police detention or custody are 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. Among the sites where collection was ceased was Footscray in Victoria, 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 and 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. The Committee believes that re-instating a Victorian data collection site would be beneficial and suggests that the Australian Institute of Criminology explore options for funding to re-establish data collection for DUMA in Victoria.

In addition, the Committee notes that the Victorian Youth Alcohol and Drug Survey (VYADS) that provides further information on substance use among young users (ie. adolescents 16 to 24 year old) in Victoria was last conducted in 2009 (Victorian Drug and Alcohol Prevention Council 2010). The results from prior surveys demonstrate that the lifetime use of amphetamines among young people has decreased over time. This survey was one of the few that assessed attitudes and perceptions of alcohol and illicit drug use and patterns and context of use amongst this demographic. It also captured information on effects of use and contact with police as well as socio-demographic characteristics of users, unlike the Australian Secondary Students Alcohol and Drug Survey (ASSADS), which is limited to age and gender information.¹⁸⁵⁴ The Committee believes it would be desirable to obtain more recent VYADS data to show what has transpired since 2009.

One particular problem that faced the Committee was the difficulty of quantifying the prevalence of the use of methamphetamine, and particularly, ice, in Victoria. This was due to official crime statistics not being collected in sufficient detail to identify trends concerning particular forms of methamphetamine, such as ice, as well as to document trends in particular geographical regions. The Committee believes that the new Victorian Crime Statistics Agency would be an appropriate body to work with Victoria Police to improve the statistical data holdings of Victoria Police relating to the use and impact of ice in Victoria, particularly in regional and remote locations in Victoria.

Other avenues for research into the harms associated with methamphetamine use could include the examination of the physical harms that arise by considering 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

¹⁸⁵⁴ St Vincent's Hospital also gave evidence to the Inquiry that with regard to better data collation and dissemination and research direction, the establishment of a clearing house for research data and support for research into new treatment paradigms may be a useful proposal. See Dr Martyn Lloyd-Jones, Acting Director, Department of Addiction Medicine, St Vincent's Melbourne, Submission, 21 October 2013.

obtained through legal means, such as heroin and ecstasy.¹⁸⁵⁵ 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 (Degenhardt, Roxburgh et al. 2008). The Committee believes that such data collections need to be up-dated and published on a national basis and that the feasibility of contributing to a national database that would permit the monitoring of drug-related hospital admissions should be further examined.

Production and supply

One of the more difficult areas to research concerns the production and supply of illicit drugs, owing to the covert nature of such conduct and the difficulties associated with gathering data from drug users and dealers. Some specific areas are, however, more amenable to research than others.

Research into online drug markets, for example, poses considerable methodological and ethical problems. 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 (Barratt, Ferris & Winstock 2013). The Committee believes that further research into online drug markets should be undertaken not only by law enforcement researchers, who are able to make use of confidential sources, but also by academic scholars who could examine issues such as the prevalence and characteristics of known websites that advertise drugs, preferred type of payment methods and delivery mechanisms. The Committee understands that the Law, Crime and Community Safety Council would be an appropriate body to facilitate research into the nature, extent and control of online drug markets including their potential impact on the importation of methamphetamine into Australia.

Further research is also needed into the overseas markets from which illicit substances are introduced into Australia. 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 (UNODC 2014b). 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 Southeast 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. As such, the Committee believes that further investigation of these aspects of the problem is warranted and that the ACC Board should consider the establishment of a Special Operation in collaboration with the UNODC to consider the short and long-term implications for Australia of the substantial growth in the methamphetamine market within the Southeast Asian region.

Organised crime

During the course of the Committee's Inquiry, frequent reference was made to the role that organised crime groups play in all aspects of the market for illicit drugs, including

1855 Mr David Kalisch, Director, The Australian Institute of Health and Welfare, Submission, 23 January 2014.

methamphetamine and ice. There is, however, a lack of information available to quantify precisely the extent of the involvement of organised crime, including members of outlaw motor cycle gangs (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 Victoria Police should 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.

In particular, further evidence is needed of the extent to which organised crime is involved in the online methamphetamine trade. The Committee was made aware of the potential problem of this nature through anecdotal evidence provided by law enforcement but believes that further investigation by the ACC is warranted. This could be achieved by the ACC Board establishing a Special Operation to examine, specifically, organised crime involvement in online illicit drug marketplaces, particularly relating to the sale of methamphetamine and ice.

Alternative regulatory approaches

As an alternative to conventional criminal justice responses to organised crime, research conducted by Ayling (2014) on the use of situational crime prevention approaches to the control of organised crime in the Netherland has shown promising results. The key premise of this approach is that, in the course of engaging in illegal activities or investing in illicitly acquired assets, criminal groups need to make use of various public services and facilities. The approach targets these supporting activities rather than the core business of organised crime in view of the fact that while opportunity structures can facilitate organised crime they can also 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 those that arise in the construction, hospitality, waste processing, transport and sex industries. Ayling (2014) argues that enhanced scrutiny of such applications could be one way of limiting the criminal opportunities available to organised crime. The Committee believes that the Victorian Government should investigate the appropriateness of using these administrative regulatory measures to reduce the opportunities available to organised crime groups for engaging in illegal activities in Victoria.

Clinical and treatment

As indicated in Chapter 28, in the area of clinical research there are still many gaps in what we know about methamphetamine, particularly with regard to possible pharmacotherapies to treat methamphetamine dependence. Much of what had been learned about methamphetamine use, particularly in the 1990s, had been extrapolated, not always appropriately, from research into cocaine. This has been partly attributed to an expected jump in cocaine use in Australia during the 1980s that never actually eventuated (Baker in Wood 1998a).

There are a variety of clinical research needs that have been raised in both the research literature and evidence given to the Inquiry. With regard to the literature a research symposium on metamphetamine use in Australia conducted in 1993 called for research that is still needed today (see Burrows, Flaherty & MacAvoy 1993). For example, Wickes' (1993a) call for research into the effects of psychostimulants on pregnancy is still timely. Chesher's (1993) advocacy of research into the transition from oral use of amphetamines to injecting is also apposite. In 2005, academics McKetin, McLaren and Kelly stated that some of the key clinical issues that arise from methamphetamine use that should be continued or would benefit from further investigation include:

- Physical health among methamphetamine users including the cause and prevalence of physical health conditions such as cardiac problems and their long term implications
- Methamphetamine use and its relationship to aggression
- Improving burden of disease estimates for methamphetamine use
- Sexual risk behaviour among methamphetamine users (2005, p.152).

In light of the evidence received by the Committee these issues are still relevant for research today.

Current imperatives in clinical research

More recently calls have been made for better research into the clinical course of methamphetamine use (Lee & Rawson 2007; Allsop & Lee 2012; McKetin et al. 2013b). The need for greater research on the natural history and progression of methamphetamine use has also been raised as a priority. Such studies are crucial for understanding the way in which methamphetamine evolves over time.¹⁸⁵⁶

There have also been calls for greater links on the relationship between methamphetamine use and the risks of HIV/AIDS acquiring (Colefax et al. 2010). Degenhardt and her colleagues have also pointed to the need for more research into the relationship between early onset amphetamine and methamphetamine use and later dependence on the drug and the possibility of cannabis acting as a 'gateway drug' to later use of methamphetamine (Degenhardt et al. 2007).

Gaps in treatment research

As has been noted in great detail in the Chapter 28, there are relatively few treatment options for methamphetamine users, certainly compared to equivalent options for heroin users for example. This relative paucity of options applies to both pharmacological/pharmacotherapy and to a lesser extent behavioural interventions. Certainly, during the course of this Inquiry a variety of organisations and individuals have put forward some ideas for further research with regard to methamphetamine. Almost all evidence raised in relation to this issue included a recommendation for further research and evaluation of pharmacotherapies and substitution therapy drugs.¹⁸⁵⁷ Research is also required as to *why* users may or may not, as the case may be, access treatment services (Baker & Lee 2003; Allsop & Lee 2012). Certainly the lack of pharmacotherapies available would seem to be one of the reasons explaining this unwillingness to access treatment but further information on this is necessary.¹⁸⁵⁸

The only two Australian studies into psychological therapies for methamphetamine use, the mainstay of treatment in the absence of pharmacotherapy, were reported in 2010 (Smout et al. 2010b) and 2004 (Baker et al.), and no research has been published since. Additional trials are required to broaden the evidence base and to inform an update of clinical treatment guidelines.

In addition, witnesses to the Inquiry have called for further research into the nature of methamphetamine withdrawal and have suggested that some clinicians are unsure whether there is a discrete withdrawal syndrome for methamphetamine and, if so, how

¹⁸⁵⁶ See the submission of the Professor Paul Dietze, Deputy Director, Centre for Population Health, Burnet Institute, Submission, 21 October 2013.

Similarly, a submission from McKillop Family Services has argued that research is required on unforeseen (long-term) impact of methamphetamine and 'unseen' health impacts with regard to both physical and mental illnesses over time. Ms Micaela Cronin, Chief Executive Officer, MacKillop Family Services, Submission, 21 October 2013.

¹⁸⁵⁷ For example St Vincent's hospital has stated that the development of new drugs such as lisdexampethetamine (Vyvanese) and atomoxetine (Strattera) provide the opportunity for clinical trials. Dr Martyn Lloyd-Jones, Acting Director, Department of Addiction Medicine, St Vincent's Melbourne, Submission, 21 October 2013.

¹⁸⁵⁸ See discussion in Chapter 28.

it is constituted.¹⁸⁵⁹ The need for further research into the areas of screening and brief interventions for methamphetamine use has also been raised.¹⁸⁶⁰

One other important issue to bear in mind in considering clinical and treatment research agendas is the relationship between methamphetamine and other conditions. This, as observed in Chapter 6, is particularly important with regard to co-morbid mental illness. The Youth Support and Advocacy Service for example, which sees many young clients who present with co-morbid mental illness, also stressed this as a research priority.¹⁸⁶¹

Use by specific populations

In addition to the specific research and projects discussed above, evidence has been given that research should explore the impact of methamphetamine use on the following population groups.

Women including pregnant women

Academics have argued that specific gendered research examining the lives and needs of female methamphetamine users and how these may differ from men is needed (Semple, Grant & Patterson 2005; Brecht et al. 2004).¹⁸⁶²

Evidence has also been given that research on the effects of methamphetamine on pregnant women is very important. A submission from the Royal Women's Hospital also called for more research studies that impacted upon women who may use methamphetamine including:

- Research into genetic predisposition for methamphetamine (and other drug) use
- Effects of methamphetamine on pregnant women and women who have recently given birth, including postnatal depression.¹⁸⁶³

Research on methamphetamine use and its effects on children

Methamphetamine use by a parent or parents may put children at risk through neglect, including not ensuring children attend school and poor nutrition, family breakdown leading to being placed in out-of-home care, and environmental hazards. The Committee was made aware of a lack of research into the extent that methamphetamine use affects children and associated problems with respect to parenting. The submission by the Commission for Children and Young People argued that further research concerning the exact nature of the risks to children is required:

While there is a good literature documenting the negative impact of parental substance misuse, combined with other life problems, on child outcome, there is no specific comparison between substance classes. For example, it is not possible to determine whether parental amphetamine abuse poses a greater risk to adverse child outcome compared to a substance such as heroin. Australian research into this area needs to be encouraged.¹⁸⁶⁴

Use of methamphetamine by Aboriginal people

The report into Aboriginal injecting drug use commissioned by the Australian National Council on Drugs (ANCD) acknowledged there is a serious knowledge deficit in what

1859 Ms Belinda McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia, Public Hearing, Geelong, 28 October 2013.

1860 Ms Sharon O'Reilly, Clinical Services Manager, Bayside Medicare Local, Submission, 21 October 2013.

1861 McKetin, McLaren & Kelly (2005) have also argued the development and evaluation of methamphetamine treatment approaches, particularly among people with co-morbid health problems such as psychosis and depression, are required.

1862 For a discussion of the patterns of and reasons for methamphetamine use among women and how this may differ from men, see discussion in Chapter 14.

1863 Ms Teresa Lynch, Manager, The Royal Women's Hospital, Submission, 11 March 2014.

1864 Bernie Geary, Principal Commissioner and Andrew Jackomos, Commissioner for Aboriginal Children, Commission for Children and Young People, Submission, 24 October 2013.

we know about Aboriginal drug use, including methamphetamine use, as well as a lack of accurate data on Aboriginal prevalence and patterns of drug use (ANCD 2011). Other issues that were identified as worthy of further research included issues of stigma, denial and shame amongst Aboriginal drug users and their families; why Aboriginal people may not access drug treatment; how culturally appropriate models of policy development and service delivery could best be developed and implemented; and how Aboriginal people could be encouraged and resourced to become researchers into drug use amongst Aboriginal populations (ANCD 2011).

Culturally and linguistically diverse (CALD) Victorians

As discussed, in Chapter 14 it is extremely difficult to ascertain the extent to which methamphetamine use may be a problem in 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. The need for more research that can lead to better interventions for people from CALD backgrounds who are using methamphetamine (and their families) was raised by both the Victorian Alcohol and Other Drug Association (VAADA) and the Centre for Multicultural Youth.¹⁸⁶⁵

Other areas of research

While greater research into epidemiological, clinical and supply side aspects of methamphetamine is clearly needed, the Committee believes there are also other important issues in the context of methamphetamine use and supply requiring research. These include topics that rely upon the use of social research and ethnographic methodologies.¹⁸⁶⁶

Colefax et al., for example, have argued with regard to crystal methamphetamine in particular, qualitative methodologies including user surveys can lead to a greater understanding of the developmental, psychological and social use of different drug-taking populations including such matters as the:

- ◆ Predictors of initiation of drug use
- ◆ What characterises episodic from heavy use and what factors may lead from one to another
- ◆ How methamphetamine dependence may develop; and
- ◆ What factors may contribute to the cessation of methamphetamine use (Colefax et al. 2010).

Similarly, academics McKetin, McLaren and Kelly have also called for greater research on the retail level of the methamphetamine drug markets through surveys of drug users and dealers and learning about their drug dealing behaviour (2005). The authors have

1865 See Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol & Drug Association VAADA, Submission, 11 November 2013; Ms Carmen Guerra, Chief Executive Officer, Centre for Multicultural Youth, Submission, 4 August 2014.

1866 Ethnography (in the context of drug use) examines:

'[t]he ways in which drug users categorise *their* worlds, the ways in which *they* ascribe meaning to their actions and the ways in which broader structural processes shape *their* lives' (Moore 2002, p.278).

Many ethnographical studies on drug use draw either explicitly or implicitly from Zinberg's analysis of 'drug, set and setting' referred to in Chapter 9. McKetin, McLaren and Kelly's study of methamphetamine drug markets in Sydney and the surveys done with local dealers and users is an excellent example of such qualitative research (2005, p.152). In other words, social and ethnographic research into drug use should not concentrate only on the pharmacology of the drug (drug) or the individual psychology of the use (set) but should also examine the social context or 'social worlds' within which these two variables are located and the values, beliefs and sanctions that are brought to drug use by various individuals and social groups (the setting). It is the interaction between the drug taken, the individual psychology of the user and the cultural or social milieu in which it is taken that is crucial in attempting to understand drug use and thus formulate appropriate interventions. Much ethnographic research, particularly that which is based on participant observation also takes place in the natural settings of the user, the dance club or the rave, rather than a clinic or institution. Such a method would not concentrate exclusively on the negatives, problems or harm of drug use. This is not to condone, encourage or lionise drug use. It is simply to acknowledge that researchers, educators and policy-makers need to understand the social world of the drug user in formulating effective interventions to reduce the harms that *are* associated with the drug.

also stressed that it is important that any drug research agenda and particularly social research initiatives be implemented or at least influenced by those who have involvement with drug policy and/or practice from either an academic or practice/experiential base. The involvement of drug users is particularly important. One way of ensuring the voices of those who use illicit drugs are heard is to encourage outreach workers to tap (with their informed consent) into their knowledge and then feed that knowledge back into policy design (McKetin, McLaren & Kelly 2005).

Dr Andrew Groves of Flinders University stressed the need for social research that understands ice use patterns, particularly amongst young people:

I think the issue is that there is not enough understanding or knowledge of how and why ice in this instance — is being used by young people... So the question is, 'Who are these young people? Why are they using it, and how are they using it?'... I think it is necessary to first understand why it is being used. Based on that information, going forward I think it is important to speak to the young people to gauge what are other alternatives to using methamphetamine.¹⁸⁶⁷

The following discussion centres on three areas of non-clinical research that have been identified as important in addressing issues pertaining to methamphetamine use.

Research on the relationship between methamphetamine use, violence and crime

Whilst the Committee received evidence particularly from Ambulance Victoria,¹⁸⁶⁸ hospital emergency staff,¹⁸⁶⁹ youth workers¹⁸⁷⁰ and family members¹⁸⁷¹ that users of crystal methamphetamine often displayed violent behaviour, academic research on this question is somewhat inconclusive (Smith & Rodwell 2009). As Gately et al. (2011) have argued, whilst a considerable amount has been written about the association between violence, crime and methamphetamine use, much of the research thus far has been descriptive and inconclusive.¹⁸⁷² Jacinta Pollard, Managing Director of Caraniche,¹⁸⁷³ in her submission to the Committee discussed various academic studies in Australia and overseas that have explored the relationship between crime, violence and methamphetamine use and, although acknowledging that there is a lack of literature that conclusively establishes a causal relationship between methamphetamine use and violence, stated:

Overall, the literature indicates a clear trend in that methamphetamine users are engaged in greater levels of crime, for longer periods of time when compared with other forms of illicit and licit substance use. The data is inconsistent in establishing whether methamphetamine use is more likely to predict crimes against the person, and further research is necessary to confirm this relationship.¹⁸⁷⁴

1867 Dr Andrew Groves, Research Officer, Flinders Law School, Flinders University (via teleconference), Public Hearing, Canberra, 11 February 2014.

1868 Associate Professor Tony Walker, General Manager, Regional Services, Ambulance Victoria, Public Hearing, Melbourne, 30 September 2013; Mr Peter Guest, Mobile Intensive Care Ambulance Paramedic, Ambulance Victoria, Public Hearing, Mildura, 5 December 2013; Mark Allen, Team Manager, Morwell Mobile Intensive Care Ambulance (MICA) Unit and Single Response Unit (SRU), Ambulance Victoria, Traralgon, 28 January 2014.

1869 Dr Andrew Crellin, Director of Emergency, Ballarat Health Services, Public Hearing, Ballarat, 18 November 2013; Dr David Eddy, Director of Emergency Medicine, Barwon Health, Public Hearing, Geelong, 28 October 2013.

1870 Ms Melanie Vidler, Youth and Family Support, The Bridge Youth Service, Shepparton, 25 February 2014.

1871 See for example, Ms Darlene Sanders, Indigenous Engagement Officer, Mallee Family Care, Public Hearing, Mildura, 5 December 2013; Ms Heather Pickard, Chief Executive Officer, Self Help Addiction Resource Centre, Public Hearing, Melbourne, 14 October 2013.

1872 See also discussion in Chapter 8.

1873 Caraniche provides alcohol and drug treatment services across the Victorian prison system.

1874 Jacinta Pollard, Managing Director, Caraniche, Submission, 30 October 2013.

See also the submission of Maribyrnong City Council. The Council argued that more clinical research is needed to understand the impact of methamphetamine on both the individual, 'at risk' groups and the community, particularly with regard to violence and community safety. Mr Arden Joseph, Director, Community Wellbeing, Maribyrnong City Council, Submission, 21 October 2013.

Arguably there needs to be a synthesis of criminology-based and health-care research to improve the understanding and quantification of underlying causal relationships. In particular, the Committee understands that 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.

Gaps in the knowledge on the cost of methamphetamine use

Another difficult area of research concerns the quantification of the financial impact of methamphetamine use on the community, particularly in Victoria. During this Inquiry, the Committee heard a range of estimates of the impact of illicit drug use, but little information was available on the actual financial cost of this type of crime to the Victorian community. Although the Committee has examined prior research into the cost to the community of drug-related crime, such as Collins and Lapsley (2008) and Manning, Smith & Mazerolle (2013), this work does not examine the economic harms associated with methamphetamine and ice as specific sub-categories of illicit drug-related harm. More precise research is needed to examine the economic implications of methamphetamine and ice that would enable the government to understand how methamphetamine affects the Victorian economy in terms of lost productivity, health-care costs, and costs associated with treatment of drug users.

Evaluation of strategies, programs and interventions

Evaluative research of both a process and outcome nature is an essential component of developing good, effective and relevant policy in this area. As Babor et al. state, it also needs to be ongoing and in many cases, locally based:

Evaluation research is necessary in order to measure whether the policy has any impact, and to provide a 'reality-check' to high expectations often attached to promising new initiatives in this area. Evaluation also needs to be ongoing. Evidence from one time period may not necessarily be applicable to situations emerging in another era. And evidence from developed countries may not always be applicable to developing countries. Furthermore, communities often want locally based evidence, or at least evidence that is close to home... While there may be general agreement about the scientific support for a specific strategy, there may be doubt among policy-makers that these findings will apply to their jurisdiction.

Evaluation research provides a useful but often under-utilised resource to decision-makers. Should resources be devoted to those policies that have at best a modest effect, or should they be directed to policies that have a chance for a broader and more substantial impact? Decisions about which strategies to implement, phase out, or modify should be informed by findings from systematic evaluation (Babor et al. 2004, p. 98).

Although the above quote was written in the context of harmful alcohol consumption, it is equally true of any form of drug use problems.

Any program or intervention that is designed or implemented should, in the view of the Committee, have an in-built requirement for evaluation. This is particularly important for harm reduction programs and strategies. It is a crucial aspect of determining not only what works but what doesn't work or what at least could be improved upon.¹⁸⁷⁵ Having said that, it is also acknowledged that evaluation of drug-related programs is exceedingly difficult as is

¹⁸⁷⁵ For example, in the context of drug health programs delivered to the Aboriginal community, it has been stated that 'evaluation processes which involve Aboriginal input into planning and evaluation will ensure service responses to Aboriginal people who inject drugs are not only culturally appropriate but also meet the needs of Aboriginal clients' (ANCD 2011, p.106).

the idea of what counts of '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 (Allsop & Lee 2012).¹⁸⁷⁶

The current National Drug Strategy 2010–2015 has placed a high premium on evaluation of drug programs:

Ongoing evaluation of approaches is critical to the success of the National Drug Strategy 2010–2015. Evaluation ensures that existing programs and policies are appropriate, effective and efficient in the context of contemporary drug use patterns, trends and settings. For example, the long standing needle and syringe programs have been regularly evaluated. The results have supported the expansion and evolution of the types of needle and syringe programs offered and demonstrated its ongoing efficiency, cost effectiveness and public health value (Ministerial Council on Drug Strategy 2011, p.21).

As part of the evaluation process, the National Drug Strategy has set a series of performance indicators to gauge progress and guide implementation of the Drug Strategy and associated programs. Such performance indicators complement and sit alongside those set down in the National Healthcare Agreements. They are intended to provide a broad indication of progress against the three pillars of the Strategy; recognising that in the area of drug preventions some outcomes, such as a complete cessation of drug use, will not always be realistic.¹⁸⁷⁷

Some evaluative approaches may also be affected by a difference in philosophy. For example, the effectiveness of a school-based education drug program may be measured differently depending on whether the desired outcome is abstinence as in the United States or a reduction in harmful consumption as happens in many other countries, including Australia (Foxcroft et al. 2003, p.407). While neither approach is necessarily wrong, it is imperative that evaluators be clear and transparent about the desired outcomes of the program they evaluate, and use objective criteria to achieve this.

There is also, therefore, 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 discussed above, whilst not specific to methamphetamine use, does provide an evaluative model that could possibly be adapted for specific drug use.

Whilst it is important to have evaluation of programs that address drug use generally and methamphetamine use in particular, often AOD and other agencies, particularly the smaller ones, are not resourced to commission evaluation studies or undertake them themselves.¹⁸⁷⁸ In such instances it is important that funding grants to agencies who undertake drug programs should have specific allocations to enable them to conduct such evaluations.

Conclusion

The Committee believes that any strategies, interventions or policies aimed at addressing methamphetamine and crystal methamphetamine use must be based on the best available

1876 For a discussion of the difficulty of evaluating health, welfare and drug programs and what counts for success, see Ms Jan Rowe, Chief Executive Officer, Mirabel Foundation, Public Hearing, Melbourne, 17 February 2014.

1877 The three main performance indicators are: Indicators of Drug Use (falls in prevalence and increase in age of initiation); Disruption of the Illegal Drug Supply; and Decreases in Harm Associated with Use. For an account of how these performance measures are achieved see Ministerial Council on Drug Strategy 2011, pp.22ff.

1878 See for example, Ms Jan Rowe, Chief Executive Officer, Mirabel Foundation, Public Hearing, Melbourne, 17 February 2014; Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol & Drug Association VAADA, Submission, November 2013.

evidence and/or best practice. Up-to-date and focused research that covers a range of quantitative and qualitative methodologies is an essential aspect of delivering effective policy outcomes in this complex area of drug use.

Research must also 'be made more attractive for policy-makers/prevention workers to work in evidence based ways; they should be enabled to relate to research' (Garretsen & Van de Goor 2004, p.148). Policy-makers therefore should be more involved in the research process. Garretsen and Van de Goor suggest to do so policy-makers and prevention workers should be involved in joint meetings with researchers and, conversely, that researchers can learn a lot from the 'hands on' experience of those working in policy and in direct alcohol and other drug practice.

The Committee believes that funding directed toward the areas of research outlined above would provide a sound evidence base for making decisions about the best ways to respond to the problem of methamphetamine and crystal methamphetamine in Victoria. Many ideas have been canvassed for addressing the problems identified in this Inquiry, but the Committee cautions against choosing particular approaches without basing decisions on appropriate and well-researched evidence. All too often regulatory and policy responses implemented without adequate prior research can lead to a range of unintended consequences that can make matters worse, rather than better (Grabosky 1995).

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.

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.*

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.

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.

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.

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.

(Continued overleaf)

- *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.

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.

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.

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.

31. The Development and Implementation of a Proposed Strategy to Address Methamphetamine Use

Introduction

The attempts to address the use of drugs in society have been described as ‘one of the key policy challenges of our time’ (Global Commission on Drug Policy 2011, p.17). However, despite myriad efforts aimed at preventing or at least reducing and controlling (illicit) drug availability and addressing its harms, the use of psychoactive stimulants including crystal methamphetamine remains commonplace. As Lancaster, Ritter and Colebatch comment:

Drug policy is a complex and often controversial policy domain, frequently characterised by the notion of ‘wicked problems’. These social problems are never ‘solved’ but ‘at best they are only re-solved — over and over again’ (Rittel & Webber 1973). In this context traditional models of the policy process which present policy-making as a linear, coherent, step by step process of authoritative problem solving...deny the inherent messiness, ambiguity and complexity of the policy process in the real world (2014, pp.147-148).

Methamphetamine use, as with many areas of drug misuse, is a complex phenomenon, indeed more complex than the Committee thought prior to commencing this Inquiry. It can readily lend itself to the policy ‘messiness’ referred to in the above quote. Nevertheless, attempts do need to be made to address methamphetamine use in all its complexity. The task is not easy given the diversity of the methamphetamine using population, the relative ease with which it is produced or sourced, and the lack of successful treatment options for people who are dependent on the drug. As Allsop states:

The diverse contexts in which [methamphetamine] is used (eg in the workplace, in entertainment venues, during sexual encounters) and the diverse range of consumers (young people in entertainment venues, older people in the workplace) has led to a consensus that we should be adopting multifaceted approaches. ...combined approaches are the most likely to be effective as no single strategy could possibly address all the potential issues of concern (eg mental health and physical health or risk taking behaviour) (Allsop 2012, p.187).

The Committee believes that to successfully address the issues relating to methamphetamine, collaborative approaches at national, state, local and community levels must be instigated. Underpinning each of these levels are the principles of the National Drug Strategy (NDS) which require attention paid equally to *supply reduction*, *demand reduction* and *harm reduction* strategies.

This chapter sets out the types of broad collaborative approaches at community and government levels required to form and support a comprehensive methamphetamine strategy. Such a strategy includes a new structure in which to implement a methamphetamine action plan.

The national framework

The National Drug Strategy Framework 2010–2015 reaffirms Australia’s commitment to harm minimisation as the guiding principle of national drug policy. The framework aims to improve health, social and economic outcomes for both the individual and the community. One of the primary objectives of the drug strategy is to develop a partnership approach to drug-related issues.

The original National Drug Strategic Framework policy document in 1998 stated:

The development of a closer working relationship between the three tiers of government and affected communities (including drug users, their families and those affected by drug-related harm), community-based organisations, business and industry, the medical profession, and research institutions has therefore been identified as a priority. In recognition of this, and acknowledging that a partnership approach is still evolving, ‘building partnerships’ is the theme for this next phase of the National Drug Strategy (Ministerial Council on Drug Strategy (MCDS) 1998, p.21).

This need for a collaborative partnership approach has been reiterated in each successive version of the Strategy, including the current model. The importance of incorporating the principles of the NDS into state models of drug policy development was emphasised to the Committee by Judith Abbott from the Victorian Department of Health:

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, *Reducing the alcohol and drug toll: Victoria’s plan 2013-2017*.¹⁸⁷⁹

The NDS also emphasises the importance of *multi modal* strategies which incorporate demand, supply and harm reduction that are nonetheless coordinated by a single entity:

Research and theoretical models suggest that multi-modal strategies are the most likely means of preventing drug use. Multi-modal strategies can address the multiple risk and protective factors for drug use in a coordinated, comprehensive and consistent manner. Ideally, they would involve a comprehensive needs assessment in a particular community and development and implementation of a range of strategies to reduce risk factors and promote protective factors as indicated by the needs assessment. The plan could include interventions targeting individuals (e.g. mass media and school-based interventions), the family (e.g. parent effectiveness training for at-risk families) and the community (e.g. revision of school policies relating to personal development and drug education, legislative changes, changes to law enforcement practices, improvements in sporting facilities, additional educational and vocational opportunities). However, planning, implementing and evaluating such strategies can be costly, time-consuming and difficult. Intersectoral cooperation on even a single intervention can be difficult, let alone on a comprehensive set of interventions. Consequently, there is not a large group of well-implemented and well-evaluated trials to demonstrate efficacy, let alone to specify the key strategies and best practice (Australian National Council on Drugs (ANCD) 2001, p.58).

¹⁸⁷⁹ 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.

The need for state and local policies

While national frameworks provide the ‘macro’ 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. As the comments of Judith Abbot indicate, state-level initiatives that have been developed have specifically incorporated the three pillars of harm minimisation into their policies and programs. The Committee believes, however, 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. Rather, the Committee supports the development of a new strategy that includes two components: a structure and an action plan that specifically addresses methamphetamine. Such an approach reflects the evidence the Committee received with regard to a lack of coordination and ad hoc responses in addressing methamphetamine use; in particular the development of policy and programs in ‘silos’ across and between government departments. The Committee agrees that there is clearly a demonstrable need for a coordinated and collaborative approach to addressing methamphetamine, and one that should cut across governmental departments and areas of responsibility. The proposed Ministerial Council on Methamphetamine and the associated State Methamphetamine Strategy discussed below are two ways in which this aim can be realised.

A Community call for a Victorian methamphetamine strategy

Throughout the Inquiry there was support for a state-wide methamphetamine strategy from a number of witnesses to the Inquiry. For example, Youth Support + Advocacy Service (YSAS) stated in its submission:

YSAS believes that the most effective way to address the increasing methamphetamine use and associated issues, including crime, is to develop an integrated statewide methamphetamine strategy.

A Victorian methamphetamine strategy would be informed by the findings of this inquiry... YSAS recommends that such a strategy be explicit about how strategies targeting and seeking to limit the supply of methamphetamine be coordinated with strategies to reduce both the demand for methamphetamine and the harm that it causes individuals, families and communities. It is particularly important that sufficient attention is dedicated to distinguishing between different groups of methamphetamine users and targeting strategies accordingly.¹⁸⁸⁰

Victoria Police also advocated for a whole of government coordinated response to methamphetamine. As discussed in Chapter 21 Victoria Police no longer believe their role in addressing drug use and drug crime is simply about law enforcement, and acknowledge the need to also view it as a health issue. As such they support a partnership approach whereby they play a role alongside other community stakeholders:

Victoria Police believes there is a need for a coordinated whole of government response to ATS [amphetamine type stimulant] issues. Solutions to most of the problems are outside the scope of police intervention alone. Collaboration between law enforcement, health, justice and education agencies is needed to ensure that all Victorian government programs addressing ATS issues are aligned.¹⁸⁸¹

Many witnesses to the Inquiry believed that current approaches to methamphetamine, and indeed drugs and alcohol generally, were overly ad hoc and uncoordinated. A submission from Vincent Care for example stated:

¹⁸⁸⁰ Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS, Submission, 21 October 2013.

¹⁸⁸¹ Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police, Submission, 7 November 2013.

There is no one single solution for problems such as the methamphetamine problems being experienced at present, and the many incremental aspects of the problem must each be addressed to create *an overall solution set*.¹⁸⁸²

Almost all witnesses who advocated the need for a new strategy to address methamphetamine use also stressed the need for such developments to be based on strong collaborative partnership models. They believe such models should incorporate the skills and expertise of local level bodies such as local councils and local drug and alcohol networks.¹⁸⁸³ In its submission to the Inquiry, Anex stressed the crucial importance of partnerships and coordination between government departments and community agencies in driving any new strategy on methamphetamine:

Methamphetamine use is a complex situation, and must be addressed through a broad range of strategies. These must be developed within a 'whole of community' approach to the issue, incorporating community, business, families and individuals. They must make the most of prevention and early intervention opportunities, but also provide harm reduction and treatment support for those who require this...

Better linkages must be resourced, supported and sustained across the public sector including AOD [alcohol and other drugs services], mental health, community welfare services, domestic violence, justice and emergency services, and with the broader community settings in which methamphetamine use may be prevalent, such as schools, sports clubs, entertainment precincts, and some workplaces. Enhanced networks and partnerships will enable the development of local strategies for addressing methamphetamine use, including better local surveillance to identify use patterns amongst particular demographics, sharing of information and better referral pathways.¹⁸⁸⁴

The Committee has acknowledged the evidence of witnesses to the Inquiry that too often in addressing drug-related issues, including methamphetamine, there are problems associated with a lack of coordination across government departments. The Committee agrees and believes that there is a demonstrable need for a coordinated and collaborative approach to addressing methamphetamine that streamlines government planning and decision making. Responsibility for dealing with the harms caused by crystal methamphetamine use, however, goes beyond the government and its agencies. It must be shared by several players. Input must also come from individuals, local communities, government at local, state and federal levels, health and education providers and non-government organisations.

The need for local community approaches

The national and state drug strategies acknowledge that those within a local community are often best placed to coordinate a response to issues that arise within that community. An appreciation of the networks and sensitivities that define a local community's culture is of utmost importance when devising a response to a community drug problem. The Committee also believes that local communities have a distinct role to play in addressing and 'owning' the crystal 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.

1882 Mr John Blewonski, Chief Executive Officer, VincentCare Victoria, Submission, 21 October 2013.

See also Mr John Ryan, Chief Executive Officer, Anex, Submission, 29 October 2013; Ms Teresa Lynch, Manager, The Royal Women's Hospital, Submission, 11 March 2014; Mr Mark Powell, Dual Diagnosis Senior Clinician, Headspace, Public Hearing, Warrnambool, 3 March 2014.

1883 Mr Arden Joseph, Director, Community Wellbeing, Maribyrnong City Council, Submission, 21 October 2013.

1884 See also Mr Stuart Gillespie, Executive Manager Citizen Services and Information Management, City of Moonee Valley, Submission, 21 October 2013.

Local governments clearly have an important role to play in this regard, particularly through their local drug and alcohol community partnerships, networks or action plans. The Committee spoke to many representatives of local government who stressed that they were key players in bringing various stakeholders together in addressing issues such as ice at a local level. For example, Suzie Mansell from the Greater Bendigo City Council told the Committee how Bendigo Council approached addressing ice use through local collaborative partnerships:

We decided in response to the concern raised by the community that we would form a partnership to look at how we would approach this issue, because council has a natural role in planning and facilitating how to respond to the community but we are not subject matter experts. We thought it would be best to involve other organisations who are working in health and community services and involved in alcohol and drug treatment.

The partnership we have formed includes local organisations such as Bendigo Community Health Services, Victoria Police, youth support services, Youth Support and Advocacy Service, Bendigo and District Aboriginal Co-operative, Bendigo Health, St Luke's, the Salvation Army and the Department of Justice regional office. The group has been pivotal in developing the community engagement we have embarked upon to address this issue...and we have done that in a range of ways through this community campaign we have developed.¹⁸⁸⁵

This is one example of similar local government led partnerships addressing drug and alcohol use, including crystal methamphetamine, throughout the state.¹⁸⁸⁶ Clearly the types of community action groups discussed in Chapter 24, such as the Northern Mallee Community Partnership, also play an incredibly important role in this regard.¹⁸⁸⁷ Other local communities, particularly in rural and regional Victoria, already have or are in the process of setting up their own partnerships. Two other such partnerships taking an 'all of community' approach to addressing methamphetamine, described in evidence to the Committee, are the Greater Geelong Collective Community Effort on Substance Abuse and the Wimmera Drug Action Taskforce based in Horsham. Such approaches consist of a variety of stakeholders in conjunction with the community coming together to plan, develop and implement strategies to address methamphetamine use.

The Ministerial Council on Methamphetamine and the State Methamphetamine Action Plan discussed below will facilitate cross-government involvement as well as community partnerships to address problems relating to crystal methamphetamine in their local areas. Such an approach recognises that sound policy in this area also incorporates (and supports) local community responses to local needs, including those of local government departments.

The approach taken by New Zealand in developing a national action plan to address methamphetamine is one which has impressed the Committee and which to some degree serves as a model for the Committee's proposed strategy for addressing methamphetamine. It is therefore appropriate to first give some consideration to the model currently implemented in New Zealand and the background to its establishment.

1885 Ms Suzie Mansell, Manager, Community Partnerships, Greater Bendigo City Council, Public Hearing, Bendigo, 25 October 2013.

1886 See also discussion in Chapter 24 and evidence of Ms Kaz Gurney, Managing Lawyer, Goulburn Valley Community Legal Centre, Public Hearing, Shepparton, 25 February 2014.

1887 On this point see Ms Michelle Withers, Integrated Services Coordinator, Northern Mallee Community Partnership (Project Ice Mildura), Public Hearing, Mildura, 5 December 2013.

Lessons from New Zealand: The ‘Tackling Methamphetamine Action Plan’

Introduction

As one of Australia’s nearest neighbours with a similar political, legal and social system it is appropriate to briefly examine the way in which methamphetamine use has been addressed in New Zealand, particularly in order to see whether any lessons can be learned from the approaches taken in that jurisdiction.

Whilst New Zealand clearly shares many similar features to Australia, with regard to the history of illicit drug markets there have been some noticeable differences. For example, due to the country’s isolation and limited border points, there is a relative absence of Class A or ‘heavy’ drugs, such as heroin or cocaine (DPMC 2009, p.1). This has meant New Zealand entirely avoided the heroin ‘epidemic’ that Australian metropolitan capitals, including Melbourne, experienced in the 1990s as well as avoiding other problems with hard drugs.

New Zealand’s illicit drug market has historically been dominated by cannabis with nearly half of the population reporting use in their lifetime, with rates as high as 63.4 percent in the indigenous Māori community (Ministry of Health 2010, p.38). This compares to 34 percent reporting lifetime use in Australia (Tressider & Shaddock 2008, p.1).

Methamphetamine in New Zealand

Notwithstanding this historical drug profile, methamphetamine has in recent years made significant inroads into the country. Previously, organised crime gangs in New Zealand had focused almost entirely on cannabis production. In recent times, due to the ease of production and the ready availability of the precursor pseudoephedrine found in cold and flu medication, such gangs have been involved in manufacturing methamphetamine for the domestic market.¹⁸⁸⁸

Under the New Zealand *Misuse of Drugs Act 1975*, methamphetamine is classified as a Class A controlled drug, with significant penalties associated with its misuse and possession.

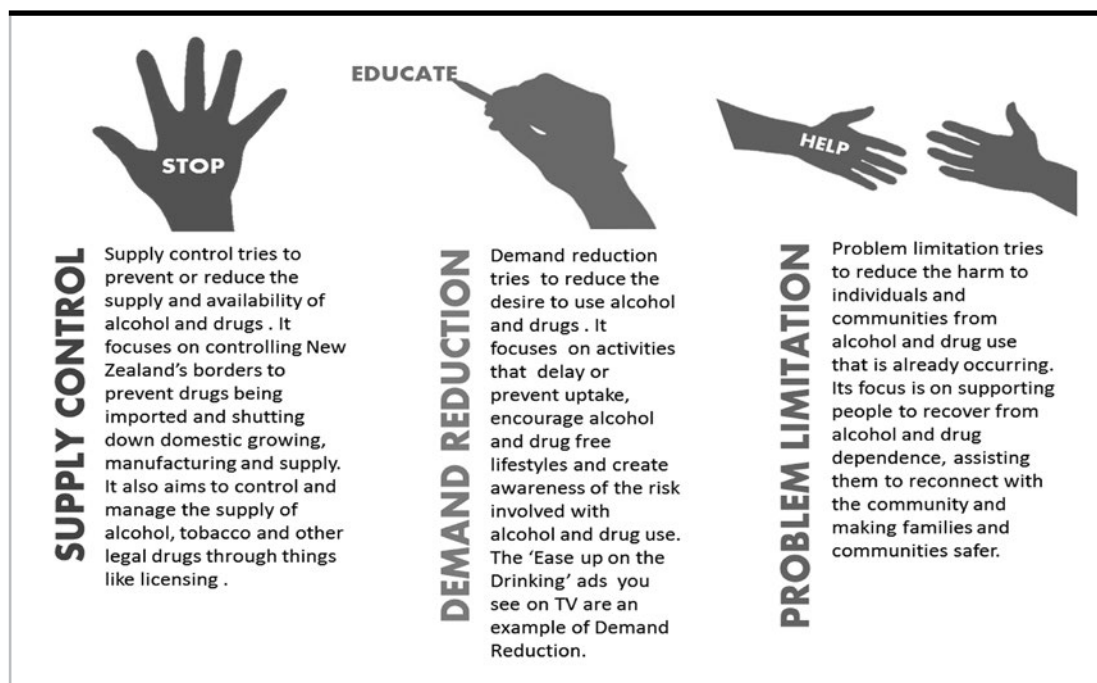
Methamphetamine in New Zealand is colloquially referred to as ‘P’, which is short for Pure Methamphetamine — the equivalent of ‘ice’ in Australia.

New Zealand National Drug Policy — The three pillars

Current approaches to addressing methamphetamine need to be viewed against the background of New Zealand’s leading policy document on drug abuse — the National Drug Policy. New Zealand’s National Drug Policy since 1998 has been founded on the principle of harm minimisation (Ministry of Health 2013, p.4) and the subsequent Government policy responses to the problem of methamphetamine have been underpinned by this approach. There are three ‘pillars’ of the New Zealand National Drug Policy of *supply controls*, *demand reduction* and *problem limitation* (Ministry of Health 2013, p.5). First, *supply control* focuses on reducing the supply and availability of alcohol and drugs. Second, *demand reduction*, tries to reduce the desire to use alcohol and drugs. And thirdly, *problem limitation* tries to limit the harm of alcohol and drug use in the community. This three tiered approach to addressing drug abuse, similar to the approach in the Australian National Drug Strategy, is outlined in greater detail in Figure 31.1

¹⁸⁸⁸ The emergence of methamphetamine in the drug market in New Zealand can be traced to the first clandestine laboratory (clan lab) being dismantled by the New Zealand Police in 1996 (Newton 2007, p.3).

Figure 31.1: The three pillars of the National Drug Policy (Ministry of Health (NZ) 2013)



Source: Ministry of Health (NZ) 2013, p. 5.

Government response — The Action Plan

In response to heightened public concern and the perceived social harms created by methamphetamine use,¹⁸⁸⁹ the Labour-led government in 2003 introduced the first Ministerial Action Group on Drugs (MAGD). The MAGD, in turn, established a Ministerial Committee on Drug Policy. This eventuated in a 'whole of government' approach to the problem (MAGD 2003, p.2). The implementation of the action plan was coordinated by the Inter-Agency Committee on Drugs (IACD), and its progress was monitored by the Ministerial Committee. The Action Plan focused on four key areas: controlling supply; reducing demand; limiting problems, and research (MAGD 2003). Out of the initial strategy came the re-classification of methamphetamine as a Class A drug, as well as other measures including the introduction of alcohol and drug clinicians in the courts (DPMC 2009).

This whole of government approach to drug policy was continued by the National-led coalition government's 2009 *Tackling Methamphetamine: an Action Plan* (the Action Plan). This is the current 'top-down' cross-agency action plan led out of the Department of Prime Minister and Cabinet (DPMC). Progress Reports on the Action Plan are provided to the Prime Minister and the Ministers of Health, Police, Customs, Justice, Corrections and Mori Affairs every six months, with the latest progress report (at the time of writing) being from April 2014.

Mike Sabin, former New Zealand police officer, drug educator and current National Party Member of Parliament, had the following to say about the Action Plan:

One of the fundamentals of the Tackling Methamphetamine Action Plan is the across-government approach, over six key government departments, all of whom report directly to the Prime Minister six-monthly on specific outcomes and accountabilities. This enables a more collaborative approach by agencies and holds CEOs to delivering on objectives as set out in the Plan. This does provide a more effective platform and breaks down silos that are often apparent in government when addressing any problem that has a cross government impact.¹⁸⁹⁰

1889 See for example New Zealand Press Association NZPA, 'Stepfather pleads guilty to killing Coral', *New Zealand Herald*, 10 December 2013, accessed 25 July 2014 at <http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=3538663>

1890 Mr Mike Sabin, New Zealand Member of Parliament, Public Hearing, Melbourne, 5 June 2014.

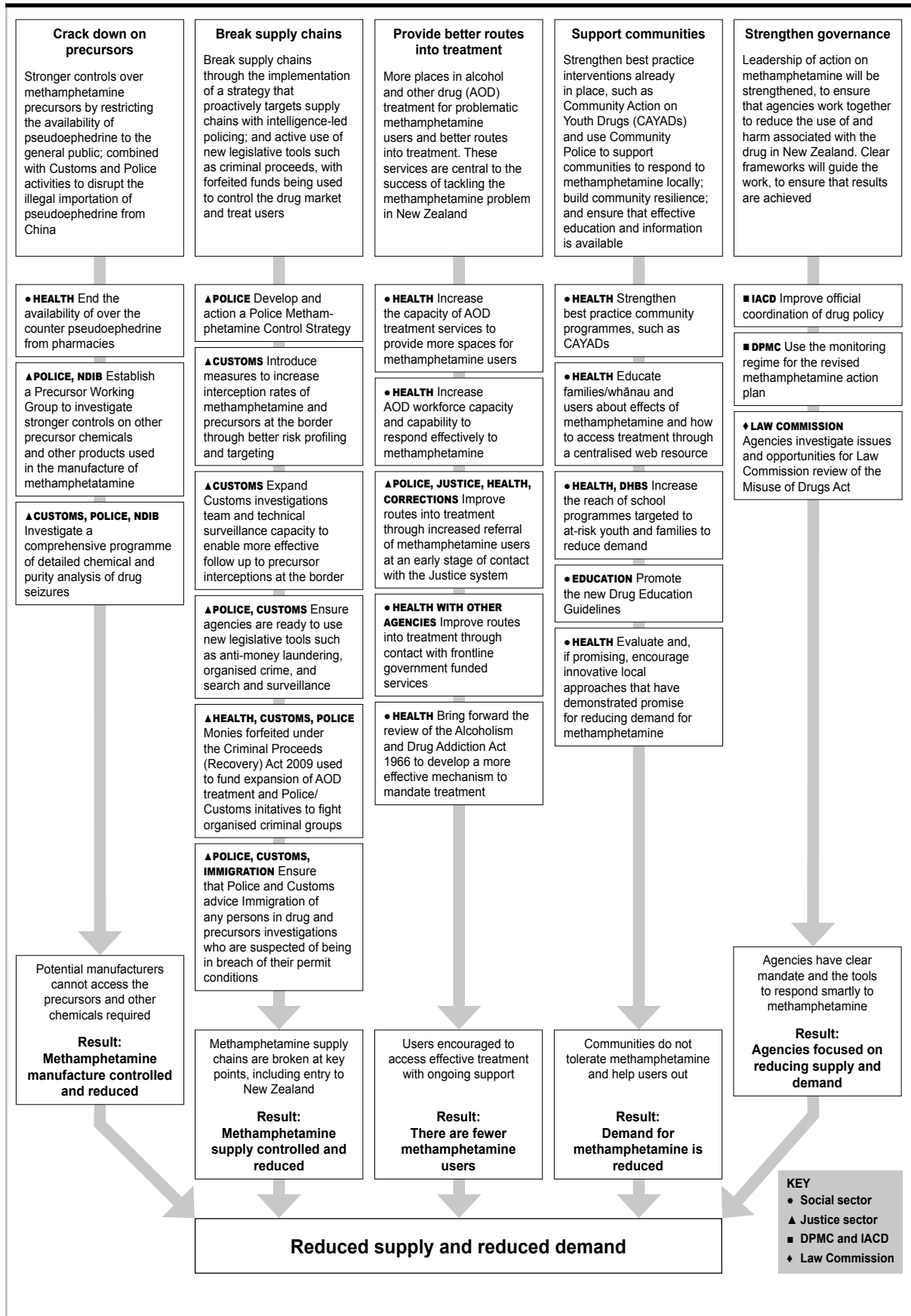
The package has five elements detailed below, with specific actions related to each of the elements, which can be seen in the list below and the flow chart, Figure 31.2:

- 1. Crack down on precursors** — Stronger controls over methamphetamine precursors by restricting the availability of pseudoephedrine to the general public, combined with Customs and Police activities to disrupt the illegal importation of pseudoephedrine from China
- 2. Break supply chains** — Break supply chains through the implementation of a Police Methamphetamine Control Strategy that proactively targets methamphetamine supply chains with intelligence-led policing. Active use of new legislative tools such as criminal proceeds recovery, with the forfeited funds being used to control the drug market and treat users
- 3. Provide better routes into treatment** — More places in AOD treatment for problematic methamphetamine users and better routes into treatment. These services are central to the success of tackling the methamphetamine problem in New Zealand
- 4. Support communities** — Strengthen best practice interventions already in place, such as CAYADs, and use Community Police to support communities to respond to methamphetamine locally. Build community resilience and ensure that effective education and information is available
- 5. Strengthen governance** — Leadership of action on methamphetamine will be strengthened, to ensure that agencies work together to reduce the use of, and harm associated with, the drug in New Zealand. Clear frameworks will guide the work, to ensure that results are achieved.

Source: DPMC 2009, p.3. ¹⁸⁹¹

¹⁸⁹¹ Community Action – Youth and Drugs (CAYADS) are community based drug and alcohol programs supported with funds from the New Zealand Ministry of Health.

Figure 31.2: New Zealand Action Plan Overview



Source: DPMC 2009

There are currently 15 ongoing and eight completed actions in total across the five parts of the Action Plan (complete list of actions shown above). Alongside the Action Plan, a monitoring framework has been set up to ensure that the plan is delivering the desired results. The progress reports specifically record changes against the Action Plans baseline data from 2008 and 2009, and details progress against the Action Plan’s activities, as well as reporting on the latest statistics on price, purity, availability and prevalence (DPMC 2014). If implementation of the action plan is falling behind schedule, Chief Executives from government departments are asked to explain how implementation will occur (DPMC 2009).

As an example of how the Action Plan works in practice, under element three of the Plan ‘Provide better routes into treatment’ (see flow chart above), there is a specific action in the original Action Plan to ‘improve routes into treatment through increased referral of methamphetamine users at an early stage of contact with the justice system’. The Action Plan details the Cabinet decision, a description of the action, a list of the responsible agencies and the timeframe for action (DPMC 2009, p.43).

Table 31.1: Action — Improving routes to treatment

Improve routes into treatment through increased referral of methamphetamine users at an early stage of contact with the justice system	
Cabinet Decision	Directed Justice and Health to report back to Cabinet Social Policy Committee by 30 November 2009 on a preferred model for Alcohol and Drug clinicians in Courts to increase referral for users from the justice system into treatment, including cost estimates.
Description	<p>The criminal justice system provides an opportunity to assess whether individuals have a problem with drug use and help users into treatment. There are a number of routes into treatment available now, which could be used more once treatment capacity is increased. This would involve assessments by qualified AOD clinicians and information provided to decision-makers about the appropriateness of treatment and referral to treatment, particularly for those involved in offences due to their dependence problems.</p> <p>The Police Methamphetamine Control Strategy will monitor the number of first time offenders directed into alcohol and drug assessment. Police adult diversion may also make greater use of brief screening tools (see next action) and refer first time offenders to appropriate treatment, if required. This will require the Ministry of Health to develop a screening tool and a guide to routes into treatment and Police to train diversion officers in its use. This is contingent on Ministry of Health work priorities (see next action).</p>
Responsible Agencies	Ministry of Justice, New Zealand Police, Department of Corrections and Ministry of Health.
Timing	Some existing processes can be used more to see immediate results. Others will require development, with a report back to the Cabinet Social Policy Committee by 30 November 2009. Availability of treatment spaces will determine the timing of some changes.

Source: DPMC 2009, p. 43.

This specific action is then followed up in each of the six-monthly progress reports which are coordinated out of the Department of Prime Minister and Cabinet, and statistics provided by Government agencies. The April 2014 Progress Report reported that there had been a two-drug five-year trial of Alcohol and Drug Courts set up in Waitakere and Auckland, as well as increases in the number of offenders who are receiving alcohol and drug treatment in prison (DPMC 2014). Each action receives similar treatment in each progress report.

Table 31.2: Progress Report 2014 — Improving routes to treatment

9	<p>Improve routes into treatment through increased referral of methamphetamine users at an early stage of contact with the justice system.</p>	<p>The number and proportion of offenders with methamphetamine convictions receiving alcohol and drug assessments as a condition of sentence continued to increase from 8% in 2004 to around 20% in 2013.</p>
	<p>Improve routes into treatment through contact with frontline government funded services.</p>	<p>The five year AODT Court Pilot commenced in the Auckland and Waitakere District Courts on 1 November 2012. As of 4 March 2014, a total of 116 participants had been accepted. CPRA funding will fund counsel costs for the AODT Court this year.</p>
		<p>The Department of Corrections is continuing to increase the number of programmes it delivers to offenders. This includes: an additional 3,700 alcohol and drug treatment places each year in prison (bringing the total to 4,720); 4,300 offenders each year receiving brief alcohol and drug interventions delivered by health staff; 5,100 additional alcohol and drug treatment places each year for community offenders (up to a total of 11,800); and, 22,000 brief alcohol and drug interventions delivered by probation officers to community offenders each year (up from 4,100 last year).</p>

Source: DPMC 2014, p. 4.

An example of an innovative community program which operates under both the *demand reduction* and *problem limitation* pillars is the Hauora program, which works in partnership with the M ori gangs such as the Mongrel Mob, to combat methamphetamine addiction (Salvation Army 2013). This program is supported as part of the Action Plan (DPMC 2014, p.6) and specifically targets methamphetamine use in some of New Zealand's indigenous Māori communities based on tikanga M ori (customs and tradition). The program works with the whanau (family) and members of the gangs and encourages them to make healthy choices using the strength of the support networks found within the gangs to deal with their methamphetamine addictions.

Other significant outcomes from the Action Plan include the end of over-the-counter pseudoephedrine based medication being available in pharmacies without a prescription (DPMC 2014). There have also been new legislative tools around money laundering, organised crime and surveillance, with the Search and Surveillance Act 2012 and the Anti-Money Laundering and Countering Financing of Terrorism (AML/CFT) Act 2009 (DPMC 2014). As well, there has been a significant increase in the alcohol and drug workforce capacity and promotion of new Drug Education Guidelines (DPMC 2014).

The latest Progress Report (April 2014) also compared the indicators with the 2008/09 baseline data, as a way to reflect progress. It shows a small, but steady increase in the retail price of methamphetamine in New Zealand, from \$96 in 2008 to \$106 in 2013 per point, or 0.1g (DPMC 2014). There had been an increase of methamphetamine purity levels from 68.9% in the baseline data from 2006–2009, to a median purity of 77% in 2012/2013 (DPMC 2014). Surveys of frequent drug users, suggested that there had been a very slight decline in the availability of methamphetamine, with an average availability of 3.2, compared to 3.3 in 2009 (based on 4 = "very easy" — 1 = "very difficult" to obtain) (DPMC 2014, p.9). The Progress Report also included data on a number of other indicators including seizures, methamphetamine-related convictions, access to treatment, education and other indicators.¹⁸⁹²

The New Zealand Action Plan and the Progress reports provide accountability for progress and provide a potential model for Victoria in dealing with methamphetamine. The Action Plan model is flexible and able to respond to specific issues as they arise. There are specific timeframes for actions, with targets and the ability to delegate actions to responsible agencies across a broad range of activities, avoiding the problem of information 'silos' and fragmentation which often occurs in implementation of government policy. There is also

1892 See http://www.dpmc.govt.nz/sites/all/files/publications/indicators_and_progress_report_april_2014.pdf

the potential for the Action Plan model to be renewed and adapted for the priorities of different state governments and indeed for different drugs. Having key indicators such as price, purity, availability and prevalence in progress reports provide a benchmark of success. A ‘top down approach’ with oversight from the Office of the Prime Minister and Cabinet, and lead Ministers, recognises the importance that New Zealand has placed on countering the problem of methamphetamine in their communities. There is no reason why a similar ‘whole of government’ Action Plan could not also be successful in Victoria, led from the office of the Department of Premier and Cabinet alongside lead Ministers, with regular progress reports on key indicators and overview of actions in the Victorian context.

What type of model for Victoria?

The New Zealand action plan on methamphetamine exemplifies a ‘whole of government’ partnership approach that is led from the ‘top’ yet at the same time employs ‘horizontal structures’. Such an approach is indicative of much modern policy-making. For instance, in developing drug policy and programs, the ANCD has for some time encouraged a move away from ‘government departments that plan, resource and implement services or activities vertically’ (ANCD 2001, p.23). In other words, Departments such as Health, Justice, and Education of themselves ‘are not well integrated to plan and work together to maximise the efficient use of scarce resources’ (ANCD 2001, p.23). It is also recognised that a duplication of economic resources is clearly inefficient, especially when good programs to address substance abuse may be expensive to implement:

[V]ertically structured government departments, and units within departments, contribute to the current system of separate funding sources, policies and programs for related issues. For example, separate policies and strategies exist for mental health, youth suicide, crime prevention and drug prevention. Given the inter-related nature of these issues... it would make sense to incorporate these issues within a broader developmental health policy. While there is a need for some focus on specific issues, the current system of multiple programs encourages duplication and resources being spread too thinly (ANCD 2001, p.23).

‘Horizontal’ approaches on the other hand integrate and coordinate responses over a wide variety of government departments and community agencies. The state government Interdepartmental Committee on Alcohol and Drugs is such an example. As Judith Abbot told the Committee:

The interdepartmental committee on alcohol and drugs that has been established, has the Department of Human Services, several parts of the Department of Justice, including Victoria Police, the Department of Health and a couple of other departments involved. It meets regularly, and issues related to ice and methamphetamine are a standing item on that [their agenda]. It is part of trying to get that big picture and make sure we are all working together.¹⁸⁹³

It is the Committee’s view that a ‘horizontal’ approach to addressing methamphetamine is required. Such an approach, whilst led from the top, would incorporate expert professional and community input. A coordinated response is only possible if clear directions and parameters are set. The Committee therefore supports the development of a new strategy that includes two components: a structure and an action plan that specifically address 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. The Committee envisages that the proposed Ministerial Council on Methamphetamine and its associated structures will realise these aims.

¹⁸⁹³ 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.

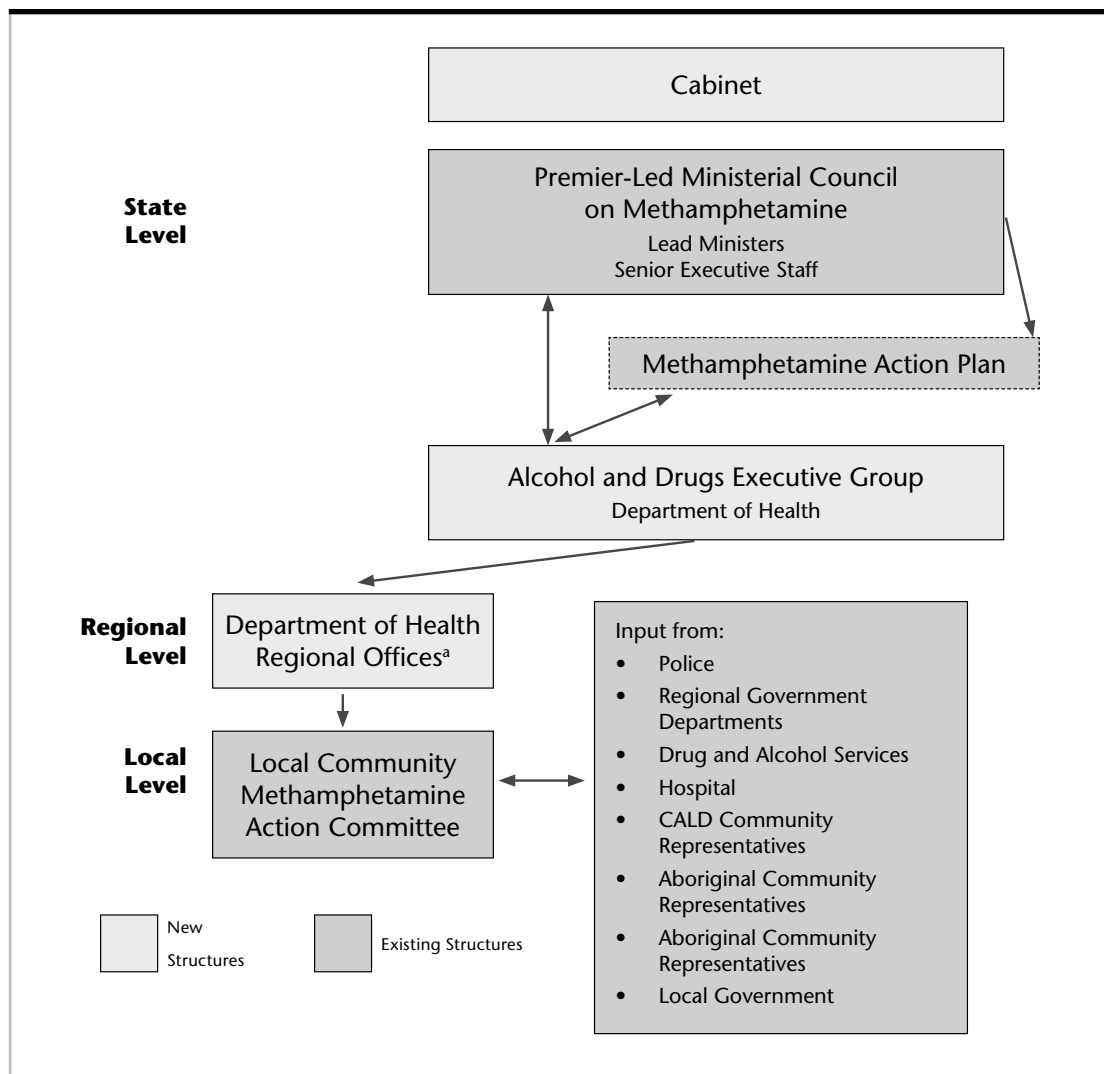
The Victorian Ministerial Council on Methamphetamine

Given the need for a strong strategy in which both the structure and the action plan developed is appropriate to address the use of methamphetamine in Victoria, the Committee is recommending the Victorian Government establish a state committee, known as the Ministerial Council on Methamphetamine (MCM). The Committee believes that the MCM should be led by the Premier of Victoria and be comprised 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.

Although for the foreseeable future the MCM should concentrate on addressing methamphetamine, in particular crystal methamphetamine, the composition of the Committee and other bodies associated with it should be flexible enough to adapt to other drug issues as they arise.

The structure for addressing methamphetamine by the Committee is presented schematically in Figure 31.3.

Figure 31.3: Suggested methamphetamine strategy



Note: ^a The Department of Health (Victoria) is comprised of eight geographical regions. These are:

- Eastern Metropolitan Region

- North and West Metropolitan Region
- Southern Metropolitan Region
- Barwon — South Western Region
- Gippsland Region
- Grampians Region
- Hume Region
- Loddon Mallee Region

Mike Sabin, the New Zealand Member of Parliament, told the Committee that in addressing crystal methamphetamine a Ministerial Council made ‘absolute sense’. Whilst he acknowledged the need for a ‘horizontal’ approach that brought all the relevant ministers and their advisors around the table, he also stressed the need for a direct line of accountability to a person who was ultimately responsible for its oversight:

One thing I do know is that bureaucracies listen to a single stream of accountability far more effectively than they do a multiple one. A ministerial council absolutely make sense if you look at, say, police, justice, education, labour, health and customs, just off the top of my mind. There are about a dozen government departments actually dealing with that, and they all have to be on the same page on this. That is a lot of ministers around the table.

In my view, an ideal model would be a situation where you have one minister who is ultimately accountable for all policy decisions. Whether those decisions be in education, whether they be in workplace employment drug testing and so forth or whether they be in justice or corrections or what have you, ultimately anything that has an implication in terms of drug policy is going to be running through that one point of accountability. In terms of your strategy and report back, it can be done at another layer down in terms of other ministers who might sit around the table, but ultimately the buck has to stop with someone.¹⁸⁹⁴

The need for strong leadership

Whatever the structure employed, Mike Sabin told the Committee that political leadership ‘from the top’ was incredibly important:

We should not underestimate the importance of a very strong political message and a very strong political leadership position in terms of a starting point that says, ‘You know what? This is a very high priority, and it is something we are going to elevate. We just do not accept it is going to go away’.¹⁸⁹⁵

The Committee agrees and has therefore recommended that the MCM be chaired by the Premier of Victoria. It also suggests it comprise the following lead Ministers and their senior executive staff:

- ◆ Minister for Health
- ◆ Minister for Human Services
- ◆ Attorney-General
- ◆ Minister for Justice
- ◆ Minister for Police and Emergency Services
- ◆ Minister for Crime Prevention
- ◆ Minister of Education and Early Childhood Development
- ◆ Minister for Youth Affairs

1894 Mr Mike Sabin MP, Member for Northland, New Zealand Parliament, Public Hearing, Melbourne, 5 June 2014.

1895 Mr Mike Sabin MP, Member for Northland, New Zealand Parliament, Public Hearing, Melbourne, 5 June 2014.

- ◆ Minister for Aboriginal Affairs
- ◆ Minister for Local Government.

Local level interventions: State and municipal approaches

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 municipalities and shires and their agencies 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 State Alcohol and Drugs Executive Group

The existing State Alcohol and Drugs Executive Group, therefore, will continue to play an important role under the new structure. 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. In particular, 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 the availability of such services; and
- ◆ Identifying best practice initiatives and assessing their applicability to local communities.

A flexible structure

Some witnesses to the Inquiry have strongly recommended that any structure to address the current problems with ice be flexible enough to factor in new developments in drug abuse, that is, not be narrowly based on a specific drug. As the Australian Drug Foundation told the Committee:

There is a current spike in methamphetamine-related harms in Victoria, but this replaced a spike in interest relating to synthetic drugs, and may be superseded again by interest in another substance that becomes more available. Many people who use illicit drugs tend to favour the substance that is most readily available or is the easiest to obtain. A real problem is by focusing on dealing with drug problems ‘drug by drug’ we lose the opportunity to respond to drug problems by removing the drivers of drug use.¹⁸⁹⁶

Similarly, in terms of service provision Lisa Briggs from NAACHO told the Committee that approaches (and structures) to address drug and alcohol-related problems had to extend beyond a single focus on one drug or at least be flexible enough to adapt to future developments:

One of the things I think we need to be clear about is that it is ice this year, but it will be something else next year. Somehow we have to stop labelling the problem as the drug of choice at the time; it is actually about how we deal with the problem as a whole condition. As I understand it...there are other drugs now that are superseding even ice — so we have to be flexible to be able to meet the needs of service delivery.¹⁸⁹⁷

Whilst the Committee believes it is important to have a specific methamphetamine structure and strategy, it also considers the model proposed is flexible enough to address new developments in drug use if or when they arise.

A State Methamphetamine Action Plan

Establishing a sound structure to direct the strategy’s policy and initiate programs to address methamphetamine issues is clearly essential. There is also, however, the need to develop a comprehensive and integrated blueprint to address methamphetamine in Victoria similar to the Action Plan implemented in New Zealand. The Committee recommends the MCM develop and implement a State Methamphetamine Action Plan. This Plan should be flexible and adaptable in approach but must address all three pillars of the National Drug Strategy as part of its remit — supply, demand and harm reduction. It should also include a monitoring framework to ensure that the plan is delivering the desired results. The progress reports used in the New Zealand Action Plan discussed earlier in this chapter may serve as a useful model.

Local level community partnerships

1896 Mr John Rogerson, Chief Executive Officer, Australian Drug Foundation, Submission, 28 October 2013.

1897 Ms Lisa Briggs, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (via teleconference), Public Hearing, Canberra, 11 February 2014.

As discussed throughout the Report, the Committee believes it is important at a local level for communities to take responsibility for the issues that affect them such as the impact of ice, especially in rural and regional communities.

In keeping with that view, the Committee recommends that the MCM establish and support, where required, Methamphetamine Community Partnerships across metropolitan and regional Victoria. Such partnerships should comprise of government and non-government representatives with relevant expertise in the area of drug-related issues. It is advisable that representatives be drawn from public health bodies and research institutes, local government and the community.

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 is required that demonstrates an appreciation of the networks and sensitivities that define a local community's culture when devising a response to a community drug problem.

The primary functions of such partnerships should be to develop and implement *local level* methamphetamine action plans. The model established through the Northern Mallee Community Partnership (Project Ice) may serve as one useful example of how these partnerships where the 'community and professionals work as a team' could be developed and sustained.¹⁸⁹⁸

The Committee believes that the Methamphetamine Community Partnerships should act independently and adapt their role to suit unique local circumstances. Nonetheless, there are some aspects of the role which would apply to all localities. These 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; and
- ◆ 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).

Conclusion

The Committee recognises that drug-related issues such as addressing crystal methamphetamine will not be resolved without community awareness and participation, cross-agency partnerships and collaboration between all tiers of government, research bodies, service providers, user groups and peer networks, and especially local communities. A well-informed community can respond to complex issues around methamphetamine in a flexible and resourceful manner. Although crystal methamphetamine may not be an issue of *pandemic* proportions as some have claimed, it is a serious issue which requires a concerted and measured response. It is the belief of the Committee that the establishment of the MCM, the development of a State Methamphetamine Action Plan, and the implementation of community partnerships to address crystal methamphetamine-related issues at a local level, will assist the community in tackling this problem.

¹⁸⁹⁸ Ms Dianne Barker, Acting Senior Manager, ICMS and Residential Care, St Luke's Anglicare, Bendigo, Public Hearing, Bendigo, 25 October 2013.

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).

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*
- *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.*

Recommendation 3

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

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.*

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.

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).*

32. Addressing Methamphetamine: Final Thoughts and Concluding Remarks

Introduction

Addressing methamphetamine in Victoria will be no easy task. The issues surrounding the drug and its impact are complex; with the viewpoints of various stakeholders differing as to the impact methamphetamine is having in Victoria. Nonetheless, throughout the Inquiry grave concerns have been expressed by members of the community, including witnesses to the Inquiry, about the use of methamphetamine and its impact. Particular concerns have been expressed that methamphetamine is having a serious effect on families and the extended community, including in rural and regional areas of Victoria and in Aboriginal communities.

It is quite clear that a 'one size fits all' approach will be inadequate to address this issue. For example, the strategies required for *preventing* the uptake of crystal methamphetamine among young people will be quite different from those needed to address chronic crystal methamphetamine consumption amongst dependent users. Therefore multifaceted interventions will be required. This is particularly the case given that methamphetamine abuse impacts in different ways upon discrete groups within the community.

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 has been stated several times throughout this Report crystal methamphetamine is *not* by any means a benign drug.

Concerns with regard to methamphetamine use in Victoria

This Report has investigated a number of concerns that have been expressed in both the research literature and the evidence given during the course of the Inquiry. These have included:

- ◆ The purity and potency of ice;
- ◆ The diversification of the forms of methamphetamine which may introduce a broader section of the community to the methamphetamine market;¹⁸⁹⁹
- ◆ The impact of methamphetamine on the families and friends of the drug's users;
- ◆ The ready availability of the drug and the ease with which it can be accessed;
- ◆ The uptake of ice smoking particularly by young recreational users of the drug;

¹⁸⁹⁹ See in particular McKetin, Kelly and McLaren 2006, p.145.

- ◆ The use of methamphetamine in conjunction with other drugs (poly-drug use) including newly emerging stimulant and synthetic drugs;
- ◆ The alleged quick transition from occasional use to dependent use;
- ◆ The links between the drug's use and violence and crime;
- ◆ The links between use of the drug and mental illness, particularly 'methamphetamine psychosis';
- ◆ The association of supply networks with organised crime;
- ◆ The lack of effective treatment modalities to address methamphetamine use particularly compared to other drugs such as heroin;
- ◆ A drug service sector that is primarily set up to address alcohol and opiate based drugs;
- ◆ The intergenerational use of methamphetamine;
- ◆ The lack of factual and credible information on methamphetamine and its consequences that neither minimises nor exaggerates the effects of the drug;
- ◆ The use of the internet and social media as a 'marketplace' to access [mis]information with regard to 'ice', including 'recipes' on its manufacture;
- ◆ The lack of workforce training to equip alcohol and other drugs (AOD) workers and other stakeholders to address the drug and its consequences;
- ◆ The *normalisation* of methamphetamine use, particularly amongst young people; and
- ◆ The arguably disproportionate effect of the drug on Aboriginal communities and those in rural and regional Victoria.

These concerns need to be factored into any proposed strategy to address methamphetamine use in Victoria.

Key findings on methamphetamine in Victoria

This section outlines the main findings of the Report based on the evidence given to the Inquiry.

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.

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 2001.¹⁹⁰⁰ What has changed, however, is that there has been a significant shift in use from the powdered form of methamphetamine to ice, 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

¹⁹⁰⁰ See discussion in Chapter 5.

discrepancy, however, between the prevalence data and the supply/seizure data¹⁹⁰¹ 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 pharmaceutical drugs.¹⁹⁰² 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 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

1901 See discussion in Chapter 5.

1902 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.

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 crystal methamphetamine, 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 ice 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 2013.¹⁹⁰³

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.¹⁹⁰⁴

¹⁹⁰³ Again such data is not able to be disaggregated to account for crystal methamphetamine (ice) specifically.

¹⁹⁰⁴ 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.

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.¹⁹⁰⁵ 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 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.

The importance of harm minimisation

Harm minimisation forms the central platform of the Australian Government's *National Drug Strategy* which is also endorsed by Victoria and all other states, and is central to the development of the Recommendations coming from this Inquiry. As stated throughout the Report this means placing equal emphasis on its three arms: demand reduction, supply reduction and harm reduction.

Demand reduction measures

Addressing methamphetamine should not just focus on dealing with problems once they have occurred. One of the key themes running throughout this Report is the importance of *preventing* drug-related harms, a major aspect of demand reduction policies. Prevention policies are essential in restricting the uptake of drug use and/or at least reducing its prevalence.

As the Australian Drug Foundation (ADF) stated in its submission:

Policies in the past have introduced some effective supply reduction measures, however as we can see from history the rise and fall of drug use will continue unless we can take an upstream approach to preventing drug use in the beginning. In practice that means reducing initiation of drug use and the subsequent prevalence and incidence of drug use across the whole population...The ADF

¹⁹⁰⁵ 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.

advocates for the use of preventive strategies to shift the focus “upstream” — preventing people from commencing drug use rather than waiting for their drug use to become a problem that requires reactive “downstream” approaches. An upstream approach means taking action to prevent people from getting into trouble with drug use, thus reducing need for (subsequent) interventions by justice officers, emergency workers or the treatment sector. It is about strengthening and supporting those protective factors (Hawkins, et al., 1992) that can reduce the likelihood that young people engage in AOD use and improve their life chances.¹⁹⁰⁶

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. As discussed in Chapter 31, New Zealand is one jurisdiction where demand reduction approaches based on prevention strategies are paramount in drug policy — a position with which this Committee concurs.

Modern approaches to prevention strategies focus on a number of issues and factors that are not specifically related to 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 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.

Education and information provision are the other essential aspects of a demand reduction approach of tackling problems arising from the use of these drugs. There is clearly a need to raise public awareness of the problems associated with methamphetamine use. However, as with any area of drug use, a balance needs to be sought between providing information that may seem to encourage or condone the uptake or continuance of use and providing too little or too negative messages that may simply be ignored by the drug using populations. Innovative educational strategies that ‘talk’ to young people in particular, and that stress the dangers of recreational use while understanding, if not condoning, its attractions, are a necessary part of any strategy to reduce demand for these drugs. Likewise, comprehensive and age appropriate prevention strategies, particularly in schools, need to be devised based on best practice models from around Australia and overseas. Any such prevention and education strategies should at all times be culturally appropriate to the audience at which they are targeted.

Finally, prevention based approaches aimed at informing the general public about drugs is 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’. Indeed evidence has suggested that mass media campaigns can be counterproductive and can risk *increasing* interest in methamphetamine use among those who currently do not use. Similarly those based on scare tactics need to be regarded with caution.

¹⁹⁰⁶ Mr John Rogerson, Chief Executive Officer, Australian Drug Foundation, Submission, 28 October 2013.

On balance the Committee believes the evidence indicates that campaigns, particularly national campaigns, can 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.

Supply reduction measures

Supply side reduction strategies aim to disrupt the production and supply of illicit drugs, and the control and regulation of licit substances. In the context of drugs such as methamphetamine this arm of harm minimisation aims to curtail the production of methamphetamine in clandestine laboratories and disrupt the importation networks of the drug coming from outside the country. As such, it places importance on border security, investigation of organised crime networks both here and abroad and the prosecution of people involved in the trafficking of illicit substances.

The evidence presented in this Report indicates that the global market for methamphetamine is expanding across most regions, particularly China, Indonesia, Malaysia and Thailand, with methamphetamine replacing 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.

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.

To address supply, control, and law enforcement issues, the Committee has made a number of recommendations with regard to curtailing the supply of methamphetamine. These have included recommendations to address organised crime and its involvement with methamphetamine production and distribution, the control and regulation of precursors and apparatus used to make methamphetamine; and a collaborative national approach to the sharing of drug intelligence amongst law enforcement bodies. It also believes that the dangers associated with methamphetamine and other drug manufacture warrant the creation of a child endangerment offence.

Harm reduction measures

Harm reduction works at many levels. It recognises that both licit and illicit drug use is a fact of life. This is a key aspect of the *National Drug Strategy* and one this Committee endorses. It is a reality that drug use occurs and that appropriate safeguards are necessary to minimise the dangers to both the user and those around him or her. In particular, efforts need to be made to prevent the up-take of high-risk patterns of methamphetamine use, such as smoking and injecting the drug.

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). Harm reduction measures may also be differently targeted at specific groups such as women or young people.

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 demonstrates there is a need for NSP services to continually evolve. In Victoria, NSPs are divided into primary and secondary outlets. At Primary NSP, 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. When it comes to drugs such as methamphetamine the Committee endorses these types of harm reduction strategies already in place and believes the work of agencies such as needle and syringe exchanges and the provision of appropriate equipment to reduce the dangers associated with injecting drug use must be supported. In particular, it believes that secondary NSPs, particularly in rural areas, should be staffed and funded on the same basis as primary NSPs.

Treatment for those whose drug use requires intervention is also an essential aspect of any overall harm reduction strategy. Whilst evidence has been given to the Committee that the majority of people who use methamphetamine do not require intensive treatment, attracting and retaining people who are experiencing methamphetamine-related problems into specialist drug treatment centres, including those who are dependent on methamphetamine, presents a significant challenge for AOD services.

As noted in the Report, there are also a number of barriers that act to prevent people with methamphetamine-related problems seeking or accessing treatment. These include: being unaware of methamphetamine-related problems until the problems became severe; choosing to self-manage withdrawal from methamphetamine in the first instance; and believing that treatment services primarily target users of other drug types such as heroin and alcohol and are therefore unable to meet their specific needs. Waiting to access treatment was also identified as a significant barrier by many witnesses to the Inquiry. Lack of timely responses by services with limited capacity can result in missing a crucial window period in which a person may be ready for treatment, as motivation often quickly wanes. Waiting for treatment may be even more problematic for people who use methamphetamine regularly due to problems with focusing attention, controlling impulses, and the intense cravings to use the drug often experienced in early abstinence. Finally, treatment services may not always be orientated to the needs of people who use methamphetamine. Specialist AOD treatment services, for example, 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.

The Committee has noted the lack of comprehensive and discrete treatment interventions for methamphetamine users. This is particularly the case with regard to pharmacotherapy (substitution therapies). Whilst some medication trials have shown promise, the Report has noted that more research needs to be conducted in this area, particularly on a national basis. Research is also clearly required on why methamphetamine users are a population that seems to find it difficult to access the treatment options that are available.

Developing and implementing policy

The remaining section of this concluding chapter outlines brief summaries of the Committee's positions on how policy can be improved in developing strategies to address methamphetamine supply and use.

Avoiding 'silos'

Any approach to addressing methamphetamine use in Victoria will need to avoid the problem of information 'silos' and fragmentation that can occur in implementation of government policy. This was seen as particularly important in service provision for Aboriginal people. As one Aboriginal AOD worker stated:

I don't think one shoe is going to fit all. You have got to have choices for people. Some people will choose Aboriginal services, and if they choose not to use Aboriginal services, then we need to make sure that the other services are meeting their needs in an appropriate way (ANCD 2011, p.76).¹⁹⁰⁷

Similarly Mark Powell told the Committee how important it was for the drug service system to be integrated with the wider health support network and avoid the traditional 'tried and true' approaches that can too often result in a compartmentalised or siloed approach to service delivery:

We see the current system as likening it a bit to a leaky pipe. There are lots of different agencies, they do tremendous work but they are doing it in pockets. That is one of the problems, where people have to go to another facility to do an inpatient detox, and then go to another facility to do some counselling, ongoing care or go to out of the area to do some residential rehabilitation. We find that has been a problem in not only engaging people into the system but also retaining people in the system. There are high dropout rates of people that are engaged in counselling services. We certainly think we need to do something about the amount of hoops that people have to jump through and review the journey. We are looking for a smoother service model that is more comprehensive and holistic in its nature.¹⁹⁰⁸

A key way of addressing these silos is through the provision of coordinated whole-of-government and partnership approaches discussed below. In particular, it is envisaged that the proposed Ministerial Council on Methamphetamine (MCM) is a structure that should break down the silos that can occur when addressing any problem that has a cross-government impact.

Flexible, and co-ordinated 'whole of government' approaches are important

It is essential that strategies developed and implemented to address methamphetamine use are, wherever possible, part of an integrated policy framework and a 'whole of government

1907 See also Dr David Edey, 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; Ms Claire Ryan, Alcohol & Other Drug Services Team Leader, Ballarat Community Health, Submission, 12 November 2013.

1908 Mr Mark Powell, Dual Diagnosis Senior Clinician, Headspace, Public Hearing, Warrnambool, 3 March 2014.

For discussion on the need for greater linkages between Aboriginal and non-Aboriginal agencies see Mr Hamish Fletcher, Chief Executive Officer, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014; Ms Lisa Briggs, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (via teleconference), Public Hearing, Canberra, 11 February 2014.

approach'. In particular, it is important that clear objectives, indicators and targets to meet them are thoroughly mapped out. The proposed MCM and the establishment of a state Methamphetamine Action Plan will provide such an integrated policy approach.

The Committee emphasises the points made in the previous chapter that given the complexity of crystal methamphetamine use it is a phenomenon that must be addressed from many angles. The Committee believes it is essential that a function of the MCM and the existing Alcohol and other Drug Executive Group should be liaising between government departments and community agencies to co-ordinate service delivery and information provision in this area.

In particular, the Committee believes leadership 'from the top' is crucial in addressing a serious issue such as methamphetamine use and its impact on Victorian communities. This is why the Committee has proposed 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 levels. 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.

A partnership approach

The Committee believes there is a demonstrable need for a co-ordinated and collaborative approach to addressing methamphetamine that utilises partnerships between government, non-government and community agencies and stakeholders. Responsibility for dealing with the harms caused by crystal methamphetamine use must be shared by several players. It cannot simply be the responsibility of government or government agencies. Input must come from individuals, local communities, government at local, state and federal levels, health and education providers and non-government organisations.¹⁹⁰⁹

As Francis Broeckman told the Committee:

For us the key messages are that this is a bigger issue than one response by one agency. It needs to be a collective of organisations coming together from across a number of sectors...¹⁹¹⁰

And Cristofer Beal from Tanderra Aboriginal AOD Service also stressed how innovative good partnership structures could be:

Partnerships between statutory and non-statutory organisations are essential. Nobody can do this alone, and I might say that we do a lot of work with the police, Child Protection, Department of Human Services, working in a collaborative and partnered way, we get really good results. The community are becoming aware of these relationships and are looking at it as a positive as opposed to a negative.¹⁹¹¹

Working in partnership has not always been advocated as a way of addressing drug use issues. However, as Tricia Quibell from Berry Street (Shepparton) told the Committee,

¹⁹⁰⁹ A key example of this partnership approach to address drug-related issues are the increasing linkages being forged between law enforcement and health agencies. A good example of these 'medical — legal' partnerships is the use of the PACER model whereby Victoria Police officers are partnered with mental health practitioners to address the needs of people who may be encountered by police in 'crisis mode'; for example a psychotic episode as a result of taking ice. This provides support to general duties officers who can then be released to other duties once the clinician has taken over. PACER programs, however, exist in only a couple of municipalities in Victoria including Geelong and Moorabbin, although currently the Latrobe Valley Hospital is in discussion with Latrobe Police Service Area to establish a PACER police, ambulance and crisis assessment team. On the need for more PACER models see Superintendent Daryl Clifton, Victoria Police, Public Hearing, Bendigo, 25 October 2013 and Superintendent Malcolm (Jock) Menzel, Divisional Commander, Eastern Region Division 5 - Morwell, Victoria Police, Public Hearing, Traralgon, 28 January 2014.

¹⁹¹⁰ Mr Francis Broeckman, Chief Executive Officer, Brophy Family and Youth Services, Public Hearing, Warrnambool, 3 March 2014.

¹⁹¹¹ Mr Christofer Beal, Coordinator, Tanderra AOD Services, Bairnsdale, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC), Public Hearing, Traralgon, 28 January 2014.

community agencies that address social issues such as drug use are now taking a far more sophisticated attitude towards working in partnership with other community agencies, recognising that this is a hallmark of efficient wraparound service delivery:

What [issues such as ice] have done in a positive way is they have brought together a whole range of agencies that work in different sectors — police, Primary Care Connect, mental health agencies like Berry Street and other youth agencies — with really I would suggest an invigorated intent towards collaboration and working together. Partnerships are now becoming more than just partnerships on paper between agencies. We are becoming far more sophisticated when opportunities arise to say from a collective impact approach, ‘Which are the best agencies to start a service or engage a cohort of young people?’ rather than, ‘We’ll go into competition for it’.

Obviously there is still a level of competition because when you have got large and small agencies there is always that push and pull around sustainability of agencies but agencies and services are now far more willing to come to the table together to discuss these issues.¹⁹¹²

Similarly, Hamish Fletcher from health and welfare agency Primary Care Connect told the Committee:

It is really important for us to also point out in response to methamphetamine and its effects on our community how we as an organisation attempt to build much greater links and partnerships with organisations such as the community legal service so that we have an ability to provide services to the Magistrates Court.¹⁹¹³

Culturally appropriate strategies

It has been a constant theme throughout this Report that whenever strategies and policies are being devised and implemented to address crystal methamphetamine in minority or otherwise distinct communities they must be culturally appropriate to the people of those communities. In addition, wherever possible these strategies must be devised and implemented by the communities for whom they are targeted. At the very least there should be significant input into the formulation of the strategies by the groups for whom they are designed. In the context of this Report the minority communities most often the subject of discussion have been Aboriginal, and the culturally appropriate nature of holistic ‘healing centres’ for Aboriginal people has been acknowledged and endorsed.

The same provisos, however, apply to strategies developed for the benefit of women, ethnic groups and of course young people across the board. It can be stated that ‘youth’ is also a culture with particular needs to be addressed. As such, the input of young people into policy in this area is also highly desirable.

Local initiatives within state and national frameworks

The Committee is of the opinion that the best strategies to address crystal methamphetamine have included those devised and implemented by local communities for local communities and tailored to local conditions and needs. Some excellent partnerships between community groups, individuals, police, schools and parent groups have been in evidence. The Northern Mallee Community Partnership and the Wimmera Drug Action Taskforce are two initiatives that are discussed in the Report. Although in its inception, the Greater Geelong Collective Community Effort on Substance Abuse is also an initiative that shows promise.

As Loxley et al. state:

The emphasis on the local community flows from the requirement to tailor prevention strategies to varying local conditions, the emerging success of community approaches and the attraction of enhancing community in order to address growing social disconnection (2004, p.239).

1912 Ms Tricia Quibell, Deputy Director, Hume Region, Berry Street, Public Hearing, Shepparton, 25 February 2014.

1913 Mr Hamish Fletcher, Chief Executive Officer, Primary Care Connect, Public Hearing, Shepparton, 25 February 2014.

The Committee also believes that local government be part of addressing methamphetamine issues in local communities. In particular, it has the ability to bring key players in local communities together in the search for solutions and the implementation of strategies tailored to meet local needs. As such, local government will play an important role in the partnership structures the Committee is proposing to address methamphetamine.

The need for research and evaluation

There is now general agreement in both the national and international literature with regard to the most effective range of responses available to policymakers to address drug-related harms (Loxley et al. 2004).

However, this is not a reason to be complacent. There is still a great deal of academic inquiry that can and should be done. Until one has an accurate idea of the extent and scope of the problem of methamphetamine use in both local communities and across the state it is difficult to devise and implement appropriate policies in this area.

A particular concern expressed during the course of this Inquiry is that there is a lack of co-ordinated data with regard to methamphetamine usage, and the data that do exist are not readily disseminated at local level. Even when (limited) data are available they are not sufficiently disaggregated into discrete drug categories. In other words, some health and drug datasets are classified into broad categories such as 'ATS' or 'amphetamine' which give very little indication as to what actual drug, or form of drug, has been taken under that broad category. Although the Committee has examined extensive statistical information on the prevalence of illicit drug usage in Australia and in Victoria, some datasets are often not able to be disaggregated to a sufficient degree to enable trends to be identified in the use of methamphetamine, and crystal methamphetamine, with respect to a number of variables of interest.

Medical research into possible treatment interventions of crystal methamphetamine use is also crucial. Currently there are few, if any, effective substitute therapies for methamphetamine. This highlights the need to undertake further development and evaluation of treatment approaches for methamphetamine use.

Moreover, it is essential that all programs dedicated to addressing methamphetamine, be they primary, secondary or tertiary initiatives be fully and professionally evaluated in order to build on successes and learn from mistakes.

Comprehensive training and workforce development on methamphetamine is required

Training of relevant professionals is a key aspect of demand reduction strategies. It is imperative that a person in a position to affect someone who has taken or been adversely affected by drug use is able to effectively respond to that circumstance.

There have been substantial changes in the AOD field in recent decades that have major implications for the development of a responsive, effective, and sustainable AOD workforce. The increase in the use of crystal methamphetamine and the consequences of that for a wide range of AOD, health, law enforcement and other workers is a challenge for workforce development.

These changes include the increased complexity of AOD issues and growth in demand for AOD services, together with issues facing the wider Australian workforce such as advances in technology, an ageing workforce, and a tight labour market. These complex and diverse changes have led to increased recognition that a coordinated strategic approach is needed to develop the capacity of the AOD workforce to effectively respond to current and emerging AOD issues.¹⁹¹⁴

The problematic use of methamphetamine in Victoria is likely to have an increasing impact on frontline health and law enforcement services. Some AOD workers for example have

1914 <http://nceta.flinders.edu.au/files/4912/7200/2031/EN422%20Roche%20%20Pidd%202010.pdf>

told the Committee that they are at loss sometimes as to how to address the needs of crystal methamphetamine users. Appropriate resources need to be directed toward training frontline workers in the identification of methamphetamine-related problems and also toward the development of ways to manage people suffering from conditions such as methamphetamine psychosis.

The evidence presented in the research literature and the views of witnesses to the Inquiry support the need for greater training and workforce development to increase awareness, understanding and an ability to respond to crystal methamphetamine and its effects. The provision of such training and the support of co-workers, supervisors and the work organisation can positively influence worker wellbeing and worker effectiveness.

Accordingly, the Committee has recommended that sufficient and appropriate training be given to a wide range of professionals who may come into contact with people who use methamphetamine including but not restricted to medical, police, emergency services and alcohol and drug workers.

The role of the media

The role of the media with regard to methamphetamine has been the subject of some coverage in this Report. Much of this has been a result of the media itself entering the debate over crystal methamphetamine. This was particularly the case in the articles and reports presented throughout the year.

According to Degenhardt and Hall, policies towards drugs, particularly illicit and newly emerging drugs, can be 'often made in response to media stories and in ignorance of the scale of their use and the problems arising from it' (2012, p.66). Sensationalist and emotive accounts of drugs such as crystal methamphetamine that use terms such as 'epidemics', or even 'pandemics', can contribute to, or even create, 'moral panics' about the extent of the drug use and the consequences for local communities, in effect manufacturing a crisis that may not in reality exist (Groves & Marmo 2009).

The Committee acknowledges that modern society relies heavily on the media for the way in which it views the world. The media also can make a valuable contribution to informing public debate and shaping social policy. The Committee would not wish to curtail that contribution. Nonetheless, in an area as delicate as crystal methamphetamine use the media need to be responsible, sensitive and level-headed in its reporting.

Final remarks

Methamphetamine use is one of a range of problem behaviours and should not be seen in isolation. As with most types of drug use, methamphetamine use needs to be addressed from many angles. One of the most important findings of the Inquiry has been that often crystal methamphetamine is merely part of a much wider 'repertoire' of licit and illicit drug use. Poly-drug use is more the norm than an aberration.

To reiterate the main points in this chapter, methamphetamine 'is far from a benign drug', with a number of methamphetamine users experiencing dependence and other mental and physical health problems related to their methamphetamine use. As McKetin, Kelly and McLaren state in the conclusion to their survey of Sydney ice users:

The more pure forms of methamphetamine, particularly ice, are likely to lead to an increase in dependent methamphetamine use. The trend toward smoking ice is a particular concern, as it has the potential to introduce a younger, less drug involved population of people into a very risky pattern of drug use. The likely net effect of these changes will be to increase the breadth of population who

use methamphetamine, and also the number of dependent methamphetamine users who are likely to place a burden on health services and the criminal justice system.

The most conspicuous problem associated with heavy methamphetamine use is the risk of experiencing psychosis. Psychosis is a very serious and disabling mental health condition, and although episodes of psychosis among methamphetamine users can be brief, the prevalence of psychosis among methamphetamine users was over eleven times higher than that seen in the general population. The behavioural sequelae associated with methamphetamine psychosis often include hostile behaviour, which presents a serious challenge for frontline workers who are required to apprehend and/or deliver these people to health services. Managing methamphetamine psychosis was found to be a very resource-intensive task that was accompanied by serious occupational health and safety risks.

A proportion of methamphetamine users...also become criminally involved to support their drug use, and, in general, methamphetamine users had very high levels of contact with the criminal justice system (2006, p.145).

In Australia, harm minimisation is an officially accepted part of national drug policy. Drug abuse is looked at as a health problem, not simply a drugs issue. The Committee endorses such an approach.

It is quite clear that a 'one size fits all' approach will be inadequate to address this issue. The strategies required to prevent crystal methamphetamine use among party goers will be very different to interventions needed for the chronic adult methamphetamine abuser. Multifaceted strategies will therefore be required. This is particularly the case given that drug use abuse may impact in different ways upon discrete groups in the community. As the Committee has noted, these may include Aboriginal youth, young women, people from culturally and linguistically diverse backgrounds, workers in industrial settings and people with mental health problems.

The Committee has continually indicated throughout this Report that addressing methamphetamine abuse requires a whole of community response. Local solutions, including local partnerships, are required for local communities. Drug misuse requires interventions that range across a number of areas — policy development, training and education, legal regulation, treatment, research, media reporting, employment and recreation, and local community initiatives to name a few. *All* of these factors need to be addressed.

It is clear that focusing on one narrow target of intervention is insufficient. There must, as has been recognised in Australian drugs policy for some years, be a three-pronged attack that incorporates supply reduction, demand reduction and harm reduction. Destroying or intercepting drugs at their point of entry, for example, is necessary but not sufficient in addressing drug misuse. Such interdiction will not of itself result in a lesser demand for drugs. As has been seen in the context of the 'heroin drought', it may simply serve to focus on a different drug of 'choice', such as methamphetamine. Similarly, treating a person who has become methamphetamine dependent is futile if the drugs are still crossing our borders or being 'cooked' in our backyards.

Addressing methamphetamine use also requires collaborative partnerships. Police, teachers, researchers, medical staff, local government and community agencies all have a role to play. The views and advice of user groups and former and current users should, wherever possible or relevant, inform the policies on strategies implemented as a result of the Committee's recommendations.

**Adopted by the Law Reform, Drugs and Crime Prevention Committee
55 St Andrews Place
East Melbourne 3002
27 August 2014**

Appendices

Appendix 1: Briefings

Melbourne 16 September 2013

Name	Position	Organisation
DC Graham Ashton AM	Deputy Commissioner, Specialist Operations	Victoria Police
Stephen Fontana	APM Assistant Commissioner	Victoria Police
Mr Andrew Minack	Director, Corporate Strategy and Operational Improvement Department	Victoria Police
Mr Paul Bird	Chief Executive Officer	Youth Support + Advocacy Service YSAS
Mr Peter Wearne	Director of Services	Youth Support + Advocacy Service YSAS

Appendix 2: List of Submissions

Submission No.	Name of Individual / Organisation	Date received
1	Ms Jacki Burgess	24 September 2013
2	Confidential	30 September 2013
3	Mr Les Twentyman, Outreach Youth Worker, 20th Man Fund Youth Services	2 October 2013
4	Anonymous	2 October 2013
5	Mr Tim Anderson, Psychologist	2 October 2013
6	Mr Greg Denham, Executive Officer, Yarra Drug and Health Forum (YDHF)	3 October 2013
7	Ms Angela Ireland, Project Development, Self Help Addiction Resource Centre Inc. (SHARC)	3 October 2013
8	Ms Elwyn Witney, Head of Counselling, Swan Hill District Health	6 October 2013
9	Ms Heather Pickard, Chief Executive Officer, Self Help Addiction Resource Centre Inc. (SHARC)	13 October 2013
10	Dr Fergus Kerr, Medical Director Medicine and Emergency CSU, Director of Emergency Medicine, Medical Clinical Lead in Patient Flow, Austin Health	14 October 2013
11	Mr Brian Kearney, Chief Executive Officer, Australian Hotels Association	17 October 2013
12	Mr Wayne Muir, Chief Executive Officer, Victorian Aboriginal Legal Service	17 October 2013
13	Mr Jake Repacholi, Team Leader Public Health, City of Casey	18 October 2013
14	Dr Karen Adams, Researcher, Victorian Aboriginal Community Controlled Health Organisation	18 October 2013
15	Mr Hamish Fletcher, Chief Executive Officer, Primary Care Connect	18 October 2013
16	Ms Rose Chesworth, SOBR Co-Events Manager, Addiction Neuroscience Laboratory, Florey Institute of Neuroscience and Mental Health	21 October 2013
17	Dr Martyn Lloyd-Jones, Acting Director, Department of Addiction Medicine, St Vincent's Melbourne	21 October 2013
18	Mrs Sue Medson, Chief Executive Officer, Gippsland Lakes Community Health	21 October 2013
19	Professor Paul Dietze, Deputy Director, Centre for Population Health, Burnet Institute	21 October 2013
20	Ms Sharon O'Reilly, Clinical Services Manager, Bayside Medicare Local	21 October 2013
21	Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria	21 October 2013

Submission No.	Name of Individual / Organisation	Date received
22	Dr Sherene Devanesen, Chief Executive, Peninsula Health	21 October 2013
23	Ms Micaela Cronin, Chief Executive Officer, MacKillop Family Services	21 October 2013
24	Mr John Blewonski, Chief Executive Officer, VincentCare Victoria	21 October 2013
25	Ms Shelley Cross, General Manager, Stepping Up Consortium	21 October 2013
26	Ms Pip Carew, Australian Nursing & Midwifery Federation (ANFM Vic Branch)	21 October 2013
27	Ms Lisa Raywood, Manager Heath and Aged Services, and Ms Kaylene Hodgkin, Health Services Project and Policy Coordinator, Banyule Health	21 October 2013
28	Mr Stuart Gillespie, Executive Manager Citizen Services and Information Management, City of Moonee Valley	21 October 2013
29	Mr Paul Bird, Chief Executive Officer, and Mr Andrew Bruun, Director REAP, Youth Support + Advocacy Service YSAS	21 October 2013
30	Mr Arden Joseph, Director, Community Wellbeing, Maribyrnong City Council	21 October 2013
31	Mr Rob McGlashan, Executive Officer, Northern Mallee Community Partnership	21 October 2013
32	Mr Rudolf Kirby, Chief Executive Officer, Mildura District Aboriginal Services	21 October 2013
33	Ms Vera Boston, Chief Executive Officer, North Yarra Community Health	21 October 2013
34	Ms Jacinta Pollard, Managing Director, Caraniche	21 October 2013
35	Ms Jacqui Watt, Director Client Services, Anglicare Victoria	21 October 2013
36	Mr Tony Parsons, Presiding Magistrate and Mr Peter Lauritsen, Chief Magistrate, Drug Court of Victoria	22 October 2013
37	Ms Melanie Raymond, Youth Projects	22 October 2013
38	Dr Kah-Seong Loke, Consultant Psychiatrist, Eastern Dual Diagnosis Service, Eastern Health Alcohol and Drug Services	22 October 2013
39	Ms Lyn Morgain, Chief Executive Officer, Western Regional Health Centre	22 October 2013
40	Ms Kit-e Kline, Drug & Alcohol Worker, Wathaurong Aboriginal Co-operative	22 October 2013
41	Mr Raymond Blessing, Chief Executive Officer, TaskForce	24 October 2013

Submission No.	Name of Individual / Organisation	Date received
42	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	24 October 2013
43	Mr Maurie Heaney, General Manager Community Services, Melton City Council	24 October 2013
44	Counsellor Ian Maddison, Mayor, Shire of Campaspe	24 October 2013
45	Mr Bernie Geary OAM, Principal Commissioner, and Mr Andrew Jackomos PSM, Commissioner for Aboriginal Children and Young People, Commission for Children and Young People	25 October 2013
46	Mr John Rogerson, Chief Executive Officer, Australian Drug Foundation	28 October 2013
47	Mr Clive Alsop, Regional Co-Ordinating Magistrate Gippsland, Magistrates' Court of Victoria	28 October 2013
48	Mr John Ryan, Chief Executive Officer, Anex	29 October 2013
49	Ms Rachael Edginton, Director of Police & Public Affairs, Australian Medical Association (Victoria) Limited (AMA Victoria)	31 October 2013
50	Ms Karen Gurney, Managing Lawyer, Goulburn Valley Community Legal Centre, and Mr Peter Noble, Coordinator, Loddon Campaspe Community Legal Centre	31 October 2013
51	Rev Ric Holland, Chief Executive Officer, Melbourne City Mission	1 November 2013
52	Mr Graham Ashton AM, Acting Chief Commissioner, Victoria Police	7 November 2013
53	Mr Sam Biondo, Chief Executive Officer, Victorian Alcohol & Drug Association VAADA	11 November 2013
54	Ms Claire Ryan, Alcohol & Other Drug Services Team Leader, Ballarat Community Health	12 November 2013
55	Confidential	12 November 2013
56	Mr Stuart Fenton, Drug & Alcohol Counsellor and ex Ice user	18 November 2013
57	Ms Stella Stuthridge, Magistrate, Shepparton Magistrates' Court, Magistrates' Court of Victoria	19 November 2013
58	Mr Allan Crosthwaite, Director and Mr Stan Goma, Manager — Professional Services, The Pharmacy Guild of Australia — Victoria	10 December 2013
59	Mr David Kalisch, Director, The Australian Institute of Health and Welfare	23 January 2014
60	Superintendent Paul O'Halloran, Superintendent and Divisional Commander Eastern Region Division 4, Victorian Police	24 February 2014

Submission No.	Name of Individual / Organisation	Date received
61	Ms Teresa Lynch, Manager, The Royal Women's Hospital	11 March 2014
62	Ms Philippa Northam, Supporting Young Parents Case Manager, Junction Support Services	10 April 2014
63	Ms Judith Lind, Executive Director, Australian Crime Commission	10 April 2014
64	Dr Mark Lauchs, Senior Lecturer, Faculty of Law, School of Justice, Queensland University of Technology	10 April 2014
65A	Mr Laurence Alvis, Chief Executive Officer, UnitingCare ReGen	11 April 2014
65B	Mr Laurence Alvis, Chief Executive Officer, UnitingCare ReGen	11 April 2014
66	Mr Roman Quaedvlieg, Deputy Chief Executive Officer, Border Enforcement, Australian Customs and Border Protection Service	11 April 2014
67	Mr Doug Smith APM, Chief Executive Officer, CrimTrac	16 April 2014
68	Mr Geoff Neideck, Head, Housing Homelessness and Drugs Group, Australian Institute of Health and Welfare	22 April 2014
69	Ms Jo Baxter, Chief Executive Officer, Drug Free Australia	30 April 2014
70	Dr Nyree Hutchins, Clinical Psychologist and Chair, Wimmera Drug Action Taskforce	12 June 2014
71	Ms Erica Lambert, Founding Partner, Rangatira Management Consultancy	15 June 2014
72	Daryl Clifton, Superintendent of Victoria Police, Geelong on behalf of Greater Geelong Collective Community Effort on Substance Abuse Limited (GGCCESA)	30 June 2014
73	Confidential	10 July 2014
74	Ms Jelena Popovic, Deputy Chief Magistrate, Magistrates' Court of Victoria, Submission, 30 July 2014.	30 July 2014
75	Mr John Ryan, Chief Executive Officer, Penington Institute	3 August 2014
76	Ms Carmel Guerra, Chief Executive Officer, Centre for Multicultural Youth (CMY)	4 August 2014
77	Ms Angela Clapperton, Manager — Data Systems, Data Requests and Reports, Victorian Injury Surveillance Unit (VISU) and Research Fellow, Monash Injury Research Institute (MIRI)	6 August 2014
78	Ms Lyndal Bugeja, Manager, Coroners Prevention Unit, Coroners Court of Victoria	7 August 2014

Appendix 3: Witnesses Appearing at Public Hearings in Melbourne and via Teleconference

Public Hearings — Melbourne

Melbourne 30 September 2013

Name	Position	Organisation
Mr John Ryan	Chief Executive Officer	Anex
Mr Laurence Alvis	Chief Executive Officer	UnitingCare ReGen
Ms Donna Ribton-Turner	Director, Clinical Services	UnitingCare ReGen
Dr Belinda Lloyd	Strategic Lead, Population Health Research	Turning Point Alcohol and Drug Centre
Dr Matthew Frei	Head of Clinical Services	Turning Point Alcohol and Drug Centre
Dr Amy Pennay	Senior Research Fellow	Turning Point Alcohol and Drug Centre
Associate Professor Karen Smith	Manager, Research and Evaluation	Ambulance Victoria
Associate Professor Tony Walker	General Manager, Regional Services	Ambulance Victoria
Mr Allan Eade	Intensive Care Paramedic	Ambulance Victoria
Professor Paul Dietze	Head, Alcohol and Other Drug Research, Centre for Research Excellence in Injecting Drug Use	Burnet Institute
Ms Jenny Kelsall	Executive Officer	Harm Reduction Victoria

Melbourne 14 October 2013

Name	Position	Organisation
Mr Sam Biondo	Chief Executive Officer	Victorian Alcohol and Drug Association
Mr Simon Ruth	Director of Services	Victorian AIDS Council
Mr John Rogerson	Chief Executive Officer	Australian Drug Foundation
Mr Geoff Munro	National Policy Manager	Australian Drug Foundation
Ms Heather Pickard	Chief Executive Officer	Self Help Addiction Resource Centre

Melbourne 9 December 2013

Name	Position	Organisation
Mr Tony Parsons	Magistrate	Drug Court of Victoria
Ms Elisa Buggy	DCV Program Manager	Drug Court of Victoria (currently on secondment to the Children's Court)
Ms Kristy Rowe	Acting DCV Program Manager	Drug Court of Victoria
Ms Samantha Hunter	Chief Executive Officer	Crime Stoppers Victoria
Mr Les Twentyman	OAM	20th Man Fund

Public Hearings — Melbourne

Melbourne 3 February 2014

Name	Position	Organisation
Ms Theresa Lynch	Manager	Royal Women's Hospital Alcohol and Drug Service
Dr Yvonne Bonomo	Addiction Specialist	Royal Women's Hospital Alcohol and Drug Service
Dr Ellen Bowman	Paediatrician	Royal Women's Hospital Alcohol and Drug Service
Dr Roger Volk	Forensic and Other Drugs Counsellor, Monash Health	South East Alcohol and Drug Service
Dr David Jacka	Addiction Medicine Specialist, Monash Health	South East Alcohol and Drug Service
Ms Eden Foster	Drug and Alcohol Counsellor, Monash Health	South East Alcohol and Drug Service
Professor Richard Midford	Professor of Health in Education, School of Education	Charles Darwin University
Mr Jason King	Chief Executive Officer	Victorian Aboriginal Health Service
Dr Niall Quiry	Senior Medical Officer	Victorian Aboriginal Health Service
Mr Angelo Pricolo	Chair, Strategic Harm Minimisation in Pharmacy (SHarP) Advisory Group	Pharmacy Guild of Australia — Victoria
Mr Stan Goma	Manager, Professional Services	Pharmacy Guild of Australia — Victoria
The Hon. Monica Gould	Director	Youth Projects
Ms Melanie Raymond	Chairperson	Youth Projects
Ms Kate Hunt	Collaborations and Development Officer	Youth Projects
Mr Colin Hudson	Clinical Services Manager	Youth Projects
Mr Richard Michell	Manager, Youth Outreach	Youth Projects
Mr David Giles	General Manager, Family and Community Services	Anglicare Victoria
Mr Paul Dillon	Director and Founder	Drug and Alcohol Research and Training Australia

Public Hearings — Melbourne

Melbourne 17 February 2014

Name	Position	Organisation
Ms Jan Rowe	Chief Executive Officer	Mirabel Foundation
Ms Elizabeth McCrea	Advocacy and Family Support	Mirabel Foundation
Ms Ruth Chattey	Family Support	Mirabel Foundation
Ms Jan Shuard	Commissioner	Corrections Victoria
Mr Luke Tucker	Acting General Manager, Community Correctional Services, Gippsland Region	Corrections Victoria
Mr John Insana	General Manager, Community Correctional Services, South-East Metropolitan Region	Corrections Victoria
Ms Michelle Wood	Assistant Director, Community Correctional Services	Corrections Victoria
Mr Wayne Muir	Chief Executive Officer	Victorian Aboriginal Legal Service
Ms Annette Vickery	Deputy Chief Executive Officer	Victorian Aboriginal Legal Service

Melbourne 24 March 2014

Name	Position	Organisation
Mr John Thompson	General Manager	Mitchell & Partners
Ms Roslyn McCarthy	General Manager Last Mile Network	Australia Post
Mr Scott Staunton	General Manager Group Security	Australia Post
Ms Martha Tsamis	Licensee	Chasers Nightclub and Inflation Nightclub
Mr Mike Richardson	Clinical Services Manager	Ngwala Willumbong Co-operative Ltd
Ms Miranda Madgick	Alcohol and Drug Women's Worker	Ngwala Willumbong Co-operative Ltd
Mr Gilbert Freeman	Counsellor	Ngwala Willumbong Co-operative Ltd
Dr Nick Thomson	Research Fellow School of Population and Global Health and Field Director, Whole of Victorian Government Hotspots Project	University of Melbourne
Ms Jan Berriman	Chief Executive Officer	YMCA Victoria
Mr Mark Watt	Chief Executive Officer	White Lion
Mr Anthony Grimm	Co-ordinator The Chatterbox Street Outreach Program	White Lion

Public Hearings — Melbourne

Melbourne 31 March 2014

Name	Position	Organisation
Ms Judith Abbott	Acting Director, Community Programs and Prevention Branch, Mental Health, Drugs and Regions Division	Department of Health
Mr Martin Turnbull	Manager, Service System Development and Reform, Community Programs and Prevention Branch, Mental Health, Drugs and Regions Division	Department of Health
Ms Cath Williams	Manager, Service Performance, Mental Health, Drugs and Regions Division	Department of Health
Prof. Melanie Wakefield	Centre for Behavioural Research in Cancer	Cancer Council Victoria

Melbourne 5 May 2014

Name	Position	Organisation
Dr Caitlin Hughes	Research Fellow, Drug Policy Modelling Program	National Drug and Alcohol Research Centre, University of New South Wales

Melbourne 5 June 2014

Name	Position	Organisation
Mr Mike Sabin MP	Member for Northland	New Zealand Parliament

Melbourne 16 June 2014

Name	Position	Organisation
Mr Dion Appel	Chief Executive Officer	Lifelounge Agency

Melbourne 4 July 2014

Name	Position	Organisation
Mr John Ryan	Chief Executive Officer	Penington Institute

Appendix 4: Witnesses Appearing at Public Hearings in Regional Victoria

Public Hearings — Bendigo

Bendigo 25 October 2013

Name	Position	Organisation
Superintendent Daryl Clifton		Victoria Police
Ms Cheryl Sobczyk	General Manager, Primary Health and Integrated Care	Bendigo Community Health Services
Mr Daniel Eltringham	Drug and Alcohol Care Coordinator, Emergency Department	Bendigo Health
Ms Carol-Anne Lever	Nurse Unit Manager, Emergency Department	Bendigo Health
Mr Brian Jacobs	Nurse Manager, ECAT/Triage/PARC, Psychiatric Services	Bendigo Health
Mr Wayne Daly	Nurse Unit Manager, Alexander Bayne Centre, Psychiatric Services	Bendigo Health
Ms Pauline Gordon	Director, Community Wellbeing	Greater Bendigo City Council
Ms Suzie Mansell	Manager, Community Partnerships	Greater Bendigo City Council
Mr Kerry Strachan	Group Manager	Ambulance Victoria
Mr Richard Marchingo	Ambulance Paramedic	Ambulance Victoria
Ms Dianne Barker	Acting Senior Manager, ICMS and Residential Care	St Luke's Anglicare, Bendigo
Ms Kerry Donaldson	Manager, Community Programs	Youth Support and Advocacy Service, Bendigo
Mr Peter Noble	Coordinator and Lawyer	Loddon Campaspe Community Legal Centre

Public Hearings — Geelong

Geelong 28 October 2013

Name	Position	Organisation
Mr Terry Marshall	MICA Paramedic and Group Manager	Ambulance Victoria, Barwon District
Ms Shea Grant	Advanced Life Support Paramedic and Team Manager	Ambulance Victoria, Barwon District
Dr David Eddey	Director of Emergency Medicine	Barwon Health
Dr Nic Reid	Emergency Staff Specialist, Emergency Department	Barwon Health
Dr Cath Peake	Clinical Coordinator, Drugs and Alcohol Services	Barwon Health
Ms Kit-e Kline	Drug and Alcohol Worker	Wathaurong Aboriginal Co-Operative

Mr Norm Stanley	Youth Justice Worker	Wathaurong Aboriginal Co-Operative
Superintendent Paul Pottage	Division Commander, Division 1 (Geelong) Western Region	Victoria Police
Mr Daniel Moyle	General Manager of Client Services	Barwon Youth
Mr Terry Robinson	Co-ordinator	Barwon Youth
Ms Melinda Grady	Youth Worker	Barwon Youth
Ms Antonia Halloran-Lavelle	Chief Executive Officer	Zena Women's Services
Ms Claire Yeatman	Support Service Manager	Zena Women's Services
Mr Darren Holyroyd	Chair	Geelong Nightlife Association
Mr Tim Bongiorno	Nightclub Proprietor	Geelong Nightlife Association
Mr Mario Gregorio	Nightclub Proprietor	Geelong Nightlife Association
Ms Belinda McNair	Service Development Officer, Southern Territory Alcohol and Other Drugs Unit	Salvation Army, Kardinia

Public Hearings — Ballarat

Ballarat 18 November 2013

Name	Position	Organisation
Superintendent Andrew Allen	Divisional Commander, Ballarat Division, Western Region	Victoria Police
Dr Andrew Crellin	Director of Emergency	Ballarat Health Services
Associate Professor Peter Miller	Principal Research Fellow, School of Psychology	Deakin University
Ms Karen Heap	Chief Executive Officer	Ballarat and District Aboriginal Co-operative
Ms Jo Warren	Health Unit Manager	Ballarat and District Aboriginal Co-operative
Mr Peter Treloar	Emotional Wellbeing Nurse	Ballarat and District Aboriginal Co-operative
Mr Grant Hocking	Clinical Support Manager, Grampians Region	Ambulance Victoria
Mr Sam Caldwell	Advanced Life Support Paramedic, Ballarat Branch	Ambulance Victoria
Mr Stuart Fenton	Drug and Alcohol Counsellor	
Ms Robyn Reeves	Chief Executive Officer	Ballarat Community Health Centre
Ms Claire Ryan	Alcohol and Other Drugs Services Team Leader	Ballarat Community Health Centre
Mr Peter Cranage	Alcohol and Other Drug Program Manager	UnitingCare Ballarat

Public Hearings — Mildura

Mildura 5 December 2013

Name	Position	Organisation
Superintendent Paul Naylor	Divisional Superintendent, Division 6, Western Region	Victoria Police
Dr Dan Turner	Medical Director of Emergency	Mildura Base Hospital
Ms Leanne Dellar	Nurse Unit Manager, Emergency	Mildura Base Hospital
Mr David Kirby	Director, Mental Health Services	Mildura Base Hospital
Ms Jill Gleeson	Dual Diagnosis Consultant	Mildura Base Hospital
Mr Rob McGlashan	Executive Officer	Northern Mallee Community Partnership (Project Ice Mildura)
Ms Michelle Withers	Integrated Services Coordinator	Northern Mallee Community Partnership (Project Ice Mildura)
Mr Rudolph Kirby	Chief Executive Officer	Mallee District Aboriginal Services
Ms Nahtanha Davey	General Manager, Health/Family/Community	Mallee District Aboriginal Services
Mr Imran Mansoor	Manager, Primary Health Care	Mallee District Aboriginal Services
Mr Brett McKinnon	Manager Mental Health Services	Tristar Medical Group
Mr Steven Fumberger	Group Manager, Sunraysia Region	Ambulance Victoria
Mr Peter Guest	Mobile Intensive Care Ambulance Paramedic	Ambulance Victoria
Mr Dale Richards	Clinical Support Officer, Loddon Mallee Region	Ambulance Victoria
Ms Mary Bassi	Manager, Primary Health	Sunraysia Community Health Services
Ms Melissa Lonsdale	Team Leader, Drug Treatment Services	Sunraysia Community Health Services
Ms Fiona Harley	Deputy Executive Director	Mallee Family Care
Ms Cath Murphy	Director of Disability and Mental Health Services	Mallee Family Care
Ms Darlene Sanders	Indigenous Engagement Officer	Mallee Family Care
Mr Martin Hawson	General Manager, Community and Culture	Mildura Rural City Council
Mr Gary Pearse	Vice-President	Sunraysia Mallee Ethnic Communities Council (SMECC)

Public Hearings — Traralgon

Traralgon 28 January 2014

Name	Position	Organisation
Superintendent Malcolm (Jock) Menzel	Divisional Commander, Eastern Region Division 5 — Morwell	Victoria Police
Detective Senior Sergeant Chris Pegg	Divisional Crime Adviser, Division 6, Eastern Region	Victoria Police
Ms Amanda Cameron	Acting Chief Executive	Latrobe Regional Hospital
Dr Simon Fraser	Chief Medical Officer	Latrobe Regional Hospital
Ms Cayte Hoppner	Director of Mental Health	Latrobe Regional Hospital
Dr Tony Chan	Emergency Department Director	Latrobe Regional Hospital
Mr Clive Alsop	Regional Coordinating Magistrate	Latrobe Valley Magistrates Court
Mr Jon Borkowski	Coordinator Alcohol and Other Drug (AOD) Services Morwell	Gippsland and East Gippsland Aboriginal Cooperative (GEGAC)
Mr Christofer Beal	Coordinator, Tanderra AOD Services, Bairnsdale	Gippsland and East Gippsland Aboriginal Cooperative (GEGAC)
Mr Mark Allen	Team Manager, Morwell Mobile Intensive Care Ambulance (MICA) Unit and Single Response Unit (SRU)	Ambulance Victoria
Mr Dave Rice	Manager, Sale Advanced Life Support Unit and Bairnsdale and Sale Single Responder MICA Units	Ambulance Victoria
Ms Kerstin Bichel	Manager AOD Service	Gippsland Lakes Community Health Centre
Mr Eion May	Alcohol and Drug Worker	Gippsland Lakes Community Health Centre
Mr James Dale	Acquired Brain Injury and Alcohol and Other Drug Clinical Consultant	Latrobe Community Health Services
Ms Debbie Stoneman	Alcohol and Other Drug Nurse Clinician	Latrobe Community Health Services
Ms Christine May	Manager Latrobe Valley	Youth Support + Advocacy Service (YSAS)
Mr Peter Wearne	Director of Services	Youth Support + Advocacy Service (YSAS)

Public Hearings — Wodonga

Wodonga 24 February 2014

Name	Position	Organisation
Superintendent Paul O'Halloran	Superintendent and Divisional Commander Eastern Region Division 4	Victoria Police
Detective Sergeant Damian Loiterton	Wangaratta Divisional Tasking Unit	Victoria Police
Detective Leading Senior Constable Jason Bray	Wangaratta Criminal Investigation Unit	Victoria Police
Ms Philippa Northam	Supporting Young Parents Case Manager	Junction Support Services
Ms Katharine Hodgens	Youth Services Manager	Junction Support Services
Mr Zach Mason	Youth Worker	Junction Support Services
Mr David Reid		
Mr Alan Fisher	Clinical Leader, Drug and Alcohol Community Treatment Services	Albury Wodonga Health
Mr Donald Currie	Team Manager Alcohol & Other Drugs	Gateway Community Health
Mr Bill Wilson	Youth Outreach, Alcohol, Tobacco and Other Drugs Team	Gateway Community Health
Mr Mike Fuery	Paramedic	Ambulance Victoria
Mr Matt Burke OAM	Chief Executive Officer	Mungabareena Aboriginal Corporation
Ms Sharyn Jenkins	Aboriginal Family Violence Worker	Mungabareena Aboriginal Corporation
Ms Di Griffin	Aboriginal Drugs and Alcohol Counsellor	Albury-Wodonga Aboriginal Health Service
Mr Tim Church	Aboriginal Drugs and Alcohol Worker	Albury-Wodonga Aboriginal Health Service
Ms Kerryn Johnston		
Mr Stephen Johnston		

Public Hearings — Shepparton

Shepparton 25 February 2014

Name	Position	Organisation
Superintendent Michael Sayer	Eastern Region	Victoria Police
Detective Acting Inspector Paul Maher	Goulburn Valley Division 3	Victoria Police
Mr Cameron McGregor	Senior Withdrawal Nurse	Goulburn Valley Health
Mr Tyler Tricarico	Alcohol and Other Drug Technician	Goulburn Valley Health
Mr Charles Oguntade	Clinical Manager, Adult MHS	Goulburn Valley Health
Mr Hamish Fletcher	Chief Executive Officer	Primary Care Connect
Ms Lynne Macdougall	Manager, Alcohol, Tobacco and Other Drugs	Primary Care Connect
Dr Paul MacCartney	Medical Practitioner	Primary Care Connect
Mr Herb Goonen	Drug and Alcohol Worker	Rumbalara Aboriginal Cooperative

Mr Daryl Sloan	Indigenous Advocate	Regional Information and Advocacy Council
Mr Michael Whelan	MICA Team Manager	Ambulance Victoria
Ms Melanie Vidler	Youth and Family Support	The Bridge Youth Service
Ms Alexandra Bruinier	Youth Connections	The Bridge Youth Service
Ms Kaz Gurney	Managing Lawyer	Goulburn Valley Community Legal Centre
Ms Tricia Quibell	Deputy Director, Hume Region	Berry Street
Ms Marg Bell	Senior Manager, Adolescent Specialist Support Programs, Shepparton	Berry Street

Public Hearings — Warrnambool

Warrnambool 3 March 2014

Name	Position	Organisation
Superintendent Don Downes	Western Region, Division 2	Victoria Police
Dr Anshuman Pant	Director of Psychiatry	South West Healthcare
Dr Rodger Brough	Drug and Alcohol Physician	South West Healthcare
Dr Tim Baker	Emergency Department Physician	South West Healthcare
Mr Mark Powell	Dual Diagnosis Senior Clinician	Headspace
Mr Allan Miller	Aboriginal Programs Manager	South West Healthcare
Mr Joey Chatfield	Aboriginal Community Liaison Officer	Victoria Police
Ms Tania Dalton	Indigenous Family Violence Regional Coordinator	Department of Human Services
Mr Peter Mellas	Magistrate	Warrnambool Magistrates' Court
Mr Gary Castledine	Group Manager South West	Ambulance Victoria
Mr Phil Benbow	Acting Team Manager, Warrnambool	Ambulance Victoria
Mr Geoff Soma	Chief Executive Officer	The Western Region Alcohol and Drug Centre (WRAD)
Ms Cathy Bligh	Youth Worker and AOD Counsellor	The Western Region Alcohol and Drug Centre (WRAD)
Ms Bev McIlroy	Manager	Glenelg Southern Grampians Drug Treatment Service (QUAMBY)
Mr Francis Broeckman	Chief Executive Officer	Brophy Family and Youth Services
Mr Peter Flanagan	Team Leader, Youth Homelessness Team	Brophy Family and Youth Services

Appendix 5: Witnesses Appearing at Interstate Public Hearings

Public Hearings — Canberra

Canberra 10 February 2014

Name	Position	Organisation
Ms Judith Lind	Executive Director	Australian Crime Commission
Mr Shane Neilson	Head of Determination	Australian Crime Commission
Dr Mark Lauchs	Senior Lecturer, Faculty of Law, School of Justice	Queensland University of Technology (via video conference)
Professor Roderic Broadhurst	Foundation Professor, Criminology, College of Arts and Social Sciences	Australian National University
Mr Geoff Neideck	Senior Manager, Housing, Homelessness and Drugs Group	Australian Institute of Health and Welfare
Ms Amber Jefferson	Head, Tobacco, Alcohol and Other Drugs Unit	Australian Institute of Health and Welfare
Assistant Commissioner Ramzi Jabbour	National Manager, Serious and Organised Crime	Australian Federal Police
Mr Peter Whowell	Manager, Government Relations	Australian Federal Police

Canberra 11 February 2014

Name	Position	Organisation
Dr Rebecca McKetin	Fellow, College of Medicine, Biology and Environment	Australian National University
Ms Lisa Briggs	Chief Executive Officer	National Aboriginal Community Controlled Health Organisation (via teleconference)
Mr Gino Vumbaca	Executive Director	Australian National Council on Drugs
Dr Terry Goldsworthy	Assistant Professor, Faculty of Society and Design	Bond University (via teleconference)
Mr Doug Smith APM	CEO	CrimTrac
Professor Steve Allsop	Professor and Director	National Drug Research Institute, Curtin University (via teleconference)
Professor Andrew Goldsmith	Strategic Professor of Criminology	Flinders University (via video conference)
Dr Andrew Groves	Research Officer, Flinders Law School	Flinders University (via video conference)

Canberra 12 February 2014

Name	Position	Organisation
Mr Jason Ferris	Senior Research Fellow, Institute for Social Science Research	University of Queensland (via video conference)

Appendix 6: Overseas Witnesses Consulted With

Meetings — Canberra

Canberra 10 February 2014

Name	Position	Organisation
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) (via video conference)
Ms Anna Sergi	Researcher	University of Essex (via video conference)

Canberra 11 February 2014

Name	Position	Organisation
Mr William Tupman	University Fellow, Terrorism and Organised Crime Consultant	University of Exeter (via video conference)

Canberra 12 February 2014

Name	Position	Organisation
Professor Richard Hobbs	Mannheim Centre for Criminology	London School of Economics and Political Science (via video conference)
Mr Jeremy Douglas	Regional Representative for South-East Asia and the Pacific	United Nations Office on Drugs and Crime
Ms Margaret Akullo	Project Coordinator, Project Childhood	United Nations Office on Drugs and Crime
Mr Sebastian Baumeister	Project Coordinator, Smuggling of Migrants	United Nations Office on Drugs and Crime

Appendix 7: Site visits in the Melbourne area

Melbourne 19 October 2013 Site Visit of Odyssey House Residential and YSAS Birribi Residential Unit

Name	Position	Organisation
Mr Stefan Gruenert	Chief Executive Officer	Odyssey House
Mr Paul Bird	Chief Executive Officer	YSAS Birribi

Melbourne 9 December 2013 Drug Court of Victoria

Name	Position	Organisation
Mr Tony Parsons	Magistrate	Drug Court of Victoria
Ms Elisa Buggy	DCV Program Manager (currently on secondment to the Children's Court)	Drug Court of Victoria
Ms Kristy Rowe	Acting DCV Program Manager	Drug Court of Victoria
Ms Amy Lalor	Manager, DCV Case Management Team	Corrections
Ms Helen Betterley	DCV Clinical Advisor	Drug Court of Victoria
Mr Tim Cunningham	DCV Homelessness Assistance Program	WAYSS
Ms Yvonne Crawford	DCV team member	Victoria Police
Ms Sharon Keith	DCV team member	Victoria Legal Aid

Melbourne 31 March 2014 Site Visit of Oznam Community Centre and Oznam House

Name	Position	Organisation
Mr John Blewonski	Chief Executive Officer	Oznam Community Centre
Mr Paul Zanatta	Executive Manager Social Policy & Research	Oznam Community Centre
Ms Rebecca Seunenber	Manager	Oznam Community Centre
Mr Danny Tilkeridis	Manager	Oznam House

Appendix 8: Supplementary Tables - Prevalence

Table 5a: Form of methamphetamine used, recent^(a) users aged 14 years or older in Australia, 2007 to 2013 (per cent)

Form of drug	2007	2010	2013
Forms ever used			
Powder	n.a.	83.1	64.9#
Liquid	n.a.	15.8	14.1
Crystal, ice	n.a.	50.8	71.5#
Base/Paste/Pure	n.a.	37.8	28.3#
Tablet	n.a.	32.9	26.5
Prescription amphetamines	n.a.	15.1	14.1
Capsules	n.a.		17.0
Other	n.a.	*1.9	*2.5
Main form used			
Powder	51.2	50.6	28.5#
Liquid	1.3	**0.9	**0.5
Crystal, ice	26.7	21.7	50.4#
Base/Paste/Pure	12.4	11.8	*7.6
Tablet	5.1	8.2	*8.0
Prescription amphetamines	3.2	6.8	*3.0#
Capsules	n.a.	n.a.	*2.0

* 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.

(a) Used in the previous 12 months.

Note: Base is recent users of meth/amphetamines.

Source: AIHW (2014).

Table 5b: Frequency of meth/amphetamine use, recent ^(a) users aged 14 years or older, 2007 to 2013 (per cent)

Frequency of use	2007	2010	2013
All recent meth/amphetamine users			
At least once a week or more	13.0	9.3	15.5#
About once a month	23.3	15.6	16.6
Every few months	27.9	26.3	19.8
Once or twice a year	35.6	48.8	48.0
Main form of meth/amphetamine used - Ice			
At least once a week or more	23.1	*12.4	25.3#
About once a month	24.3	*17.5	20.2
Every few months	20.7	*23.1	14.3
Once or twice a year	31.8	47.0	40.2
Main form of meth/amphetamine used - Powder			
At least once a week or more	7.7	*2.9	**2.2
About once a month	22.9	13.8	16.6
Every few months	31.6	29.0	20.0
Once or twice a year	37.6	54.4	61.2

Notes:

* 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.

(a) Used in the previous 12 months.

Note: Base is recent users of meth/amphetamine.

Source: AIHW (2014).

Table 5c: Summary of drug use patterns, people aged 14 years or older, Australia, 2013

Drug	Drug of most serious concern ^(a)	Drug that causes most deaths	Ever used	Monthly or more	Used with alcohol ^(b)
	%	%	%	%	%
Alcohol	42.5	33.6	86.3	6.5	n.a.
Meth/amphetamine ^(c)	16.1	8.7	7.0	32.1	66.5
Tobacco	14.5	32.0	39.8	12.8	n.a.
Heroin	10.7	14.1	1.2	n.p.	n.a.
Ecstasy ^(c)	5.2	4.6	10.9	13.8	66.6
Marijuana/cannabis	3.8	1.0	34.8	45.4	81.9
Cocaine	3.6	3.7	8.1	10.8	80.9
Pharmaceuticals ^(c)	2.2 ^(d)	1.4 ^(d)	11.4#	32.3	32.3 ^(d)
Hallucinogens	n.a.	n.a.	9.4	8.4	n.a.
Inhalants	n.a.	n.a.	3.8	29.5	n.a.

(a) For alcohol, respondents were asked about 'excessive drinking of alcohol'. For inhalants, respondents were asked about 'sniffing glue, petrol, solvents, rush.'

(b) Used at the same time on at least one occasion.

(c) For non-medical purposes.

(d) Only included pain killers.

Source: AIHW unpublished.

Table 5d: Lifetime prevalence of amphetamine use, by age and sex, in Victoria and nationally, 2011

Age (years)	Victoria		National	
	Male	Female	Male	Female
12	2	1	1	2
13	3	1	2	2
14	1	2	2	2
15	2	1	5	2
16	4	3	4	4
17	5	5	6	5

Source: Adapted from the Victorian and national ASSAD surveys 2011

Table 5e: Patterns of methamphetamine use (any form) among REU/RPU by jurisdictions, 2012-2013 (national) and 2013 (states and territories)

(%)	National		NSW	ACT	VIC	TAS	SA	WA	NT	QLD
	2012	2013	n=100	n=77	n=100	n=76	n=100	n=100	n=44	n=88
	N=607 N=686									
Ever used	84	70	59	74	91	96	64	45	62	71
Ever injected	13	12	6	4	19	17	8	69	7	10
Used in the last six months	61	49	36	65	71	57	46	31	44	48
Median days used* last six months (n;range)	6	4	2	5	8	3	4	5	6.5	4
	(1-180)	(1-180)	(1-48)	(1-180)	(1-172)	(1-95)	(1-120)	(1-180)	(1-96)	(1-104)

*Among those who had used recently.

Note: Included speed, base and ice/crystal. Medians rounded to nearest whole number.

Source: Ecstasy and Related Drug Reporting System interviews in 2013 reporting recent use (%), p.18.

Table 5f: Patterns of crystal methamphetamine (ice/crystal) use among REU/ RPU by jurisdiction, 2012-2013 (national) and 2013 (states and territories)

(%)	National		NSW	ACT	VIC	TAS	SA	WA	NT	QLD
	2012	2013	n=100	n=77	n=100	n=76	n=100	n=100	n=45	n=88
	N=607		N=686							
Ever used	48	35	21	23	62	38	37	32	36	26
Ever injected	10	6	5	3	12	5	5	16	0	5
Used in the last six months	29	23	11	14	45	17	28	22	56	21
Snorted*	20	24	0	18	36	23	11	46	11	17
Swallowed*	30	25	18	27	27	15	33	23	0	33
Injected*	20	20	46	9	27	23	14	14	0	17
Smoked*	88	92	82	100	93	92	96	82	100	89
Median days used* last six months (n;range)	6	4	4	3	10	3	4	6	3^	3.5
	(1-170)	(1-180)	(1-48)	(1-180)	(1-170)	(1-72)	(1-96)	(1-180)	(1-30)	(1-80)
Binged on ice/crystal**	40	32	20	15	55	20	44	34	21	25

*Of those who used in the six months preceding interview.

**Of those that had used stimulants for more than 48 hours.

^Small numbers responded, interpret with caution.

Note: medians rounded to the nearest whole number.

Source; EDRS interviews, table 20, pg. 21.

Table 5g: Patterns of crystal methamphetamine (ice) use among EDRS participants, 2008-2013, Victoria

Crystal methamphetamine	2008	2009	2010	2011	2012	2013
	(N=100)	(N=100)	(N=100)	(N=101)	(N=100)	(N=100)
Ever used (%)	53	36	45	56	57	62
Used last six months (%)	22	13	18	38	48	45
Median days used last 6 months* (range)	4.5	3	3	8	8.5	10
	(1-60)	(1-60)	(1-24)	(1-120)	(1-170)	(1-170)
	n=22	n=13	n=18	n=37	n=48	n=45
Median quantities used* (points)						
Typical (range)	1	1.5	1	2	1.5	2**
	(0.1-5)	(0.1-4)	(1-6)	(0.2-10)	(0.1-7)	(0.3-15)
	n=18	n=9	n=13	n=36	n=40	n=42
Heavy(range)	2	2	1.5	3	2.5	3.5**
	(0.1-10)	(0.1-15)	(1-6)	(0.4-17)	(0.1-10)	(1-50)
	n=17	n=9	n=11	n=36	n=37	n=42

*Among those who used crystal methamphetamine in the last 6 months

**Figures in the Victorian EDRS report differ slightly to the national report due to inclusion of grams in the calculation of points

Source: EDRS Victoria 2013, RPU interviews, 2008-2013, p.13.

Appendix 9: DirectLine and ADIS Amphetamine Data

- | | |
|--------------|--|
| Attachment 1 | Total number and Proportion of Courses of Treatment (COT) and clients receiving services from specialist alcohol and drug agencies, by primary drug of concern, Victoria, for 2011-12; 2012-13 and 2013-14 (if available). |
| Attachment 2 | Calls to DirectLine by drug type, 2009 to 2014, including 213% of drug-identified calls and % change between 2013 and 2013. |
| Attachment 3 | Not included in this document. |
| Attachment 4 | Number of calls to DirectLine where methamphetamine (and if not available amphetamines) were cited as drugs of concern, 2013. |
| Attachment 5 | Gender and Age distribution of callers to DirectLine where methamphetamine (and if not available amphetamines) were cited as drugs of concern, 2013. |

Note: The Alcohol and Drug Information System (ADIS) does not collect information on methamphetamine use as distinct from amphetamine use. Amphetamine is the drug class reported in ADIS, inclusive of methamphetamine.
Source: The Hon. Mary Wooldridge, Minister for Mental Health, Community Services, Disability Services and Reform, Correspondence, 13 August 2014.

Attachment 1

Total number and proportional of Courses of Treatment (COT) and clients receiving services from specialist alcohol and drug agencies, by primary drug of concern, Victoria for 2011-2012; 2012-2013; and 2013-14 (if available) – ADIS data.

Completed Courses of Treatment by Primary Drug of Concern						
Primary Drug	Year			Year		
	11/12 nbr	12/13 nbr	13/14 nbr	11/12 %	12/13 %	13/14 %
Alcohol	22,476	22,699	23,762	45.56%	43.04%	41.64%
Amphetamines	5,012	7,654	10,140	10.16%	14.51%	17.77%
Anabolic steroids and selected hormones	8	10	7	0.02%	0.02%	0.01%
Analgesics n.f.d.	381	431	364	0.77%	0.82%	0.64%
Antidepressants and Anti psychotics n.f.d.	35	31	37	0.07%	0.06%	0.06%
Barbiturates	16	10	5	0.03%	0.02%	0.01%
Benzodiazepines	888	864	889	1.80%	1.64%	1.56%
Buprenorphine	234	216	203	0.47%	0.41%	0.36%
Caffeine	29	29	39	0.06%	0.05%	0.07%
Cannabis	11,290	11,830	12,015	22.88%	22.43%	21.06%
Cocaine	82	103	127	0.17%	0.20%	0.22%
Codeine	240	236	271	0.49%	0.45%	0.47%
Ecstasy	225	344	334	0.46%	0.65%	0.59%
Heroin	5,702	5,216	5,258	11.56%	9.89%	9.21%
LSD	18	13	10	0.04%	0.02%	0.02%
Methadone	490	498	544	0.99%	0.94%	0.95%
Morphine	317	256	240	0.64%	0.49%	0.42%
Nicotine	506	738	937	1.03%	1.40%	1.64%
Opioid Analgesics n.f.d.	600	636	721	1.22%	1.21%	1.26%
Other drugs n.e.c.	290	337	457	0.59%	0.64%	0.80%
Other Stimulants and Hallucinogens nfd	59	125	137	0.12%	0.24%	0.24%
Psychostimulants n.f.d.	98	188	355	0.20%	0.36%	0.62%
Sedatives and Hypnotics	186	120	103	0.38%	0.23%	0.18%
Volatile Substances	152	159	107	0.31%	0.30%	0.19%
Grand Total	49,334	52,743	57,062	100.00%	100.00%	100.00%
NOTE: Excludes forensic AOD brokerage						

Completed Courses of Treatment by Primary Drug of Concern						
Primary Drug	Year			Year		
	11/12 nbr	12/13 nbr	13/14 nbr	11/12 %	12/13 %	13/14 %
Number of clients completing one or more Courses of Treatment by Primary Drug of Concern						
Primary Drug	11/12 nbr	12/13 nbr	13/14 nbr	11/12 %	12/13 %	13/14 %
Alcohol	12,408	12,449	12,829	42.92%	39.88%	38.44%
Amphetamines	3,321	5,029	6,443	11.49%	16.11%	19.31%
Anabolic steroids and selected hormones	8	9	7	0.03%	0.03%	0.02%
Analgesics n.f.d.	245	284	249	0.85%	0.91%	0.75%
Antidepressants and Anti psychotics n.f.d.	30	26	29	0.10%	0.08%	0.09%
Barbiturates	13	10	5	0.04%	0.03%	0.01%
Benzodiazepines	533	574	536	1.84%	1.84%	1.61%
Buprenorphine	166	139	145	0.57%	0.45%	0.43%
Caffeine	21	26	36	0.07%	0.08%	0.11%
Cannabis	6,506	6,811	7,046	22.51%	21.82%	21.11%
Cocaine	71	83	98	0.25%	0.27%	0.29%
Codeine	139	134	163	0.48%	0.43%	0.49%
Ecstasy	214	330	315	0.74%	1.06%	0.94%
Heroin	3,368	3,144	2,979	11.65%	10.07%	8.93%
LSD	17	10	9	0.06%	0.03%	0.03%
Methadone	343	354	382	1.19%	1.13%	1.14%
Morphine	195	166	155	0.67%	0.53%	0.46%
Nicotine	384	546	652	1.33%	1.75%	1.95%
Opioid Analgesics n.f.d.	392	430	478	1.36%	1.38%	1.43%
Other drugs n.e.c.	184	237	329	0.64%	0.76%	0.99%
Other Stimulants and Hallucinogens nfd	52	90	107	0.18%	0.29%	0.32%
Psychostimulants n.f.d.	80	136	220	0.28%	0.44%	0.66%
Sedatives and Hypnotics	119	92	90	0.41%	0.29%	0.27%
Volatile Substances	99	110	69	0.34%	0.35%	0.21%
Grand Total	28,908	31,219	33,371	100.00%	100.00%	100.00%
nb a client can complete multiple CoTs each with different Primary Drugs of Concern during a year.						
excludes forensic AOD brokerage						

Attachment 2

Calls to DirectLine by drug type, 2009 to 2014, including 2013 % of drug-identified calls and % change between 2012 and 2013.

DirectLine callers - Drug(s) of concern

Note that DirectLine reporting by drug of concern was expanded in 2012/13 to include a wider range of drug classes.

Drug/s of concern	2009/10 # (%) (where n = 18,511)	2010/11 # (%) (where n=18,434)	2011/12 # (%) (where n=18,830)	2012/13 # (%) (where n=19,613)	2013/14 # (%) (where n=18,722)
Alcohol	6275 (33.9%)	5991 (32.5%)	5574 (29.6%)	5354 (27.3%)	4774 (25.5%)
Amphetamines	1074 (5.8%)	1843 (10%)	3069 (16.3%)	4315 (22%)	4830 (25.8%)
Antidepressants				196 (1%)	150 (0.8%)
Benzodiazepines	685 (3.7%)	756 (4.1%)	847 (4.5%)	883 (4.5%)	786 (4.2%)
Buprenorphine	573 (3.1%)	479 (2.6%)	490 (2.6%)	490 (2.5%)	487 (2.6%)
Cannabis	2221 (12%)	2341 (12.7%)	2997 (12.2%)	3293 (12.2%)	2415 (12.9%)
Cocaine	204 (1.1%)			177 (0.9%)	169 (0.9%)
Ecstasy	167 (0.9%)			137 (0.7%)	94 (0.5%)
GHB				118 (0.6%)	112 (0.6%)
Hallucinogens				39 (0.2%)	56 (0.3%)
Heroin	2480 (13.4%)	2544 (13.8%)	2184 (11.6%)	1863 (9.5%)	1684 (9.0%)
Inhalants				39 (0.2%)	19 (0.1%)
LAAM				0%	0%
Major tranquillisers				118 (0.6%)	131 (0.7%)
Methadone	5664 (30.6%)	5733 (31.1%)	5536 (29.4%)	5099 (26%)	4362 (23.3%)
Naltrexone				78 (0.4%)	37 (0.2%)
Non-narcotic analgesics				196 (1%)	206 (1.1%)
Other narcotic analgesics	315 (1.7%)	387 (2.1%)	358 (1.9%)	432 (2.2%)	431 (2.3%)
Party Drugs other				59 (0.3%)	169 (0.9%)
SROM				59 (0.3%)	56 (0.3%)
Steroids and related				20 (0.1%)	19 (0.1%)
Stimulants other				20 (0.1%)	19 (0.1%)
Tobacco				59 (0.3%)	37 (0.2%)
Other			1318 (7%)	274 (1.4%)	393 (2.1%)

% change in drug of concern between 2012 and 2013

Note that DirectLine reporting by drug of concern was expanded in 2012/13 to include a wider range of drug classes.

Drug/s of concern	2011/12 % (where n = 18,830)	2012/13 % (where n=19,613)	% change
Alcohol	29.6%	27.3%	-2.3%
Amphetamines	16.3%	22.0%	+5.7%
Antidepressants		1.0%	
Benzodiazepines	4.5%	4.5%	no change
Buprenorphine		2.5%	
Cannabis	12.2%	12.2%	no change
Cocaine		0.9%	
Ecstasy		0.7%	
GHB		0.6%	
Hallucinogens		0.2%	
Heroin	11.6%	9.5%	-2.1%
Inhalants		0.2%	
LAAM		0.0%	
Major tranquillisers		0.6%	
Methadone	29.4%	26.0%	-3.4%
Naltrexone		0.4%	
Non-narcotic analgesics		1.0%	
Other narcotic analgesics	1.9%	2.2%	+0.3%
Party Drugs other		0.3%	
SROM		0.3%	
Steroids and related		0.1%	
Stimulants other		0.1%	
Tobacco		0.3%	
Other	7%	1.4%	

% of drug-identified DirectLine calls in 2013

In 2012-2013, 52% of callers reported that a 'drug problem' was the reason for calling. More than one 'reason for call' may be recorded.

ATTACHMENT 4

Number of calls to DirectLine where methamphetamine (and if not available amphetamines) were cited as drugs of concern, 2013.

Amphetamine was cited as a drug of concern by 4,317 callers in 2012/13.

ATTACHMENT 5

Gender and Age distribution of callers to DirectLine where methamphetamine (and if not available amphetamines) were cited as drugs of concern, 2013.

DirectLine 2013 - Amphetamines related calls

N=3953		
Gender	No	%
Female	2604	65.9%
Male	1349	34.1%

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%

Appendix 10: Coroners Court of Victoria - Submission

Background

The *Coroners Act 2008* (Vic) requires that unexpected deaths and deaths resulting from unnatural causes (for example motor vehicle crashes, assaults and drug overdoses) must be reported to the CCOV. These are referred to as 'reportable deaths' (see Section 4 of the Act for more detailed information about reportable deaths).

Following a medico-legal investigation (which may include forensic medical and scientific tests and the gathering of statements from family, friends, witnesses and health practitioners) if the coroner determines that the death meets the criteria of 'reportable', the coroner will make a written finding. The coroner's finding must state the identity of the person (if known), the cause of death, and include information to enable the death to be registered with Births, Deaths and Marriages. The finding may also include information about the circumstances in which the death occurred. Coroners also have discretion to make recommendations on issues of public health and safety and the administration of justice. Any statutory authority or entity that is directed a coroners' recommendation, must respond within three calendar months about what action has or will be taken. This response and a copy of the coroners' finding must be published on the CCOV website.

Given the mandate of Victorian coroners and the nature of the forensic medical and scientific tests conducted to establish cause of death, the presence of methamphetamine amongst deaths investigated by coroners can be established by interrogating information generated for these investigations.

The Committee sought data on the frequency of deaths reported to the CCOV where methamphetamine was detected during the period 1 January 2009 to 31 December 2013, including:

- ◆ the age group, sex and region of usual residence of persons who died
- ◆ the mechanism of death (e.g. transport crash) and deceased's intent (e.g. intentional self-harm)
- ◆ the presence and combination of other substances detected, in particular alcohol, other illegal drugs (e.g. cannabis), and/or pharmaceutical drugs (e.g. diazepam)

The State Coroner approved the Committee's request and directed the Coroners Prevention Unit (CPU) to collate and analyse the data.



**Coroners Court
of Victoria**

Data Summary

Coroners Prevention Unit

**Presence of methamphetamine amongst deaths reported to
the Coroners Court of Victoria, 2009-2013**

Date	7 August 2014
Agency	Parliament of Victoria Law Reform, Drugs and Crime Prevention Committee
Approving Coroner	State Coroner Judge Ian Gray
Investigators	Lyndal Bugeja Jeremy Dwyer Ciara Miller Mel Willoughby

Table of Contents

1. Introduction.....	3
1.1 Methamphetamine Reference.....	3
1.2 Death Investigation and the Coroners Court of Victoria.....	3
1.3 Scope of the Data Summary.....	4
2. Method.....	5
2.1 Research Design	5
2.2 Inclusion Criteria	5
2.3 Case Identification.....	5
2.4 Data Collection.....	5
2.5 Data Analysis	5
2.6 Limitations	5
3. Results.....	7
3.1 Sex and Age Group	7
3.2 Location of Usual Residence	7
3.3 Case Type, Intent and Mechanism	8
3.4 Drugs Combinations.....	8
4. Discussion	11
4.1 Summary of Results.....	11
4.2 Implications	11
4.3 Conclusion.....	12

1. Introduction

1.1 Methamphetamine Reference

In response to concerns about a suspected increase in harms associated with methamphetamine use, the Parliament of Victoria referred an inquiry into the supply and use of methamphetamines - particularly ice - in Victoria to the Law Reform, Drugs and Crime Prevention Committee for consideration and report no later than 31 August 2014. The terms of reference for the inquiry were 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
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).

The Committee approached the Coroners Court of Victoria (CCOV) for data that might illuminate the terms of reference. Specifically, the Committee requested information regarding the detection of methamphetamine in deaths investigated by Victorian coroners, and how this has changed over time.

1.2 Death Investigation and the Coroners Court of Victoria

The *Coroners Act 2008* (Vic) ('the Act') requires that unexpected deaths and deaths resulting from unnatural causes (for example motor vehicle crashes, assaults and drug overdoses) must be reported to the CCOV. These are referred to as 'reportable deaths' (see Section 4 of the Act for more detailed information about reportable deaths).

Following a medico-legal investigation (which may include forensic medical and scientific tests and the gathering of statements from family, friends, witnesses and health practitioners) if the coroner determines that the death meets the criteria of 'reportable', the coroner will make a written finding. The coroner's finding must state the identity of the person (if known), the cause of death, and include information to enable the death to be registered with Births, Deaths and Marriages. The finding may also include information about the circumstances in which the death occurred. Coroners also have discretion to make recommendations on issues of public health and safety and the administration of justice. Any statutory authority or entity that is directed a coroners' recommendation, must respond within three calendar months about what action has or will be taken. This response and a copy of the coroners' finding must be published on the CCOV website.

Given the mandate of Victorian coroners and the nature of the forensic medical and scientific tests conducted to establish cause of death, the presence of methamphetamine amongst deaths investigated by coroners can be established by interrogating information generated for these investigations.

1.3 Scope of the Data Summary

In consultation with the Committee's Executive Officer, the CCOV clarified that the Committee would be assisted by data on the frequency of deaths reported to the CCOV where methamphetamine was detected during the period 1 January 2009 to 31 December 2013, including:

- the age group, sex and region of usual residence of persons who died
- the mechanism of death (e.g. transport crash) and deceased's intent (e.g. intentional self-harm)
- the presence and combination of other substances detected, in particular alcohol, other illegal drugs (e.g. cannabis), and/or pharmaceutical drugs (e.g. diazepam)

The State Coroner approved the Committee's request and directed the Coroners Prevention Unit (CPU) to collate and analyse the data.

2. Method

2.1 Research Design

A retrospective case series study design was employed to examine the frequency of deaths where methamphetamine was detected amongst the population of deaths reported to the CCOV.

2.2 Inclusion Criteria

A death was considered relevant if it was reported to the CCOV during the period 1 January 2009 to 31 December 2013, and methamphetamine was recorded as being detected in the course of the medico-legal investigation.

2.3 Case Identification

Parallel overlapping searches of multiple databases were conducted to identify relevant deaths:

- The National Coronial Information System (NCIS) coroners' search screen was used to identify all deaths reported to the CCOV between 1 January 2009 and 31 December 2013, where the term 'methamphetamine' or 'methamphetamine' appeared in the text of the forensic pathology report.
- The NCIS drugs search screen was used to identify all deaths reported to the CCOV between 1 January 2009 and 31 December 2013, where methamphetamine was recorded as having been detected by forensic toxicology procedures.
- The CPU's Drug Overdose Deaths Register (DODR) was searched for overdose deaths where methamphetamine was determined by the expert death investigator as contributory.

The search results were exported to Microsoft Excel, combined and duplicates eliminated. For each death identified, two research interns reviewed the toxicology report, and (where available) the coroner's finding, to determine whether the death met the inclusion criteria.

2.4 Data Collection

For each death identified, the following variables were recorded in Microsoft Excel: CCOV Court Reference Number; year death reported; age; age group; sex; cause of death; intent; mechanism of death; toxicology results; presence of alcohol; presence of illegal drugs other than methamphetamine; presence of pharmaceutical drugs; and the Department of Human Services region where the deceased usually resided.

2.5 Data Analysis

A series of bivariate descriptive statistical analyses were conducted, which comprised:

- age group and sex by year death occurred
- region of usual residence by year death occurred
- deceased's intent and mechanism of death by drug combinations

2.6 Limitations

A number of limitations with the data source and the case identification process may have impacted on the results. The searches of the NCIS would have only identified deaths where a post-mortem report was attached. This may have been overcome to some extent by using the NCIS Drugs Module and the CPU DODR, however some under-reporting may still have occurred. In addition, the use of keywords to identify potentially relevant deaths is fallible because of known issues with how material

(particularly in PDF format) is stored in NCIS and CCOV databases. The data produced in this report should be regarded as indicative (rather than definitive) of deaths reported to the CCOV where methamphetamine was detected.

3. Results

There were 574 deaths identified that met the inclusion criteria. The annual frequency of deaths increased steadily each year from 66 in 2009 to 166 in 2013. This represented a 165% increase over the five-year period.

3.1 Sex and Age Group

Table 1 shows the majority of deaths occurred amongst males (n=463), ranging in age from 16 to 79 years (median = 34, IQR 27-42 years). The remaining 111 deaths were of females, who ranged in age from 14 to 59 years (median = 31, IQR 25-40 years).

Table 1: Annual frequency of deaths where methamphetamine was present by age group and sex, Victoria 2009-2013

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

3.2 Location of Usual Residence

Table 2 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.

Disaggregating the deaths further by the Department of Human Services (DHS) region where the deceased usually resided, the general trend across all Metropolitan and rural DHS regions was for the annual frequency of deaths to increase. The only exception was the Grampians region, however given the relatively low number of deaths in this region (ranging from two in 2009 to 11 in 2012), the apparent decrease in deaths between 2012 and 2013 might be a statistical artefact.

Table 2: Annual frequency of deaths where methamphetamine was present by location of usual residence, Victoria 2009-2013

Region of Usual Residence	2009	2010	2011	2012	2013	Total
<u>Metropolitan Melbourne</u>						
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
<u>Rural Victoria</u>						
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
<u>Other Location</u>						
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

3.3 Case Type, Intent and Mechanism

Table 3 shows that methamphetamine was most frequently detected amongst persons who died from external causes (n = 482, 84.0%) rather than natural (n = 85, 14.8%) or unknown causes (n = 7, 1.2%).

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).
- 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.

3.4 Drugs Combinations

Table 3 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:

- 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 3: Frequency of deaths where methamphetamine was present by case type, deceased's intent, mechanism of death and drug combinations, Victoria 2009-2013

Case Type, Deceased's Intent and Mechanism of Death	Methamphetamine only	Methamphetamine & Alcohol	Methamphetamine & Alcohol & Illegal Drugs	Methamphetamine & Alcohol & Pharmaceutical Drugs	Methamphetamine & Alcohol & Pharmaceutical Drugs	Methamphetamine & Illegal Drugs	Methamphetamine & Illegal Drugs & Pharmaceutical Drugs	Methamphetamine & Pharmaceutical Drugs	Total
Natural Causes	13	-	3	3	11	23	31	85	
External Causes									
- Assault	9	1	5	1	2	5	13	40	
- Suicide	29	15	11	15	14	26	32	148	
- Legal Intervention	-	-	-	1	1	2	2	6	
- Unintentional									
Transport	17	8	4	4	10	16	13	89	
Falls	-	-	1	-	-	-	-	1	
Poisoning	6	1	22	11	7	78	31	157	
Threats to Breathing	1	1	-	-	-	1	2	6	
Other Unintentional	-	1	-	1	2	3	3	12	
- Undetermined Intent									
Transport	1	-	-	-	1	-	1	3	
Poisoning	-	-	1	1	1	6	8	17	
Other	-	-	1	-	-	-	2	3	
Unknown Causes	-	-	-	2	-	3	2	7	
Total	76	27	48	39	49	163	140	574	

CCOV

Data Summary Report - Methamphetamine deaths

9/12

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%).
- Alcohol was detected in 146 of the 574 deaths (25.4%).

Considering drug combinations in the context of both deceased intent and mechanism, the following were some 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%).
- Methamphetamine alone was detected in 76 deaths (13.2%), 29 of which (38.2%) were suicides.

4. Discussion

4.1 Summary of Results

This review of deaths reported to the CCOV showed 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.

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 methamphetamines were commonly detected.

4.2 Implications

While there has been a clear increase over time in the frequency of deaths reported to the CCOV, interpreting the significance of this increase is more challenging.

One central challenge is teasing apart the difference between the presence of methamphetamine in a death, and the contributory role of methamphetamine to that death. For example:

- 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.

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.

This observation leads onto the second challenge faced by anybody trying to measure the role and contribution of methamphetamine to deaths investigated by coroners, which is the challenge of identifying deaths where the deceased is not the methamphetamine user. This is clearly illustrated in the case of assaults. As discussed in Section 3 of this report, there were 40 Victorian assault deaths between 2009 and 2013 where methamphetamine was detected in the post-mortem examination of the deceased. However, 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. The same principle applies in

transport deaths, where the methamphetamine-affected driver often lives while a passenger, pedestrian or driver of another vehicle dies.

A third challenge is evaluating the circumstances of deaths from natural causes in a setting of methamphetamine use; for example a death from cardiomegaly where the deceased had taken methamphetamine. Did the methamphetamine use exacerbate the cardiomegaly and thus contribute to the death, or was the death going to occur anyway because of the severity of the cardiomegaly?

A fourth challenge is identifying deaths where chronic methamphetamine abuse might have contributed but the deceased had not taken methamphetamine proximal to death; for example, suicides where the deceased had developed a serious mental illness through past chronic methamphetamine abuse.

Clearly, then, methamphetamine use by the deceased is only part of the overall picture of methamphetamine involvement in deaths investigated by coroners. Developing a richer and more nuanced understanding of the range of ways that methamphetamine might contribute to deaths investigated by coroners, requires resource-intensive review of material generated for the coroner's investigation that was beyond the resources of the CPU in preparing this report for the Committee.

However, this is not to say that the data included in this report is entirely useless. Despite the interpretative limitations, methamphetamine detection in deaths can still be used at the very least as a heuristic indicator of patterns and trends that might be occurring in the underlying harms associated with the drug.

From this perspective, the data indicates that harms associated with methamphetamine in Victoria have steadily increased over the past five years. This increase has occurred across both Metropolitan Melbourne and rural Victoria, across both males and females, and across a range of age groups. This indication is consistent with the concern underpinning the Committee's inquiry, which was that harms associated with methamphetamine use have increased in Victoria.

A particularly pertinent finding for the purposes of the Committee, is that in most deaths where methamphetamine was detected, other drugs - particularly pharmaceutical and illegal drugs - were also detected. This indicates that methamphetamine use might be more productively approached as part of a broader substance misuse issue, rather than as a discrete phenomenon.

4.3 Conclusion

These findings provide support to the concerns raised that harms associated with methamphetamine use was increasing in Victoria. Further examination of these deaths is warranted to advance our understanding of how this drug contributes to deaths in Victoria, and thus to inform targeted prevention-focussed interventions.

Appendix 11: Drug Laws in the Australian States and Territories

New South Wales — Drug Misuse and Trafficking Act 1985

The New South Wales Act divides offences into those of summary and indictable jurisdictions.

Summary Offences

The New South Wales Act relates to offences pertaining to *prohibited drugs*. A prohibited drug is defined in turn as a reference to any 'preparation, admixture, extract or other substance containing *any* proportion of the prohibited drug' (s.4).

A reference to the use or administration of a prohibited drug includes a reference to the ingestion, injection and inhalation of a prohibited drug, the smoking of a prohibited drug, the inhalation of fumes caused by the heating or burning of a prohibited drug and any other means of introducing a prohibited drug into any part of the body of a person (s.5).

Self-administration of prohibited drugs (s.12)

The equivalent of the Victorian use offence is the self-administration of a prohibited drug under Section 12. It reads as follows:

- (1) A person who administers or attempts to administer a prohibited drug to himself or herself is guilty of an offence.
- (2) Nothing in this section renders unlawful the administration or attempted administration by a person to himself or herself of a prohibited drug which has been lawfully prescribed for or supplied to the person.

Other summary offences

There are other miscellaneous summary offences under Division One of the Act that include administering a prohibited drug to another (s.13), possession of equipment for administration of prohibited drugs (s.11), forging and obtaining prescriptions by false representation (ss 15–17) and aiding and abetting drug administration [ss19 and 20].

The sale or commercial supply of ice pipes are also prohibited under Section 11A of the Act. All summary offences attract the penalty of 20 penalty units or 2 years' imprisonment or both.¹⁹¹⁵

Indictable offences

Indictable offences are those usually heard in the higher courts by a judge and jury, although in certain circumstances where the parties agree they can be heard summarily. Penalties for indictable offences are significantly higher than summary offences.

Manufacture and Production of Prohibited Drug (s.24)

Under Section 24 (1) a person who manufactures or produces, or who knowingly takes part in the manufacture or production of, a prohibited drug is guilty of an offence and is liable to a fine of 2,000 penalty units or imprisonment for a term of 15 years, or both.

¹⁹¹⁵ Currently one penalty unit is worth \$110.00 in New South Wales.

Under Section 24 (2) a person who manufactures or produces, or who knowingly takes part in the manufacture or production of, an amount of a prohibited drug which is not less than the commercial quantity applicable to the prohibited drug is guilty of an offence. The penalty for this offence is a fine of 3,500 penalty units or imprisonment for 20 years, or both. This penalty is augmented for manufacture or production of large commercial quantities to a fine of 5,000 penalty units or imprisonment for life, or both.¹⁹¹⁶

Offences involving children

As with many jurisdictions across Australia there are separate criminal offences with greater penalties for drug-related crimes that involve or affect children.

Section 24 (1A) of the Act for example pertains to child endangerment. Under this section a person who:

- (a) manufactures or produces, or who knowingly takes part in the manufacture or production of, a prohibited drug, and
- (b) exposes a child (under the age of 16) to that manufacturing or production process, or to substances being stored for use in that manufacturing or production process, is guilty of an offence. The penalty applied will be a fine of 2,400 penalty units or imprisonment for 18 years, or both.

Under Section 24 (2A) a person who:

- (a) manufactures or produces, or who knowingly takes part in the manufacture or production of, an amount of a prohibited drug which is not less than the commercial quantity applicable to the prohibited drug, and
- (b) exposes a child (under the age of 16) to that manufacturing or production process, or to substances being stored for use in that manufacturing or production process, is guilty of an offence. The penalty applicable will be a fine of 4,200 penalty units or imprisonment for 25 years, or both.

These greater penalties express the legislature's particular abhorrence of involving children in the manufacture of illicit drugs with all the attendant risks and dangers involved.¹⁹¹⁷

Possession of precursors for manufacture or production of prohibited drugs (S.24A)

Most states have drug laws that penalise people not only for the possession of the finished drug product but, as in the case of methamphetamine, also for those chemicals that are associated with its manufacture. In New South Wales under Section 24A for example:

(1) A person who has possession of:

- (a) a precursor, or
- (b) a drug manufacture apparatus,

intended by the person for use in the manufacture or production, by that person or another person, of a prohibited drug is guilty of an offence.

(2) Nothing in this section renders unlawful the manufacture or production of a prohibited drug by:

- (a) a person licensed or authorised to do so under the Poisons and Therapeutic Goods Act 1966, or

¹⁹¹⁶ See Section 33, DMATA. The quantum of a large commercial quantity will be determined by the list in Column 5 of Schedule 1 of the Act.

¹⁹¹⁷ See discussion in Chapters 7 and 20.

- (b) a person acting in accordance with an authority granted by the Director-General of the Department of Health where the Director-General is satisfied that the manufacture or production of the prohibited drug is for the purpose of scientific research, instruction, analysis or study.¹⁹¹⁸

The penalty for an offence under this section is a fine of 2,000 penalty units or imprisonment for a term of 10 years, or both.

Supply (Trafficking) — (S. and S.29)

Offences under these sections pertain to trafficking of various quantities of illicit drugs. As with most state drug laws lesser penalties apply to the supply of cannabis compared to other drugs and increased penalties arise when the supply is to children under the age of 16 years. Section 25 states:

- (1) A person who supplies, or who knowingly takes part in the supply of, a prohibited drug is guilty of an offence and is liable to a fine of 2,000 penalty units or imprisonment for a term of 15 years, or both.
- (1A) A person of or above the age of 18 years who supplies, or who knowingly takes part in the supply of, a prohibited drug (other than cannabis leaf) to a person under the age of 16 years is guilty of an offence and is liable to a fine of 2,000 penalty units or imprisonment for a term of 15 years, or both.
- (2) A person who supplies, or who knowingly takes part in the supply of, an amount of a prohibited drug which is not less than the commercial quantity applicable to the prohibited drug is guilty of an offence.
- (2A) A person of or above the age of 18 years who supplies, or who knowingly takes part in the supply of, an amount of a prohibited drug (other than cannabis leaf) which is not less than the commercial quantity applicable to the prohibited drug to a person under the age of 16 years is guilty of an offence and liable to a penalty of fine of 4,200 penalty units or imprisonment for 25 years, or both.
- (2B) Where, on the trial of a person for an offence under subsection (1A) or (2A), the jury are satisfied that the person charged had, at the time the offence is alleged to have been committed, reasonable cause to believe, and did in fact believe, that the person to whom the prohibited drug was supplied was of or above the age of 16 years, they may acquit the person of the offence charged and find the person guilty of an offence under subsection (1) or (2), respectively, and the person is liable to punishment accordingly.
- (2C) A person of or above the age of 18 years who procures a person under the age of 16 years to supply, or take part in the supply of, a prohibited drug (other than cannabis leaf) to another person is guilty of an offence.
- (2D) A person of or above the age of 18 years who procures a person under the age of 16 years to supply, or take part in the supply of, an amount of a prohibited drug (other than cannabis leaf) which is not less than the commercial quantity applicable to the prohibited drug is guilty of an offence.
- (2E) It is a defence to a prosecution for an offence under subsection (2C) or (2D) if the defendant establishes that the defendant had, at the time the offence is alleged to have been committed, reasonable cause to believe, and did in fact believe, that the person who was procured to supply, or take part in the supply of, the prohibited drug was of or above the age of 16 years.

¹⁹¹⁸ In this section, 'precursor' means a substance specified or described in the regulations as a precursor for the purposes of this section.

- (3) Where, on the trial of a person for an offence under subsection (2), the jury are not satisfied that the amount of prohibited drug involved is equal to or more than the commercial quantity applicable to the prohibited drug, they may acquit the person of the offence charged and find the person guilty of an offence under subsection (1), and the person shall be liable to punishment accordingly.
- (4) Nothing in this section renders unlawful the supply of a prohibited drug by:
- (a) a person licensed or authorised to do so under the *Poisons and Therapeutic Goods Act 1966*, or
 - (b) a person acting in accordance with an authority granted by the Secretary of the Department of Health where the Secretary is satisfied that the supply of the prohibited drug is for the purpose of scientific research, instruction, analysis or study, or
 - (c) a person acting in accordance with a direction given by the Commissioner of Police,

or renders unlawful the taking part by any other person in the supply of a prohibited drug by a person to whom paragraph (a), (b) or (c) applies.

Supplying prohibited drugs on an ongoing basis (S.25A)

This section of the Act penalises ongoing or continuous cases of drug trafficking or supply within a specified period. It has been colloquially referred to as a 'three strikes and you're out' provision. It reads as follows:

- (1) A person who, on 3 or more separate occasions during any period of 30 consecutive days, supplies a prohibited drug (other than cannabis) for financial or material reward is guilty of an offence.
- (2) A person is liable to be convicted of an offence under this section whether or not the same prohibited drug is supplied on each of the occasions relied on as evidence of commission of the offence.
- (4) If, on the trial of a person for an offence under this section, the jury is not satisfied that the offence is proven but is satisfied that the person has, in respect of any of the occasions relied on as evidence of commission of the offence under this section, committed a relevant supply offence, the jury may acquit the person of the offence charged and find the person guilty of the relevant supply offence, and the person is liable to punishment accordingly.

A person convicted under this section will be liable to a maximum penalty of 3,500 penalty units or imprisonment for 20 years, or both.

Trafficable quantities — deeming provisions

As in Victoria, the possession of a trafficable quantity of the relevant drug will be prima facie evidence of trafficking or supplying a prohibited drug unless the defendant can prove otherwise as follows:

A person who has in his or her possession an amount of a prohibited drug which is not less than the trafficable quantity of the prohibited drug shall, for the purposes of this Division, be deemed to have the prohibited drug in his or her possession for supply, unless:

the person proves that he or she had the prohibited drug in his or her possession otherwise than for supply, or

except where the prohibited drug is prepared opium, cannabis leaf, cannabis oil, cannabis resin, heroin or 6-monoacetylmorphine or any other acetylated derivatives of morphine, the person proves that he or she obtained possession of the prohibited drug on and in accordance with the prescription of a medical practitioner, nurse practitioner, midwife practitioner, dentist or veterinary practitioner.¹⁹¹⁹

In the case of methamphetamine the trafficable threshold quantity is 3 grams.

Queensland — Drugs Misuse Act 1986

The Queensland legislation refers to ‘dangerous’ rather than prohibited drugs. Under section 4 a dangerous drug is defined as including a number of substances listed in Schedules 1 and 2 of the *Drugs Misuse Regulations* (Schedule 1 includes the amphetamines, methamphetamine and the main forms of ‘party’ drugs) and includes salts, derivatives or stereo-isomers in addition to anything that is contained within a natural substance or ‘any solution or admixture’.

Serious drug offences in Queensland include *trafficking* (s.5) (for Schedule 1 drugs a maximum penalty of 25 years imprisonment), *supply* (s.6) (for Schedule 1 drugs a maximum penalty of 20 years or 25 years or life imprisonment with circumstances of aggravation such as supply to a minor under 16 years of age), *possession* (various penalties depending on the amount of the drug, but an average maximum of 20 years), *producing*, (also various penalties depending on the amount in question). The distinction between trafficking and supply is not clear under the Act. However, the use of the term ‘business’ in the trafficking offence suggests trafficking is always construed as a commercial enterprise whereas the offence of supply may include cases where the offender has given or distributed the drug to another not expecting payment.¹⁹²⁰

A unique offence in the Queensland legislation is found in Section 8A — Publishing or possessing instructions for producing.

(1) A person who unlawfully publishes instructions, or unlawfully has possession of a document containing instructions, about the way to produce a dangerous drug commits a crime.

(3) In this section —

‘document’ containing instructions about the way to produce a dangerous drug includes anything designed to enable electronic access specifically to the instructions.

‘publish’ includes publish to any person and supply, exhibit and display to any person, whether the publication is made orally or in written, electronic or another form.

Clearly, such an offence would cover online drug recipe manuals and advice sheets available on the Internet.¹⁹²¹

South Australia — Controlled Substances Act 1984

The South Australian Act needs to be read in conjunction with the Controlled Substances (Controlled Drugs, Precursors and Plants) Regulations 2000. These regulations define

¹⁹¹⁹ Section 29 DMATA 1985.

¹⁹²⁰ Sec.5 — Trafficking in dangerous drugs:

‘A person who carries on the business of unlawfully trafficking in a dangerous drug is guilty of a crime.

Sec.4 — ‘supply’ means:

(a) give, distribute, sell, administer, transport or supply;

(b) offering to do any act specified in paragraph (a);

(c) doing or offering to do any act preparatory to, in furtherance of, or for the purpose of, any act specified in paragraph (a)’.

¹⁹²¹ See discussion in Chapter####.

prohibited substances and drugs of dependence as including admixtures. Under Schedule 1, Part 2 of the regulations, methamphetamine is classified as a drug of dependence. The Schedule also contains relevant quantities for trafficable, commercial and large commercial amounts.

Possession — Section 33L

The following section outlines the provisions and penalties for possession.

Possession or consumption of controlled drug

- (1) A person who—
- (a) Has possession of a controlled drug (other than cannabis, cannabis resin or cannabis oil); or
 - (b) Smokes, consumes or administers to himself or herself, or permits another person to administer to him or her, a controlled drug (other than cannabis, cannabis resin or cannabis oil); or
 - (c) Has possession of any piece of equipment for use in connection with the smoking, consumption or administration of a controlled drug (other than cannabis, cannabis resin or cannabis oil), or the preparation of such a drug for smoking, consumption or administration, is guilty of an offence.

The penalty for an infringement of the above offence is \$2 000 or imprisonment for 2 years, or both.

Supply — Section 33I

The supply or administration of a controlled drug to a person other than the supplier is an offence under Section 33I as follows:

- (1) A person who—
- (a) supplies or administers a controlled drug (other than cannabis, cannabis resin or cannabis oil) to another person; or
 - (b) has possession of a controlled drug (other than cannabis, cannabis resin or cannabis oil) intending to supply or administer the drug to another person, is guilty of an offence.

The maximum penalty for an infringement of the above offence is \$50 000 or imprisonment for 10 years, or both.

Manufacture — Section 33J

A person who manufactures a controlled drug is guilty of an offence under Section 33J of the Act. The maximum penalty is \$35 000 or imprisonment for 7 years, or both.

A person who has possession of—

- (a) a controlled precursor; or
- (b) any prescribed equipment,

intending to use it to manufacture a controlled drug is also guilty of an offence.

The maximum penalty for an infringement of the above offence is \$15 000 or imprisonment for 5 years, or both.

Manufacture for Sale — Section 33

In certain circumstances the manufacture of controlled drugs for sale will in effect be dealt with on the same basis as trafficking. Under Section 33:

A person who manufactures a large commercial quantity¹⁹²² of a controlled drug intending to sell any of it or believing that another person intends to sell any of it is guilty of an offence.

The maximum penalty for the offence is \$500 000 or imprisonment for life, or both.

Under Section 33 (2) a person who manufactures a commercial quantity¹⁹²³ of a controlled drug intending to sell any of it or believing that another person intends to sell any of it is guilty of an offence with a maximum penalty:

- (a) for a basic offence—\$200 000 or imprisonment for 25 years, or both;
- (b) for an aggravated offence—\$500 000 or imprisonment for life, or both.¹⁹²⁴

A person who manufactures a controlled drug intending to sell any of it or believing that another person intends to sell any of it is also guilty of an offence under Section 33 (3).

The maximum penalty:

- (a) for a basic offence is \$50 000 or imprisonment for 10 years, or both;
- (b) for an aggravated offence is \$75 000 or imprisonment for 15 years, or both.

Under Section 33 (4) If—

- (a) in any proceedings for an offence against subsection (1), (2) or (3) it is proved that the defendant manufactured a trafficable quantity¹⁹²⁵ of a controlled drug; or
- (b) in any proceedings for an offence of attempting or conspiring to commit an offence against subsection (1), (2) or (3) it is proved that the defendant attempted or conspired (as the case may require) to manufacture a trafficable quantity of a controlled drug,

it is presumed, in the absence of proof to the contrary, that the defendant had the relevant intention or belief concerning the sale of the drug necessary to constitute the offence.

Trafficking — Section 32

There are a variety of trafficking offences depending on the quantities of drug in question. In the following sections the amounts of *trafficable*, *commercial* and *large commercial* quantities are also to be found in Part 2 of Schedule 1 and are the same amounts as for manufacturing in the previous section.

Under Section 32:

A person who traffics in a *large commercial quantity* of a controlled drug is guilty of an offence.

The maximum penalty is \$500 000 or imprisonment for life, or both.

A person who traffics in a *commercial quantity* of a controlled drug is guilty of an offence.

The maximum penalty is:

- (a) for a basic offence—\$200 000 or imprisonment for 25 years, or both;

1922 In the case of methamphetamine 0.75kgs pure and 1 kg mixed. Schedule 1, Part 2. CS(CDPP) Regulations.

1923 In the case of methamphetamine 0.1kg pure and 0.5kg mixed. Schedule 1, Part 2. CS(CDPP) Regulations.

1924 An aggravated offence will generally apply when the offender committed the offence for the benefit of a criminal organisation, or 2 or more members of a criminal organisation, or at the direction of, or in association with, a criminal organisation. See Section 43 *Controlled Substances Act 1984 (SA)*.

1925 In the case of methamphetamine 2grams mixed. Schedule 1, Part 2. CS(CDPP) Regulations.

(b) for an aggravated offence¹⁹²⁶—\$500 000 or imprisonment for life, or both.

(2a) A person who, in a *prescribed area*, traffics in a controlled drug is guilty of an offence.

The maximum penalty is:

(a) for a basic offence—\$75 000 or imprisonment for 15 years, or both;

(b) for an aggravated offence¹⁹²⁷—\$200 000 or imprisonment for 25 years, or both.

A *prescribed area* is a designated area which has special significance and which will attract higher penalties because of this significance. Under Section 32 (6) ‘prescribed area’ means:

(a) prescribed licensed premises¹⁹²⁸ or an area being used in connection with prescribed licensed premises; or

(b) premises at which members of the public are gathered for a public entertainment¹⁹²⁹ or an area being used in connection with such premises;

For example, areas “being used in connection with” premises could include—

(a) a car parking area specifically provided for the use of patrons of the premises;

(b) an area in which people are queuing to enter the premises.

(3) A person who *traffics* in a controlled drug is guilty of an offence.

The maximum penalty is:

(a) for a basic offence—\$50 000 or imprisonment for 10 years, or both;

(b) for an aggravated offence¹⁹³⁰—\$75 000 or imprisonment for 15 years, or both.

Deeming Provisions

There are deeming provisions under the Act in cases for offences of trafficking controlled substances, trafficking in prescribed areas and trafficking in commercial and large commercial quantities. Under Section 32 (5) if in any proceedings for one of these offences it is proved that the defendant had possession of a *trafficable quantity* of a controlled drug, it is presumed, in the absence of proof to the contrary—

(a) in a case where it is alleged that the defendant was taking part in the process of sale of the drug, that the defendant—

(i) was acting for the purpose of sale of the drug; and

(ii) had the relevant belief concerning the sale of the drug necessary to constitute the offence; or

(b) in any other case—that the defendant had the relevant intention concerning the sale of the drug necessary to constitute the offence.

1926 Aggravated offence has the same meaning as for manufacturing offences in Section 33 of the Act and again will generally apply when the offender committed the offence for the benefit of a criminal organisation, or 2 or more members of a criminal organisation, or at the direction of, or in association with, a criminal organisation. See Section 43 *Controlled Substances Act 1984 (SA)*.

1927 Aggravated offence has the same meaning as for manufacturing offences in Section 33 of the Act and again will generally apply when the offender committed the offence for the benefit of a criminal organisation, or 2 or more members of a criminal organisation, or at the direction of, or in association with, a criminal organisation. See Section 43 *Controlled Substances Act 1984 (SA)*.

1928 These include the standard licensed premises such as a premise with a hotel, restaurant, club, entertainment or casino licence or other licence issued under South Australia’s *Liquor Licensing Act 1997* or *Casino Act 1997*.

1929 “Public entertainment” under Section 32 (6) of the Act means a dance, performance, exhibition or event that is calculated to attract and entertain members of the public, whether admission is open, procured by the payment of money or restricted to members of a club or a class of persons with some other qualification or characteristic.

1930 Aggravated offence has the same meaning as for manufacturing offences in Section 33 of the Act and again will generally apply when the offender committed the offence for the benefit of a criminal organisation, or 2 or more members of a criminal organisation, or at the direction of, or in association with, a criminal organisation. See Section 43 *Controlled Substances Act 1984 (SA)*.

Documents in possession for manufacture — Section 33LAB

Recent amendments to the Act also makes it an offence for a person to have in their possession a document containing instructions for the manufacture of a controlled drug such as methamphetamine (or the cultivation of a controlled plant); or supplying to another person a document containing instructions for the manufacture of a controlled drug or the cultivation of a controlled plant. *Document* in this context includes any record of information whether in documentary, magnetic, electronic or other form.¹⁹³¹

Western Australia — Misuse of Drugs Act 1981

As with most states and territories the Western Australian drugs legislation differs between offences relating to cannabis and those pertaining to other drugs, with cannabis offences attracting lesser penalties such as cautions and fines when the offence relates to first time or minor use.¹⁹³²

Drugs subject to this Act are either ‘drugs of addiction’ such as methamphetamine or drugs listed in Schedule 1.¹⁹³³ Section 5 of the Act concerns offences pertaining to being the occupier or owner of premises used for the manufacture, preparation, sale, supply or use of a prohibited drug or plant. A unique feature of the legislation is that a person found in any place used for the purpose of smoking a prohibited drug such as methamphetamine may have committed a simple offence and is liable to a penalty of a maximum fine of \$2000 or a term of imprisonment of 2 years or both.¹⁹³⁴ Possession, display and sale of drug paraphernalia such as ‘ice pipes’ are prohibited under Section 7B of the Act

Offences concerned with prohibited drugs generally (Section 6)

Section 6 of the Act is a general offences prescription¹⁹³⁵ that applies to all drugs but has different penalties for cannabis and varying amounts of other drugs. Penalties for display and sale vary from \$10,000 for sale to an adult to \$24,000 and imprisonment of up to 2 years or both if such is sale to a child (under 18). If a person is found in possession of drug paraphernalia such as an ice pipe with a prohibited drug (such as methamphetamine) contained therein he or she will be subject to greater penalties of up to \$36,000 fine and/or 3 years maximum term of imprisonment.

Section 6 states that:

- (1) a person who —
- (a) with intent to sell or supply it to another, has in his possession;
 - (b) manufactures or prepares; or
 - (c) sells or supplies, or offers to sell or supply, to another

a prohibited drug commits an indictable offence, except when he is authorised by or under this Act or by or under the *Poisons Act 1964* to do so and does so in accordance with that authority.

Penalties for offences under this section include a maximum fine of \$100,000 and a term of imprisonment not exceeding 25 years.¹⁹³⁶ Use or possession of a prohibited drug under the threshold amount for sale of supply is a ‘simple offence’ and will attract penalties of 2 years maximum imprisonment and/or \$2000 fine.¹⁹³⁷

1931 See Section 33LAB *Controlled Substances Act 1984* (SA).

1932 Part 2A, *Misuse of Drugs Act 1981*.

1933 See Section 4, *Misuse of Drugs Act 1981*.

1934 Section 34 *Misuse of Drugs Act 1981*.

1935 That includes provisions with regard to use, possession, sale and supply.

1936 Section 34 (1)(a).

1937 Section 6(2) and Section 34 (1)(e).

Trafficking

Indictable offences under section 6(1) are classified as 'serious drug offences'. These in turn form the basis for the trafficking provisions under Section 32A. The Section 32A provisions apply to an offender who has either:

- ◆ committed multiple accounts of serious drug offences,
- ◆ committed a serious drug offence in respect of a particular quantity of drug, the quantum of which is listed in Schedule 7 of the Act; or
- ◆ committed a drug offence and at the time of the commission was a member of a declared criminal organisation.¹⁹³⁸

Under Schedule 5 the amount of methamphetamine required to give rise to a presumption that the drug was in the possession of the offender to sell or supply same is 2 grams. Under Schedule 7 the amount of methamphetamine that will give rise to a presumption of the drug being in possession for the purposes of trafficking is 28 grams.

If a person meets the criteria of either of the Section 32 provisions the court can on the application of the Director of Public Prosecutions or a police prosecutor declare the person to be a drug trafficker.

Mandatory Sentencing

Under recent amendments to the Act, mandatory sentencing provisions will apply if an offender was an adult when a trafficking, manufacturing or supply offence was committed and the offence:

- ◆ involved a child
- ◆ endangered the life, health or safety of a child under 16; or
- ◆ caused bodily harm to a child under 16 years.¹⁹³⁹

Such provisions will restrict the sentencing options available to the judiciary in such circumstances (ACC 2012, p.185).¹⁹⁴⁰

Tasmania — Misuse of Drugs Act 2001

Drugs law in Tasmania is governed by the provisions of the *Misuse of Drugs Act 2001* which provides for both summary and indictable offences with greater penalties applying to the latter.¹⁹⁴¹

Summary Offences

The summary or minor offences under the Act are found in Part 3. They concern controlled drugs such as methamphetamine which are listed under Part 2 of Schedule 1. These include:

- ◆ Manufacturing a controlled precursor (Section 20)
- ◆ Manufacturing a controlled drug (Section 21)
- ◆ Possessing an implement (including ice pipes) for administering a controlled drug (Section 23)
- ◆ Possessing, using or administering a controlled drug (Section 24)

¹⁹³⁸ Defined in the *Criminal Organisations Control Act 2012*, Section 3(1).

¹⁹³⁹ See Section 34 *Misuse of Drugs Act 1981* (WA).

¹⁹⁴⁰ See also Section 34 (3). *Misuse of Drugs Act 1981* (WA).

¹⁹⁴¹ Where relevant the *Misuse of Drugs Act 2001* should be also read alongside the provisions of the *Poisons Act 1971*, Part 5 of which contains some overlapping provisions with regard to narcotic drugs and prohibited plants.

◆ Selling or supplying a controlled drug (Section 26)

These offences apply to controlled drugs the quantum of which is less than the trafficable quantities in Schedule 1, Part 2.¹⁹⁴²

Manufacturing offences under Sections 20 and 21 attract maximum penalties of 50 penalty units and/or 2 years imprisonment. Possession offences attract a maximum of 50 penalty units fine under Section 23 (possessing implement for use) and 50 penalty units fine of maximum of 2 years of imprisonment for possessing, using or administering a controlled drug under Section 24. Sale or supply of a controlled drug less than the trafficable amount attracts a penalty of 100 penalty units fine or imprisonment for a term of 4 years maximum (Section 26).

Indictable Offences

The major indictable drug offences are contained within Part Two of the legislation. These offences also pertain to controlled drugs which are listed in Part 2 of Schedule 1. Methamphetamine is a controlled drug under the Schedule. The relevant offences include:

- ◆ Manufacturing a controlled drug for sale (Section 6)
- ◆ Possessing an implement for use in manufacture of a controlled substance for sale (Section 8)
- ◆ Manufacturing a controlled precursor intended for use in manufacture of controlled drugs for sale (Section 10)
- ◆ Trafficking in controlled substances (Section 12)
- ◆ Procuring a child to traffic in a controlled substance (Section 13)
- ◆ Supplying a controlled drug to a child (Section 14)

The trafficking offences attract a maximum penalty of 21 years. A trafficable quantity for the purposes of the offence is for methamphetamine in pure or admixture form is 25 grams or 20 individual packages of the drug.¹⁹⁴³ If it is proved under Section 12 that the accused:

- (a) prepared a trafficable quantity of a controlled substance for supply; or
- (b) transported a trafficable quantity of a controlled substance; or
- (c) guarded or concealed a trafficable quantity of a controlled substance; or
- (d) possessed a trafficable quantity of a controlled substance; or
- (e) imported a trafficable quantity of a controlled substance into Tasmania –

it is presumed, unless the accused on the balance of probabilities proves otherwise, that the accused had the relevant intention or belief concerning the sale of the controlled substance required to constitute the offence.

Procuring a child to traffic a controlled drug or supplying a controlled drug to a child will also attract penalties of 21 years maximum imprisonment.

Amendments to the *Misuse of Drugs Act 2001* (Misuse of Drugs Order 2011) have increased the number of controlled drugs and precursors under the Act's schedule to better align with current legislation in other Australian states and territories.

¹⁹⁴² A trafficable quantity for the purposes of the offence is for methamphetamine in pure or admixture form is 25 grams or 20 individual packages of the drug. See discussion of indictable offences below.

¹⁹⁴³ Schedule 1, Part 2. *Misuse of Drugs Act 2001*.

An *aggregated trafficable quantity* formula will apply when two or more controlled substances are contained within the same quantity. See Section 3A(2).

Australian Capital Territory — Drugs of Dependence Act 1989 and Criminal Code 2002

The offences associated with methamphetamine and other drug use, supply, traffick or manufacture in the Australian Capital Territory are to be found in Part Ten of the *Drugs of Dependence Act* read in conjunction with the Drugs of Dependence Regulations and the Part 6.1 of the ACT Criminal Code 2002.¹⁹⁴⁴

Offences under the Drugs of Dependence Act

Under this Act the legislation divides drugs into drugs of dependence and prohibited substances. Methamphetamine fall in the former categories with most other party drugs belonging in the latter group.

The sale or supply of a drug of dependence, which under Schedule One of the Regulations includes amphetamine and methamphetamine, is an offence under Section 164 as follows:

A person shall not—

- (a) sell or supply a drug of dependence to any person;
- (b) participate in the sale or supply of a drug of dependence to any person; or
- (c) possess a drug of dependence for the purpose of sale or supply to any person.

The maximum penalty applicable for an offence against this section is 500 penalty units fine and/or five years maximum imprisonment.

Possession and administration offences for non-trafficable amounts of drugs of dependence are covered under Section 169 and generally attract a penalty of 50 penalty units fine, 2 years' imprisonment or both, with the exception of cannabis which attracts a lesser penalty.

Offences under the Criminal Code 2002

The Criminal Code contains the more serious offences applicable to drug trafficking, manufacturing and sale.

Trafficking

Trafficking offences for methamphetamine and related drugs is found in the Criminal Code 2002. Under Section 602 a person traffics in a controlled drug if the person—

- (a) sells the drug; or
- (b) prepares the drug for supply—
 - (i) with the intention of selling any of it; or
 - (ii) believing that someone else intends to sell any of it; or
- (c) transports the drug—
 - (i) with the intention of selling any of it; or
 - (ii) believing that someone else intends to sell any of it; or
- (d) guards or conceals the drug with the intention of—
 - (i) selling any of it; or
 - (ii) helping someone else to sell any of it; or
- (e) possesses the drug with the intention of selling any of it.

¹⁹⁴⁴ See Commonwealth Criminal Code.

Under Section 603 a person commits an offence of trafficking in a controlled drug if the person traffics in a *large commercial quantity* of a controlled drug. The maximum penalty is imprisonment for life.

A person also commits an offence if the person traffics in a *commercial quantity* of a controlled drug. The maximum penalty is 2500 penalty units, imprisonment for 25 years or both. The lesser offence is where the person traffics in a controlled drug other than cannabis which is not a commercial or large commercial quantity. The maximum penalty in this case is 1000 penalty units, imprisonment for 10 years or both.

Under Section 604 a presumption applies in a prosecution for an offence against section 603, if it is proven that the defendant—

- (a) prepared a trafficable quantity of a controlled drug for supply; or
- (b) transported a trafficable quantity of a controlled drug; or
- (c) guarded or concealed a trafficable quantity of a controlled drug; or
- (d) possessed a trafficable quantity of a controlled drug;

it is presumed, unless the contrary is proved, that the defendant had the intention or belief about the sale of the drug required for the offence and the defendant bears the onus to prove otherwise.

Commercial, large commercial and trafficable quantities of controlled drugs including methamphetamine are prescribed by the regulations.¹⁹⁴⁵

Manufacturing offences

Under Section 607 of the Criminal Code a variety of manufacturing offences apply. These include:

- ◆ Manufacturing a controlled drug for selling (Large commercial quantity)
 - (1) A person commits an offence if the person manufactures a large commercial quantity of a controlled drug—
 - (a) with the intention of selling any of it; or
 - (b) believing that someone else intends to sell any of it.

The maximum penalty is imprisonment for life.

- ◆ Manufacturing a controlled drug for selling (commercial quantity)
 - (3) A person commits an offence if the person manufactures a commercial quantity of a controlled drug—
 - (a) with the intention of selling any of it; or
 - (b) believing that someone else intends to sell any of it.

The maximum penalty is 2,500 penalty units, imprisonment for 25 years or both.

- ◆ Manufacturing a controlled drug for selling (non large commercial or non commercial quantity)
 - (5) A person commits an offence if the person manufactures a controlled drug—
 - (a) with the intention of selling any of it; or
 - (b) believing that someone else intends to sell any of it.

¹⁹⁴⁵ See *Criminal Code Regulations* 2005.

The maximum penalty is 1,500 penalty units, imprisonment for 15 years or both.

Under Section 608 there is a presumption that if in a prosecution for an offence against section 607 it is proved that the defendant manufactured a trafficable quantity of a controlled drug, that unless the contrary is proved, the defendant had the intention or belief about the sale of the drug required for the offence.

Under Section 609 a person commits an offence if the person manufactures a controlled drug (less than a trafficable, commercial or large commercial quantity).

This offence attracts a maximum penalty of 1,000 penalty units, imprisonment for 10 years or both.

Northern Territory — Misuse of Drugs Act

In the Northern Territory most illicit drugs are classified as *dangerous drugs*. Dangerous drugs are listed in a variety of schedules to the Act. Schedule 1 contains major drugs and drug groups including methamphetamine.

Possession

Possession of dangerous drugs is covered in Section 9 of the Act. For Schedule One drugs such as methamphetamine, a commercial quantity (40 grams) attracts 25 years' maximum imprisonment. Possession of a trafficable quantity (2 grams) attracts a penalty of 14 years maximum imprisonment if the person is found in possession of it in a public place and 7 years maximum imprisonment in other circumstances. The Northern Territory also distinguishes between possession in a *public* and *private* place for those amounts which are less than trafficable. Possession in a public place of less than a trafficable quantity may result in 85 penalty units or 5 years maximum imprisonment. Possession in a non-public place attracts a fine of 40 penalty units or a maximum of 2 years imprisonment.

Supply

Supply is covered under Section 5 of the Act as follows:

- (1) A person who unlawfully supplies, or takes part in the supply of, a dangerous drug to another person, whether or not –
 - (a) that other person is in the Territory; and
 - (b) where the dangerous drug is supplied to a person at a place outside the Territory, the supply of that dangerous drug to the person constitutes an offence in that place, is guilty of a crime.
- (2) A person guilty of a crime under subsection (1) is, punishable on being found guilty by a penalty not exceeding:
 - (a) Where the amount of the dangerous drug supplied is *not* a commercial quantity –
 - (i) where the dangerous drug is a dangerous drug specified in Schedule 1, the offender is an adult and the person to whom it is supplied is a child — maximum imprisonment for life; and
 - (iv) where the dangerous drug is a dangerous drug specified in Schedule 1 and subparagraph (i) does not apply — maximum imprisonment for 14 years.
 - (b) Where the amount of the dangerous drug supplied is a *commercial quantity* –
 - (ii) where the dangerous drug is a dangerous drug specified in Schedule 1, the offender is an adult and the person to whom it is supplied is a child — imprisonment for life and

- (iii) in any other case where the dangerous drug is a dangerous drug specified in Schedule 1 — imprisonment for 25 years.

Manufacture

Provisions against the illicit manufacture and production of dangerous drugs are listed in Section 8 of the Act. For Schedule One drugs, production of a commercial quantity may result in a maximum sentence of life imprisonment. Production of a non-commercial quantity attracts a maximum penalty of 25 years imprisonment. Manufacture is interpreted to include the extraction and the refinement of the drug under Section Three of the Act.

Miscellaneous provisions apply for the possession of precursors of dangerous drugs¹⁹⁴⁶, possession of documents containing instructions for manufacture of dangerous drugs or precursors¹⁹⁴⁷, possessions of manufacturing equipment¹⁹⁴⁸ and possession of implements for administering drugs including ice pipes¹⁹⁴⁹ and supplying precursors knowing they are intended to be used in the manufacture or production of dangerous drugs.¹⁹⁵⁰

1946 Section 8A.

1947 Section 8B.

1948 Section 8C.

1949 Section 12.

1950 Section 8D.

Appendix 12: Audit of Illicit Drug Training Modules

Audience	Mode of Delivery	Content of Modules
Recruits & Probationary Constable (Foundation Training)	Face to face (classroom environment)	<p><u>Drugs</u>: Centre for Law and Operational Development Week 5: definitions, powers of arrest, search, disposal, diversion programs</p> <p><u>Drugs and Harm Minimisation</u>: Centre for Law and Operational Development Week 5: Harm minimisation – supply reduction, demand reduction, harm reduction</p> <p><u>Behavioural Warning Signs</u>: Centre for Operational Safety Week 1: Defensive Tactics Introduction</p>
Protective Service Officers (Foundation Training)	Face to face (classroom environment)	<p><u>Drugs</u>: Centre for Law and Operational Development Week 6: definitions, powers of arrest, search, disposal, diversion programs</p> <p><u>Drugs and Harm Minimisation</u>: Centre for Law and Operational Development Week 6: Harm minimisation – supply, demand and harm</p> <p><u>Behavioural Warning Signs</u>: Centre for Operational Safety Week 1: Defensive Tactics Introduction</p>
Available to all Police Members	E-learning – available via Victoria Police Learning Hub	<p>Drug and Alcohol:</p> <ul style="list-style-type: none"> Drug classification and spectrum Drug overdose Managing drug affected people Human rights principles Signs and symptoms Harm minimisation strategies <u>Diversion</u>: (Max. 5 hour) Understanding diversion programs Diversion eligibility Scenarios and process

Source: Victoria Police 2014

Appendix 13: Ice forum flyer example

Ice, and the Impact on Families

Community forum to develop strategies for local families to find support in dealing with addiction.

7:30pm

Thursday, February 21st, 2013.

Moorabool Shire Town Hall.

Main St, Bacchus Marsh.

Guest speakers:

- Heather Pickard – CEO – Self Help Addiction Resource Centre (SHARC)
- Rosie Cluett – Senior Clinician – SHARC
- S C Jim Ross - Youth Resource Officer – Bacchus Marsh police

A light supper will be served.

For catering purposes, please RSVP to John - 9573 1784, or Jim – 0437 981 316.

An on-going family support group will be established following the forum.



FDH is a program of sharc

blah

Bibliography

- Aboriginal and Torres Strait Islander Healing Foundation 2012a, *Healing Centres, Final Report*. Accessed at <http://healingfoundation.org.au>
- Aboriginal and Torres Strait Islander Healing Foundation 2012b, Why Aboriginal and Torres Strait Islander healing services are a good investment for business and industry. Accessed at <http://healingfoundation.org.au>
- ACT Government 2010, *Alcohol, Tobacco and Other Drug Strategy 2010–2014*, ACT Government, Canberra.
- Akram, G & Forsyth, AJM 2000, 'Speed freaks? A literature review detailing the nature and prevalence of dance drugs and driving', *International Journal of Drug Policy*, vol. 11, pp. 265–277.
- Alberti, S, King, J, Hales, J & Swan A 2004, *Court Diversion Program Evaluation: Overview Report: Final Report: Vol. 1*, Turning Point Alcohol and Drug Centre Inc in collaboration with Health Outcomes International Pty Ltd.
- Alcohol and other Drugs Council of Australia (ADCA) 2003, *ADCA policy positions — Prevention*, September, ADCA, Canberra.
- Ali, R, Marsden, J, Srisurapanont, M, Sunga, A, Baigent, M and Monteiro, M 2010, 'Methamphetamine psychosis in Australia, Philippines, and Thailand: Recommendations for acute care and clinical inpatient management', *Addictive Disorders & Their Treatment*, vol. 9, no. 4, pp. 143–149.
- Ali, R, Meena, S & Gowing, L 2012, 'Effective responses in general health and other mainstream services', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 173–189.
- Allen, C 2012, 'The impact of amphetamine-type stimulants on operational policing: a personal choice for which everyone pays', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 137–141.
- Allsop, S 2012, 'Prevention and public health approaches to amphetamine-type stimulant use and related harm', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 173–189.
- Allsop, S & Lee, N (eds.) 2012, *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic.
- American Psychiatric Association, 2013, *Diagnostic and statistical manual of mental disorders*, 5th edn., American Psychiatric Publishing, Arlington, VA.
- Anex 2014, 'A Community Response to Ice', A Report to the Department of Justice Stakeholder Workshop, Grampians Region, April 2014.
- Anglin, M, Burke, C, Perrochet, B, Stamper, E & Dawud-Noursi, S 2000 'History of the methamphetamine problem', *Journal of Psychoactive Drugs*, vol. 32, no. 2, pp. 137–141.
- Armstrong, J & Guthrie, K 2012 'The impact of amphetamine-type stimulant use on emergency department services', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 149–153.
- Attorney-General's Department (AGD) 2007, *Submission of the Criminal Justice Division to the Productivity Commission's Study into Chemicals and Plastics Regulation*, AGD, Canberra. <http://www.pc.gov.au/projects/study/chemicals-plastics/docs/submissions>.

- Attorney-General's Department, *Criminal Justice Division Submission to the Productivity Commission's Study into Chemicals and Plastics Regulation*, Attorney-General's Department, Canberra, accessed 23 July 2014 www.pc.gov.au/___data/assets/pdf_file/0011/69356/sub032.pdf.
- Attorney-General's Department (AGD) 2010a, *Commonwealth Organised Crime Strategic Framework*, AGD, Canberra. <http://www.ag.gov.au/CrimeAndCorruption/OrganisedCrime/Pages/default.aspx>.
- Attorney-General's Department (AGD) 2010b, *National Organised Crime Response Plan 2010-13: A National Response to a National Issue*, AGD, Canberra. <http://www.ag.gov.au/CrimeAndCorruption/OrganisedCrime/Pages/default.aspx>.
- Attorney-General's Department (AGD) 2011, *Clandestine Drug Laboratory Remediation Guidelines*, AGD, Canberra. <http://www.ag.gov.au/CrimeAndCorruption/Drugs/Documents/Clandestinedruglaboratoryremediationguidelines.pdf>.
- Attorney-General's Department (AGD) 2013, *Annual Report 2012-13*, AGD, Canberra. <http://www.ag.gov.au/Publications/AnnualReports/Annualreport2012-13/Pages/default.aspx#pdfversion>.
- Australian Commission for Law Enforcement Integrity (ACLEI) 2013, *Annual Report of the Integrity Commissioner*, ACLEI, Canberra. <http://www.aclei.gov.au/Documents/AnnualReportoftheIntegrityCommissioner2012-13.doc>.
- Australian Crime Commission (ACC) 2009, *Inquiry into the Adequacy of aviation and maritime security measures to combat serious and organised crime*, Submission to the Parliamentary Joint Committee on the Australian Crime Commission, ACC, Canberra. <https://senate.aph.gov.au/submissions/comitees/viewdocument.aspx?id=6d82d123-be72-4f1f-b45b-f28fb40086a3>
- Australian Crime Commission (ACC) 2013a, *Australian Illicit Drug Report 2011–2012*, ACC, Canberra.
- Australian Crime Commission (ACC) 2013b, *Organised Crime in Australia*, ACC, Canberra, accessed 5 June 2014 at <http://www.crimecommission.gov.au/sites/default/files/files/ACC%20OCA%202013.pdf>.
- Australian Crime Commission 2013c (ACC), 'Amphetamine-type stimulants', *Crime Profile Series*, ACC, Canberra, accessed 5 June 2014 at <http://www.crimecommission.gov.au/sites/default/files/files/FACT%20SHEETS%20JULY%202013/AMPHETAMINE%20TYPE%20STIMULANTS%20JULY%202013.pdf>.
- Australian Crime Commission (ACC) 2013d, 'Clandestine laboratories and precursors', *Crime Profile Series*, ACC, Canberra. <https://www.crimecommission.gov.au/organised-crime/crime-types/illicit-drugs/>
- Australian Crime Commission (ACC) 2013e, *Outlaw Motorcycle Gangs Fact Sheet*, ACC, Canberra. <http://www.crimecommission.gov.au/sites/default/files/OUTLAW%20MOTORCYCLE%20GANGS%20JULY%202013.pdf>
- Australian Crime Commission (ACC) 2013f, *Crime in the maritime sector*, ACC, Canberra. <https://www.crimecommission.gov.au/sites/default/files/CRIME%20IN%20THE%20MARITIME%20SECTOR%20JULY%202013.pdf>.
- Australian Crime Commission (ACC) 2014a, *Illicit Drug Data Report 2012-2013*, ACC, Canberra, accessed 5 June 2014 at <https://www.crimecommission.gov.au/sites/default/files/290414-IDDR-2012-13.pdf>.
- Australian Crime Commission (ACC) 2014b, 'Task Force Eligo generates more than \$580 million in cash, drugs and assets', *Media Release*, 23 January, ACC, Canberra. <https://www.crimecommission.gov.au/media-centre/release/australian-crime-commission-joint-media-release/task-force-eligo-generates-more>.

- Australian Crime Commission (ACC) 2014c, *Eligo National Task Force*, ACC website. <https://www.crimecommission.gov.au/organised-crime/joint-task-forces-and-initiatives/eligo-national-task-force>.
- Australian Customs and Border Protection Service 2012, *2011-2012 Annual Report*. ACBPS, Canberra, accessed 5 June 2014 at <http://www.customs.gov.au/webdata/resources/files/annualreport2011-12.pdf>.
- Australian Customs and Border Protection Service (ACBPS) 2013, *Annual Report 2012-13*, ACBPS, Canberra, accessed 5 June 2014 at <http://www.customs.gov.au/webdata/resources/files/ACBPSAnnualReport2012-13.pdf>.
- Australian Customs and Border Protection Service (ACBPS) 2014, 'About us', ACBPS website. <http://www.customs.gov.au/site/page4222.asp>.
- Australian Drug Foundation (ADF) 2012, *Policy Talk — Workplace Drug Testing*, ADF. Online at http://www.adf.org.au/attachments/518_PolicyTalkWorkplaceDrugTesting.pdf.
- Australian Federal Police (AFP) 2010, *Operational Priorities*, AFP, Canberra. <http://www.afp.gov.au/about-the-afp/operational-priorities.aspx>.
- Australian Federal Police (AFP) 2011, *Annual Report 2010-11*, AFP, Canberra. <http://www.afp.gov.au/media-centre/publications/~media/afp/pdf/a/assumed-identities-annual-report-2010-2011.ashx>
- Australian Federal Police (AFP) 2013, *Annual Report 2012-2013*. AFP, Canberra. <http://www.afp.gov.au/media-centre/publications/annual-reports.aspx>.
- Australian Federal Police (AFP) 2014, *Australian Illicit Drug Data Centre*, AFP, Canberra. <http://www.afp.gov.au/what-we-do/operational-support/aiddc.aspx>.
- Australian Government 2013, *Australian Government Response to the Parliamentary Joint Committee on Law Enforcement Inquiry into Commonwealth Unexplained Wealth Legislation and Arrangements*, Commonwealth of Australia, Canberra. http://www.aph.gov.au/~media/wopapub/senate/committee/le_ctte/completed_inquiries/2010_13/unexplained_wealth/govt%20response_pdf.ashx
- Australian Institute of Health and Welfare 2008, *National Drug Strategy Household Survey – Detailed findings*, Drug statistics series no 22, Cat no PHE107, AIHW, Canberra.
- Australian Institute of Health and Welfare 2010, *National Drug Strategy Household Survey Report*, AIHW, Canberra, accessed 5 June 2014 at <http://tobacco.health.usyd.edu.au/assets/pdfs/2010-NDSHS-Report.pdf>.
- Australian Institute of Health and Welfare 2011, *National Drug Strategy Household Survey Report 2010*, AIHW, Canberra, accessed 5 June 2014 at <http://tobacco.health.usyd.edu.au/assets/pdfs/2010-NDSHS-Report.pdf>.
- Australian Institute of Health and Welfare 2010, *The health of Australia's prisoners 2009*, AIHW, Canberra. Accessed at: <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442459982>
- Australian Institute of Health and Welfare 2013b, *The health of Australia's prisoners 2012*. AIHW, Canberra, accessed 5 June 2014 at <https://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129543945>.
- Australian Institute of Health and Welfare (AIHW), 2013c, *Alcohol and other drug treatment services in Australia*, Drug treatment series 21, Cat. no. HSE139 2011-12, AIHW, Canberra.
- Australian Institute of Health and Welfare 2014, *National Drug Strategy Household Survey Report 2013, data and references*, AIHW website. <http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs/2013/data-and-references/>.
- Australian National Council on Drugs (ANCD) 2001, *Structural determinants of youth drug use*, A report prepared by National Drug and Alcohol Research Centre, UNSW in collaboration with Spooner, C, Hall, W & Lynskey, M, ANCD Research Paper 2.

- Australian National Council on Drugs (ANCD) 2011, *Injecting Drug Use and Associated Harms among Aboriginal Australians*, ANCD, Canberra.
- Australian Psychological Society (APS) 2010, *Evidence-based Psychological Interventions in the Treatment of Mental Disorders*, 3rd edn, Australian Psychological Society.
- Australian Sport Anti-Doping Authority (ASADA) 2007/8–20012/1320 Annual Reports, ASADA.
- Australian Transaction Reports and Analysis Centre (AUSTRAC) 2009, *AUSTRAC Overview*, Commonwealth of Australia, Canberra. http://www.austrac.gov.au/about_austrac.html.
- Australian Transaction Reports and Analysis Centre (AUSTRAC) 2011, *Typologies and Case Studies Report 2011*, AUSTRAC, Canberra. http://www.austrac.gov.au/files/typ11_full.pdf.
- Australian Transaction Reports and Analysis Centre (AUSTRAC) 2012, *Typologies and Case Studies Report 2012*, AUSTRAC, Canberra. http://www.austrac.gov.au/files/typ12_full.pdf
- Australian Transaction Reports and Analysis Centre (AUSTRAC) 2013, *Typologies and Case Studies Report 2013*, AUSTRAC, Canberra. http://www.austrac.gov.au/files/typ13_full.pdf.
- Ayling, J 2009, 'Criminal organisations and resilience', *International Journal of Law, Crime and Justice*, vol. 37, no. 4, pp. 182–96.
- Ayling, J 2011, 'Pre-emptive strike: how Australia is tackling outlaw motorcycle gangs', *American Journal of Criminal Justice*, vol. 36, no. 3, pp. 250–64.
- Ayling, J 2014, "'Going Dutch"? Comparing approaches to preventing organised crime in Australia and the Netherlands', *The European Review of Organised Crime*, vol. 1, no. 1, pp. 78–107. <http://sgocnet.org/site/wp-content/uploads/2014/06/EROCC115.pdf>.
- Ayling, J & Broadhurst, R 2013, *Organized Crime Control in Australia and New Zealand* in Paoli, L (ed.), *Oxford Handbook of Organized Crime*, Oxford University Press, Oxford.
- Ayling, J 2014, "'Going Dutch"? Comparing approaches to preventing organised crime in Australia and the Netherlands', *The European Review of Organised Crime*, vol. 1, no. 1, pp. 78–107. <http://sgocnet.org/site/wp-content/uploads/2014/06/EROCC115.pdf>
- Babor, T, Caetano, R, Casswell, S, Edwards, G, Giesebrecht, N, Graham, K, Grube, J, Gruenewald, P, Hill, L, Holder, H, Homel, R, Osterberg, E, Rehm, J, Room, R & Rossow, I 2004, *Alcohol: No ordinary commodity — Research and public policy*, Oxford University Press, Oxford.
- Babor, TF, McRee, BG, Kassebaum, PA, Grimaldi, PL, Ahmed, K & Bray, J 2007, 'Screening, Brief Intervention, and Referral to Treatment (SBIRT): Toward a public health approach to the management of substance abuse', *Substance Abuse*, vol. 28, no. 3, pp. 7–30.
- Baker, A & Lee, N 2003, 'A review of psychosocial interventions for amphetamine use', *Drug and Alcohol Review*, vol. 22, no. 3, pp. 323–335.
- Baker, A, Kay-Lambkin, F, Lee, N, Claire, M & Jenner, L 2003, *A brief cognitive behavioural intervention for regular amphetamine users*, The Australian Government Department of Health and Ageing, Canberra.
- Baker, A, Lee, N, Claire, M, Lewin, T, Grant, T, Pohlman, S, Saunders, J, Kay-Lambkin, F, Constable, P, Jenner, L & Carr, V, 2004, 'Drug use patterns and mental health of regular amphetamine users during a reported 'heroin drought,' *Addiction*, vol. 99, no. 7, pp. 875–884.
- Baker, A, Lee, N, Claire, M, Lewin, T, Grant, T, Pohlman, S, Saunders, J, Kay-Lambkin, F, Constable, P, Jenner, L & Carr, V 2005, 'Brief cognitive behavioural interventions for regular amphetamine users: A step in the right direction', *Addiction*, vol. 100, no. 3, pp. 367–378.
- Baker, A, Kay-Lambkin, F, deVillie, M, McKetin, R & N. Lee, N 2012, 'Stepped-care approaches for amphetamine-type stimulant problems', in A Allsop & N Lee (eds.), *Perspectives on Amphetamine-type Stimulants*, IP Communications, East Hawthorn, Melbourne, pp. 329–341.
- Baker, R & McKenzie, N 2013, 'Ice use devastating rural Victoria', *Age (Melbourne)*, 29 August, accessed 5 June 2014 at <<http://www.theage.com.au/victoria/ice-use-devastating-rural-victoria-20130829-2stc7.html>>

- Baldock, MRJ & Woolley, JE 2013, 'Reviews of the effectiveness of random drug testing in Australia: the absence of crash-based evaluations', *Proceedings of the 2013 Australasian Road Safety Research, Policing & Education Conference — Peer Review Stream*, 28–30 August, Brisbane, Australia.
- Bariola E & White V 2012a, *Australian secondary school student's use of tobacco, alcohol, and over-the-counter and illicit substances in 2011*, Centre of Behavioural Research in Cancer, Cancer Council Victoria, accessed 5 June 2014 at [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/BCBF6B2C638E1202CA257ACD0020E35C/\\$File/National%20Report_FINAL_ASSAD_7.12.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/BCBF6B2C638E1202CA257ACD0020E35C/$File/National%20Report_FINAL_ASSAD_7.12.pdf).
- Bariola, E & White, V 2012b, *Victorian secondary school students' use of licit and illicit substances in 2011: Results from Australian Secondary Students' Alcohol and Drug (ASSAD) Survey*, Centre of Behavioural Research in Cancer, Cancer Council Victoria, Melbourne, Vic, accessed 5 June 2014 at [http://docs.health.vic.gov.au/docs/doc/A5FADAF7819F3BE7CA257B96001CDD3B/\\$FILE/ASSAD%20Victorian%20report%202011lx.pdf](http://docs.health.vic.gov.au/docs/doc/A5FADAF7819F3BE7CA257B96001CDD3B/$FILE/ASSAD%20Victorian%20report%202011lx.pdf).
- Barratt, MJ, Ferris, JA & Winstock, AR 2013, 'Use of Silk Road, the online drug marketplace, in the United Kingdom, Australia and the United States', *Addiction Research Report*, vol. 109, no. 5, pp. 774–783.
- Bartels, L 2010, 'The status of laws on outlaw motorcycle gangs in Australia', *Research in Practice* no. 2, 2nd ed., Australian Institute of Criminology, Canberra.
- Baskin-Sommers, A & Sommers, I 2006, 'Methamphetamine use and violence among young adults', *Journal of Criminal Justice*, vol. 34, no. 6, pp. 661–674.
- Bassett, L 2007, *Restorative justice: Background and discussion paper*, Neighbourhood Justice Centre Project Team, Collingwood, Victoria.
- Bell, D 1973, 'The experimental reproduction of amphetamine psychosis', *Archives of General Psychiatry*, vol. 29, no. 1, pp. 35–40.
- Bempechat, J & Shernoff, DJ 2012. 'Parental influences on achievement motivation and student engagement', in SL Christenson, AL Reschley, & C Wylie (eds.), *The Handbook of Research on Student Engagement*, New York, Springer Science, pp. 315–342.
- Berman, G & Feinblatt, J 2001, 'Problem solving courts: A brief primer', *Law and Policy*, no. 23, pp.125–141.
- Berry, J, Pidd, K, Roche, A & Harrison J 2007, 'Prevalence and patterns of alcohol use in the Australian workforce: Findings from the 2001 National Drug Strategy Household Survey', *Addiction*, vol. 102, no. 9, pp. 1399–1410.
- Berry, S & Crowe, T 2009, 'A review of engagement of Indigenous Australians within mental health and substance abuse services', *Advances in Mental Health*, vol. 8, no. 1, pp. 16–27.
- Berthelsen, D & Walker, S 2008, 'Parents' involvement in their children's education', *Family Matters*, no.79, 34–41.
- Besser, L & McKenzie, N 2009, 'Crime gangs infest ports', *Sydney Morning Herald*, 25 June. <http://www.smh.com.au/national/crime-gangs-infest-ports-20090624-cwxd.html>
- Birgden, A & Grant, L 2010, 'Establishing a compulsory drug treatment prison: Therapeutic policy, principles, and practices in addressing offender rights and rehabilitation', *Int Journal of Law Psychiatry*, Nov-Dec, vol. 33, no. 5-6, pp. 341–349.
- Black's Law Dictionary* 2009, Ninth edn., Bryan A Garner, Editor in Chief, West Group Publishing, St Paul.
- Block, LG, Morwitz, VG, Putsis, WP & Sen SK 2002, 'Assessing the impact of antidrug advertising on adolescent drug consumption: results from a behavioural economic model', *Am J Public Health*, vol. 92, pp. 1346–1351.
- Boorman, MC, *Random drug testing of drivers in Victoria*, Accessed at <http://acrs.org.au>

- Boorman, M & Owens, KP 2009, 'The Victorian Legislative Framework for the Random Testing of Drivers at the Roadside for the Presence of Illicit-Drugs: An evaluation of the characteristics of drivers detected from 2004 to 2006', *Traffic Injury Prevention*, vol. 10, no. 1, pp.16–22.
- Bramness, J, Gundersen, H, Guterstam, J, Rognli, E, Konstenius, M, Loberg, E, Medhus, S, Tanum, L & Franck, J 2012, 'Amphetamine-induced psychosis-a separate diagnostic entity or primary psychosis triggered in the vulnerable?' *BMC Psychiatry*, vol. 12, no. 1, p. 221, accessed 3 June 2014 at <<http://www.biomedcentral.com/content/pdf/1471-244X-12-221.pdf>>.
- Brecht, M, O'Brien, A, von Mayrhauser, C & Anglin, M 2004, 'Methamphetamine use behaviors and gender differences', *Addictive Behaviors*, vol. 29, no. 2, pp. 89–106.
- Brecht, ML & Herberk, DM 2013, 'Methamphetamine use and violent behaviour: User perceptions and predictors', *Journal of Drug Issues*, vol. 43, no. 4, pp. 1-15. <http://jod.sagepub.com/content/early/2013/06/14/0022042613491098.full.pdf>.
- Breen, C, Degenhardt, L & Roxborough, A 2002, *IDRS Drug Trends Bulletin*, National Drug and Alcohol Research Centre, University of New South Wales, Sydney.
- Brensilver, M, Johnson, V, Grotheer, A, Heinzerling, K, Bholat, M & Shoptaw, S 2012, 'Pharmacotherapy of amphetamine-type stimulants', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 149–153.
- Bricker, J, Wyszynski, C, Comstock, B, & Heffner, JL 2013, 'Pilot randomized controlled trial of web-based acceptance and commitment therapy for smoking cessation', *Nicotine & Tobacco Research*, vol. 15, no. 10, pp. 1756–1764.
- Brown, D 2013, 'Justice reinvestment: The circuit breaker?', *Insight*, Issue 8, pp. 36–38.
- Brown, RA, Palm, KM, Strong, DR, Lejuez, CW, Kahler, CW, Zvolensky, MJ, Hayes, SC, Wilson, KG & Gifford, EV 2008, 'Development of an exposure- and ACT-based distress tolerance treatment for early lapse smokers: Rationale, program description, and preliminary findings', *Behavior Modification*, vol. 32, pp.302–332.
- Brown VA, Manderson D, O'Callaghan M & Thompson R 1986, *Our Daily Fix: Drugs in Australia*, Australian University Press.
- Bruun, A, Ennis, D, Wansborough, H, Green, R, & Mitchell, P 2012, 'Treatment and care for young amphetamine-type stimulant users', in S Allsop & N Lee (eds.), *Perspectives on Amphetamine-Type Stimulants*, IP Communications, East Hawthorn, pp. 277–293.
- Buchacz, K, McFarland, W, Kellogg, TA, Loeb, L 2005, 'Amphetamine use is associated with increased HIV incidence among men who have sex with men in San Francisco', *AIDS*, vol. 19: pp. 2075–2079.
- Bull, D, Edmonds, C, Frei, M, Gill, T, Navathe, P, & Plumley, N 2010, *Problematic alcohol and other drug use in the Australian aviation sector: Comprehensive assessment guidelines*, Civil Aviation Safety Authority, Canberra.
- Bundick, MJ 2011, 'Extracurricular activities, positive youth development, and the role of meaningfulness of engagement', *The Journal of Positive Psychology*, vol. 6, no. 1, pp. 57–74.
- Bureau of Justice Assistance (USA) 2004, *Defining Drug Courts — The Key Components*, Drug Courts Resource Series, BJA, Washington DC.
- Burrows D, Flaherty, B & MacAvoy, M (eds.) 1993, *Illicit psychostimulant use in Australia*, Commonwealth Department of Housing and Community Services and Drug and Alcohol Directorate, New South Wales Health Department, Australian Government Printing Service, Canberra.
- Butler, T & Papanastasiou, C 2008, *National prison entrants' bloodborne virus and risk behaviour survey report 2004-2007*, Curtin University, Perth.
- Cahill, H 2005, *Taking an Evidence Based Approach to Classroom Drug Education*, Victorian Department of Education and Training, Melbourne.

- Cahill, K, Stevens, S, Perera, R & Lancaster, T 2013, 'Pharmacological interventions for smoking cessation: an overview and network meta-analysis', *Cochrane Database Syst Rev*, vol. 5, no. 5.
- Caldicott, D, Pigou, PE, Beattie, R & Edwards, JW 2005, 'Clandestine drug laboratories in Australia and the potential for harm', *Australian and New Zealand Journal of Public Health*, vol. 29, no. 2, pp. 155-62.
- Caldwell, LL & Smith, EA 2006, 'Leisure as a context for youth development and delinquency prevention', *Australian and New Zealand Journal of Criminology*, vol. 39, no. 3, pp.398-418.
- Canfield, D, Hordinsky, J, Millett, D, Endecott B & Smith, D 2000, *Prevalence of Drugs and Alcohol in Fatal Civil Aviation Accidents between 1994 and 1998, Final Report*, Federal Aviation Administration, US Department of Transportation, Washington DC.
- Carlyon, P 2013, 'Anti-fortification bill gives bikies "nowhere to hide"', ABC News Online, 17 April. <http://www.abc.net.au/news/2013-04-17/legislation-introduced-to-remove-bikie-gang-fortifications/4634470>.
- Carrico, AW, Flentje, A, Gruber, VA, Woods, WJ, Discepola, MV, Dilworth, SE, et al. 2014, 'Community-based harm reduction substance abuse treatment with methamphetamine-using men who have sex with men', *Journal of urban health*, Bulletin of the New York Academy of Medicine.
- Carson, D, Hermens, D, Guastella, A, Bosanquet, D & McGregor, I 2012, 'Neurocognitive effects of amphetamine-type stimulants and implications for intervention', in Allsop S, Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 33-55.
- Cartier, J, Farabee, D & Prendergast, M 2006, 'Methamphetamine use, self-reported violent crime, and recidivism among offenders in California who abuse substances', *Journal of interpersonal violence*, vol. 21, no. 4, pp. 435-445.
- Caruana, C 2010, 'Healing services for Indigenous people', *Family Relationships Quarterly No. 17*, Australian Institute of Family Studies (AIFS), Child Family Community Australia.
- Center for Tobacco Research and Intervention 2003, *How Smokers are quitting: Action*, paper number 3, University of Wisconsin Medical School.
- Chalmers, J, Bradford, D & Jones, C 2010, 'The effect of methamphetamine and heroin price on polydrug use: A behavioural economics analysis in Sydney, Australia', *International Journal of Drug Policy*, vol. 21, pp.381-389.
- Chen, CK, Lin, SK, Sham, PC, Ball, D 2005, 'Morbid risk for psychiatric disorder among the relatives of methamphetamine users with and without psychosis', *American Journal of Medical Genetics, Part B — Neuropsychiatric genetics*, vol. 136B, no. 1, pp. 87-91.
- Cherney, A, O'Reilly, J & Grabosky, P 2005, *The governance of illicit synthetic drugs*, National Drug Law Enforcement Research Fund, Commonwealth of Australia, Canberra.
- Chesher, G 1993, 'Pharmacology of the sympathomimetic psychostimulants', in D Burrows, B Flaherty & M MacAvoy (eds.), *Illicit psychostimulant use in Australia*, Commonwealth Department of Housing and Community Services and Drug and Alcohol Directorate, New South Wales Health Department. Australian Government Printing Service, Canberra, pp. 9-30.
- Choo, K-KR & Smith, RG 2008, 'Criminal exploitation of online systems by organised crime groups', *Asian Criminology*, vol. 3, pp. 37-59.
- Churchill, A 1991, 'An investigation of amphetamine dependence', in *1991 Autumn School of Studies on Alcohol and Drugs: Proceedings*, Ruth Godding & Greg Whelan (eds.), Department of Community Medicine, St Vincent's Hospital, Melbourne, pp. 69-76.
- Ciketic, S, Hayatbakhsh, M, Doran, C, Najman, J & McKetin, R 2012, 'A review of psychological and pharmacological treatment options for methamphetamine dependence', *Journal of Substance Use*, vol. 17, no. 4, pp. 363-383.

- Cogger, S, Dietze, P & Lloyd, B 2013, 'Victorian Drug Trends 2012: Findings from the Illicit Drug Reporting System (IDRS)', *Australian Drug Trends*, no. 94, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, accessed 5 June 2014 at <http://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/VIC_IDRS_2012_FINAL.pdf>.
- Cogger S, Dietze P & Lloyd 2014, 'Victorian Drug Trends 2013: Findings from the Illicit Drug Reporting System (IDRS)', *Australian Drug Trends*, no.112, National Drug and Alcohol Research Centre, University of New South Wales, Sydney. <http://ndarc.med.unsw.edu.au/resource/victorian-drug-trends-2013-findings-illicit-drug-reporting-system-idrs>
- Colfax, G, Santos, G, Chu, P, Vittinghoff, E, Pluddemann, A, Kumar, S & Hart, C 2010 'Amphetamine-group substances and HIV', *Lancet*, vol. 376, no. 9739, pp. 454–574.
- Collins, B 2014 *The rise of methamphetamine use in Aboriginal communities*, ABC Kimberley, 10 June. Online at <http://www.abc.net.au/local/stories/2014/06/10/4022280.htm>
- Collins, DJ & Lapsley, HM 2008, *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*, National Drug Strategy Monograph Series No. 64.
- Commonwealth of Australia 2004, *Principles for school drug education* — Prepared by Lois Meyer, Learning Paradigms with Helen Cahill, Youth Research Centre, University of Melbourne.
- Commonwealth of Australia 2005, *L.E.A.D — Leading Education About Drugs, Student Participatory Approaches Support Materials for School Drug Education Forums*, Department of Education, Science and Training, Canberra.
- Commonwealth of Australia 2006, *Keeping in Touch — Working with Alcohol and other Drug Use*, Department of Education, Science and Training, Canberra.
- Commonwealth of Australia 2011, *National Drug Strategy 2010–2015*, Ministerial Council on Drug Strategy, Canberra.
- Commonwealth of Australia, Department of Health and Aged Care 1999, *National drug strategic framework 1998–1999*, Commonwealth Department of Health and Aged Care, Canberra.
- Commonwealth Department of Health and Ageing 2008, *Patterns of use and harms associated with specific populations of methamphetamine users in Australia — exploratory research*. Accessed online at <http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-npi-methamphetamine-report>
- Commonwealth Director of Public Prosecutions (CDPP) 2012, *Annual Report 2011-12*, CDPP, Canberra. http://www.cdpp.gov.au/publications/?publication_category=annual-reports
- Commonwealth Director of Public Prosecutions (CDPP) 2014a, 'About us', CDPP website. <http://www.cdpp.gov.au/about-us/>.
- Commonwealth Director of Public Prosecutions (CDPP) 2014b, 'Crimes we prosecute', CDPP website. <http://www.cdpp.gov.au/crimes-we-prosecute/>.
- Connolly, S 2000, *Need to know amphetamines*, Heinemann Library, Oxford.
- Coomber, K, Toumbourou, J, Miller, P, Staiger, P, Hemphill, S & Catalano, R 2011, 'Rural adolescent alcohol, tobacco, and illicit drug use: a comparison of students in Victoria, Australia, and Washington State, United States', *The Journal of Rural Health*, vol. 27, no. 4, pp. 409–415, accessed 5 June 2014 at <http://www.ncbi.nlm.nih.gov/pubmed/21967385>.
- Corns, C 2005, 'Combating organised crime in Victoria: Old problems and new solutions', *Criminal Law Journal*, vol. 29, no. 205, pp. 154–168.
- Corruption and Crime Commission of Western Australia (CCC WA) 2005, *Report to the Joint Standing Committee on the Corruption and Crime Commission with Regard to the Commission's Organised Crime Function and Contempt Powers*, CCC WA, Perth. <http://www.ccc.wa.gov.au/Publications/Reports/Documents/Published%20Reports/2005/organised-crime.pdf>
- Covington, S 2008, 'Women and addiction: A trauma-informed approach', *Journal of Psychoactive Drugs*, vol. 40, no. 5 (sup), pp. 377–385.

- Cowdery, N 2009, 'Contemporary comments — A threat to the rule of law: The New South Wales Crimes (Criminal Organisations Control) Act 2009', *Current Issues in Criminal Justice*, vol. 21, no. 1, pp. 321–324.
- Crime and Misconduct Commission (Qld) 2008, 'Mandatory treatment and perceptions of treatment effectiveness', *Research and Issues Paper Series*, no. 7, Crime and Misconduct Commission, Brisbane.
- Croke, C 2010, 'Civil forfeiture: forfeiting civil liberties? A critical analysis of the Crimes Legislation Amendment (Serious and Organised Crime) Act 2010 (Cth)', *Current Issues in Crime and Criminal Justice*, vol. 22, no. 1, pp. 149–58.
- Cronin, D 2008, *Public Policy and Parental Engagement in Education*, Fellowship Report, The Winston Churchill Memorial Trust of Australia, at http://www.churchilltrust.com.au/site_media/fellows/CRONIN,_Danielle_2008.pdf.
- Cruddas, L 2005, *Learning Mentors in Schools: Policy and Practice*, Trentham Books Ltd, England.
- Cruickshank, C & Dyer, K 2009, 'A review of the clinical pharmacology of methamphetamine', *Addiction*, vol. 104, no. 7, pp. 1085–1099.
- Cruickshank, C, Montebello, M, Dyer, K, Quigley, A, Blaszczyk, J, Tomkins, S & Shand, D 2008, 'A placebo-controlled trial of mirtazapine for the management of methamphetamine withdrawal', *Drug and alcohol review*, vol. 27, no. 3, pp. 326–333.
- Cruickshank, C & Dyer, K 2009, 'A review of the clinical pharmacology of methamphetamine', *Addiction*, vol. 104, no. 7, pp. 1085–1099.
- Curtis, W, & Wendel, T 2000, 'Toward the development of a typology of illegal drug markets', *Crime Prevention Studies*, vol. 11, pp. 121–52.
- d'Abbs, P. & MacLean, S. 2000, *Petrol Sniffing in Aboriginal Communities: A Review of Interventions*, Cooperative Research Centre for Aboriginal and Tropical Health, Darwin.
- Daily Mail 2014, 'How Canadians can blow 25 cents on a crackpipe! Vancouver vending machines hope to curb spread of HIV among addicts' 2014, *Daily Mail*, 9 Feb 2014, accessed 5 June 2014 at <http://www.dailymail.co.uk/news/article-2555007/Crackpipe-vending-machines-installed-Vancouver-curb-spread-HIV-hepatitis-addicts.html>.
- Darke, S, Kaye, S, McKetin, R & Dufrou, J 2008, 'Major physical and psychological harms of methamphetamine use', *Drug and Alcohol Review*, vol. 27, no. 3, pp. 253–262.
- Darke, S, Torok, M, Kaye, S, Ross J, McKetin, R 2010, Comparative rates of violent crime among regular methamphetamine and opioid users: offending and victimisation. *Addiction*, vol. 105, pp. 916–919.
- Davey, J, Richards, N & Freeman, J 2007, 'Fatigue and beyond; patterns of and motivations for illicit use among long haul truck drivers', *Traffic Injury Prevention*, vol. 8, 253–259.
- Davies, J 2006, 'Life on Ice', *The Bulletin with Newsweek*, 10 October 2006, vol. 124, no. 6541, pp. 20–21.
- Dawe, S, Frye, S, Best, D, Moss, D., Atkinson, J, Evans, C, Lynch, M & Harnett, P 2006, 'Parental substance misuse in Indigenous communities: a social ecology perspective', in *Drug Use in the Family: impacts and implications for children*, (ANCD Research Paper 13), Australian National Council on Drugs, Canberra, pp. 92–109.
- Day, C, Conroy, E, Lowe, J, Page, J & Dolan, K 2006, 'Patterns of drug use and associated harms among rural injecting drug users: Comparisons with metropolitan injecting drug users', *Journal of Rural Health*, vol. 14, pp. 120–125.
- Dean, A 2004, 'Pharmacology of psychostimulants', in Baker, A, Lee, N & Jenner LK, (eds.), *Models of interventions and care for psychostimulant users*, 2nd edn., Monograph Series No 51, Australian Government Department of Health and Ageing, Canberra, pp.35–50.
- Degenhardt, L & Hall, W 2012, 'Extent of illicit drug use and dependence, and their contribution to the global burden of disease', *The Lancet*, vol. 379, no. 9810, pp.55–70.

- Degenhardt, L & Topp, L 2003, "'Crystal meth" use among polydrug users in Sydney's dance party subculture: Characteristics, use patterns and associated harms', *International Journal of Drug Policy*, vol. 14, pp. 17–24.
- Degenhardt, L, Coffey, C, Moran, P, Carlin, J & Patton, G 2007, 'The predictors and consequences of adolescent amphetamine use: findings from the Victoria Adolescent Health Cohort Study', *Addiction*, vol. 106, no. 1, pp. 1076–1084.
- Degenhardt, L, Roxburgh, A, Black, E, Raimando, B, Campbell, G, Kinner, S & Fetherston, J 2008, 'The epidemiology of methamphetamine use and harm in Australia', *Drug and alcohol review*, vol. 27, no. 3, pp. 243–252.
- Degenhardt, L, Mathers, Vickerman, P, Rhodes T 2010, 'Meth/amphetamine use and associated HIV infection for people who inject drugs: Why individual, structural and combination approaches are needed', *Lancet*, vol. 376, pp. 285–301.
- Dekker, J, O'Brien, K & Smith, N 2010, *An evaluation of the Compulsory Drug Treatment Program (CDTP): Final report*, NSW Bureau of Crime Statistics and Research, Sydney.
- De Leon, G 2000, *The therapeutic community*, 1st edn, Springer Publishers, New York.
- Department for Children, Schools and Families (UK) 2008, *The Impact of Parental Involvement on Children's Education*, Report by the Department for Children, Schools and Families (UK) at: www.education.gov.uk/publications/.../DCSF-Parental_Involvement.pdf.
- Department of Education and Early Childhood Development (DEECD) (Victoria) 2009, *Accountability and improvement framework for Victorian Government schools 2009*, DEECD, Melbourne.
- Department of Education, Science and Training, Commonwealth of Australia 2004, *Principles for school drug education* — Prepared by Lois Meyer, Learning Paradigms with Helen Cahill, Youth Research Centre, University of Melbourne.
- Department of Education, Science and Training, Commonwealth of Australia 2005, *L.E.A.D — Leading Education About Drugs, Student Participatory Approaches Support Materials for School Drug Education Forums*, Department of Education, Science and Training, Canberra.
- Department of Health (Cth) 2011, *National Psychostimulants Initiative*, Department of Health, Canberra, accessed 23 July 2014 at www.health.gov.au/internet/main/publishing.nsf/Content/phd-npi-index.
- Department of Health (Cth) 2013, *List of Drug Substances Requiring Import and Export Authorisations*, Department of Health and Ageing, Canberra. <http://www.health.gov.au/internet/main/publishing.nsf/Content/ocs-treaties-compliance-prohibited-impexp-precursor.htm>
- Department of Health (Cth) 2014a, *Illicit Drugs and Precursors, National Industrial Chemicals Notification and Assessment Scheme*, Department of Health, Canberra. <http://www.nicnas.gov.au/about-nicnas/regulatory-partners/illicit-drugs-precursor-chemicals>.
- Department of Health (Cth) 2014b, *The Poisons Standard (the SUSMP)*, Department of Health and Ageing, Canberra. <http://www.tga.gov.au/industry/scheduling-poisons-standard.htm#.U6uZii2KDYI>.
- Department of Health (Cth) 2014c, 'Drug Control Section', The Department of Health Website. <http://www.health.gov.au/internet/main/publishing.nsf/Content/treaties-and-compliance>.
- Department of Health and Ageing (Cth) 2004, *Illicit Drug Diversion Initiative — COAG Framework*, Commonwealth of Australia, Canberra.
- Department of Health and Ageing (Cth) 2007, 'National amphetamine-type stimulant strategy 2008-2011: Background paper 2007', *National Drug Strategy Monograph Series* no. 69, Department of Health and Ageing, Canberra. [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/\\$File/mono69.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/$File/mono69.pdf)

- Department of Health and Aging (Cth) 2011, *National Drug Strategy 2010-2015*, Commonwealth of Australia, Canberra, accessed 5 June 2014 at [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/DB4076D49F13309FCA257854007BAF30/\\$File/nds2015.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/DB4076D49F13309FCA257854007BAF30/$File/nds2015.pdf).
- Department of Health (Vic) 2012, *Reducing the alcohol and drug toll: Victoria's plan 2013-2017*, Melbourne, Vic.
- Department of Health (DHS) (Vic) 2012, *Clandestine Laboratory Remediation, Environmental Health Practice Note*, Department of Health, Melbourne.
- Department of Human Services (DHS) (Vic) 2007, *Victorian amphetamine-type stimulants (ATS) and related drugs strategy 2007-2010 Discussion Paper*, Department of Human Services, Melbourne, Vic.
- Department of Human Services (DHS) (Vic) 2008, *Vulnerable youth framework: Discussion paper*, DHS, Melbourne.
- Department of Human Services (DHS) (Vic), Primary Health Branch 2008b, *Towards a demand management framework for community health services*, DHS, Melbourne.
- Department of Justice (Vic) 2010, *Court Integrated Services Program — Tackling the causes of crime — Executive Summary Evaluation Report*, Department of Justice, Melbourne, Vic.
- Department of Justice 2011, 'Four communities receive funding for court-based program to prevent reoffending', 18 October 2011, Office of Justice Programs, Department of Justice, accessed 20 June 2014 http://ojp.gov/newsroom/pressreleases/2011/OJP_PR-101811.pdf.
- Department of the Prime Minister and Cabinet (DPMC) (NZ) 2008, *Tackling Methamphetamine: an Action Plan*, Department of the Prime Minister and Cabinet, Wellington.
- Department of the Prime Minister and Cabinet (DPMC) (NZ) 2014, *Tackling Methamphetamine: Indicators and Progress Report: April 2014*, Department of the Prime Minister and Cabinet, Wellington.
- Dietze, P, Laslett, A & Rumbold, G 2004, 'The epidemiology of Australian drug use', pp. 33-52.
- Directorate-General for Internal Policies 2013, *The Economic, Financial & Social Impacts of Organised Crime in the European Union*, Special Committee on Organised Crime, Corruption and Money Laundering, Policy department C — Citizens' rights and Constitutional Affairs, accessed 5 June 2014 at [http://www.europarl.europa.eu/RegData/etudes/etudes/join/2013/493018/IPOL-JOIN_ET\(2013\)493018_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/etudes/join/2013/493018/IPOL-JOIN_ET(2013)493018_EN.pdf).
- Donath, S 2004, 'Women and drugs', in *Drug Use in Australia: Preventing Harm*, 2nd edition, Hamilton, M, King, T & Ritter, A (eds.), Oxford University Press, South Melbourne, pp. 102-115.
- Doran, CM 2012, 'The role of health economics in understanding and responding to amphetamine type stimulants', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, Hawthorn, Vic pp. 104-116.
- Dornier, C, Simon, S, Rawson, R, Huber, A & Ling, W 2000, 'A comparison of injecting and non-injecting methamphetamine users', *Journal of Psychoactive Drugs*, vol. 21, no. 32, pp. 229-332.
- Drug and Alcohol Services South Australia (DASSA) 2011, *South Australian Alcohol and Other Drug Strategy 2011-2016*, DASSA, Adelaide.
- Drugs and Crime Prevention Committee 1998, *Harm minimisation principles & policy frameworks*, Occasional Paper No.1, Parliament of Victoria, Melbourne.
- Drugs and Crime Prevention Committee 2004, *Inquiry into Amphetamine and 'Party Drugs' use in Victoria: Final Report*, Parliament of Victoria, Melbourne, accessed 5 June 2014 at http://www.parliament.vic.gov.au/images/stories/committees/dcpc/Party_drugs/DCPC-Report_Amphetamine_2004-05-05.pdf.

- Drugs and Crime Prevention Committee 2008, *Inquiry into Strategies to Prevent High Volume Offending and Recidivism by Young People*, Parliament of Victoria, Melbourne.
- Drugs Poisons and Controlled Substances Act 1981* (Vic), accessed 28 February 2014 at <http://www.legislation.vic.gov.au/>.
- Drummer, OH, Gerastamoulos, J, Batziris, H, Chu, M, Caplehorn, J, Roberston, MD & Swann, P 2003, 'The involvement of drugs in drivers of motor vehicles killed in Australian road traffic crashes', *Accident Analysis and Prevention*, no. 943, pp.1–10.
- Drummer, O, Gerastamoulos, J, Batziris, H, Chu, M, Caplehorn, J, Robertson, M, et al. 2004, 'The involvement of drugs in drivers of motor vehicles killed in Australian road traffic crashes', *Accident Analysis and Prevention*, vol. 36, no. 2, pp. 239-248.
- Drummer, OH, Jourtis, I, Beyer, J, Taylor, P, Boorman, M & Gerostamoulos, D 2004, *The prevalence of drugs in injured drivers*, *Forensic Science International*, vol. 215, nos. 1–3, pg. 14.
- Du Plessis, K & Corney, T 2011, 'Construction industry apprentices' substance use', *Youth Studies Australia*, vol. 30, no. 4, pp. 40–50.
- Duff, C 2003, 'Drugs and youth cultures: Is Australia experiencing the "normalisation" of adolescent drug use?', *Journal of Youth Studies*, vol. 6, no. 4, pp. 433–446.
- Dunn, M, Thomas, JO, Swift, W & Burns, L 2011, 'Recreational substance use among elite Australian athletes', *Drug and Alcohol review*, January, no. 30, p. 63.
- Durkin, S Brennan, E & Wakefield, M 2012, Mass media campaigns to promote smoking cessation among adults: an integrative review, *Tobacco Control*, vol. 21, pp. 127–138.
- Dusenbury, L & Falco, M 1995, 'Eleven components of effective drug abuse prevention curricula', *J Sch Health*, vol. 65, no. 10, pp. 420-25.
- Dwyer, R, Pennay, A, Green, R, Siokou, C, Barratt, M, Thomson, N & Moore, D 2012, 'The Social contexts and cultural meanings of amphetamine-type stimulant use and their implications for policy and practice', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 56–68.
- Eade, A 2012, 'The impact of amphetamine-type stimulants on ambulance services', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 142–148.
- Edwards, J 2004, 'Hazardous chemicals', in Cromar, N et al. (eds.), *Environmental Health in Australia and New Zealand*, pp. 319-36, Oxford University Press, Melbourne.
- Elvik, R 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.
- Embry, D, Hankins, M, Biglan, A & Boles, S 2009, 'Behavioral and social correlates of methamphetamine use in a population-based sample of early and later adolescents', *Addictive Behaviours*, vol. 34, pp. 343–51.
- Erceg-Hurn, DN 2008, Drugs, money and graphic ads, A critical review of the Montana Meth Project', *Prevention Science*, vol. 9, pp. 256-263.
- European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2009, *Methamphetamine: A European Union perspective in the global context*, EMCDDA, Lisbon, Portugal.
- European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2012, *The state of the drugs problem in Europe*, EMCDDA Papers, Publications Office of the European Union, Luxemburg, accessed 5 June 2014 at http://www.emcdda.europa.eu/attachements.cfm/att_190854_EN_TDAC12001ENC.pdf.
- European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2013, *European Drug Report — Trends and Developments*, EMCDDA, Luxembourg, Publications Office of the European Union.

- European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2014, *Exploring methamphetamine trends in Europe*, EMCDDA Papers, Publications Office of the European Union, Luxemburg, accessed 5 June 2014 at http://www.emcdda.europa.eu/attachements.cfm/att_222738_EN_TDAU14001ENN.pdf.
- European Police Office 2013, *European Union Serious and Organised Crime Threat Assessment*. Europol, The Hague, accessed 5 June 2014 at <https://www.europol.europa.eu/sites/default/files/publications/socta2013.pdf>.
- Farabee, D, Cousins, S, Brecht, M, Antonini, V, Lee, A, Brummer, J, Hemberg, J, Karno, M & Rawson, R 2013, 'A comparison of four telephone-based counseling styles for recovering stimulant users', *Psychology of Addictive Behaviors*, vol. 27, no. 1, p. 223.
- Farrell, M, Marsden, J, Ali, R & Ling, W 2002, 'Editorial — Methamphetamine: drug use and psychoses becomes a major health issues in the Asia Pacific region', *Addiction*, vol. 97, no. 7, pp. 771—772.
- Financial Action Task Force on Money Laundering (FATF) 2012, *International Standards of Combating Money Laundering and the Financing of Terrorism and Proliferation — the FATF Recommendations*, FATF, Paris. <http://www.fatf-gafi.org/topics/fatfrecommendations/documents/internationalstandardsoncombatingmoneylaunderingandthefinancingofterrorismproliferation-thefatfrecommendations.html>.
- Fischer, A, Curruthers, S, Power, R, Allsop, S & Degenhardt, L 2012, 'The link between amphetamine-type stimulants use and the transmission of HIV and other blood-borne viruses in the Southeast Asia region', *ANCD Research Paper*, vol. 25, Australian National Council on Drugs, accessed 5 June 2014 http://apdic.ncnd.org.au/images/PDFs/Projects_and_initiatives/rp25-amphetamine-type-stimulants.pdf.
- Fitzroy Legal Service 2014, *The Law Handbook*, Fitzroy Legal Service, Melbourne.
- Foxcroft, DR, Ireland, D, Lister-Sharp, DJ, Lowe, G & Breen, R 2003, 'Longer-term primary prevention for alcohol misuse in young people: A systematic review', *Addiction*, vol. 98, no. 4, pp. 397–411.
- Franco, C 2010, *Drug Courts: Background, Effectiveness, and Policy Issues for Congress*, Congressional Research Service, Washington DC.
- Frankland, A, Lee, E, Zablotska, I & Prestage G 2009, *Gay Community Periodic Survey*, February, National Centre in HIV Social Research, UNSW, Sydney.
- Franks, C 2006, 'Gallinyalla: A town of substance? A descriptive study of alcohol, tobacco, medicines and other drug use in a rural setting', *Rural and Remote Health*, vol. 6, no. 2, p. 491.
- Frei, M, Berends, L, Kenny, P, Swan, A, Jenner, L, Hunter, B & Mugavin, J 2012, *Alcohol and Other Drug Withdrawal Practice Guidelines* (2nd edition), Turning Point Alcohol and Drug Centre, Melbourne.
- Fulde, G & Wodak, A 2007, 'Ice: cool drug or real problem', *Medical Journal of Australia*, vol. 186, no. 7, p. 334.
- Galloway, G, Polcin, D, Kielstein, A, Brown, M & Mendelson, J 2007, 'A nine session manual of motivational enhancement therapy for methamphetamine dependence: adherence and efficacy', *Journal of psychoactive drugs*, vol. 39, no. sup 4, pp. 393–400.
- Garretsen, H & Van De Goor, I 2004, 'Towards evidence based policy', in R Muller & H Klingemann (eds.), *From science to action? 100 years later — Alcohol policies revisited*, Kluwer Academic Publishers, Dordrecht/Boston/London, pp. 141–151.
- Gately, N, Fleming, J, Morris, R & McGregor, C 2011, *Amphetamine use among detainees at the East Perth Watch House: What is the impact on crime?*, Criminology Research Council, School of Law & Justice, Edith Cowan University.
- German, D, Sherman, SG, Sirirojn, B, Thomson, N, Aramrattana, A, & Celentano, DD 2006, 'Motivations for methamphetamine cessation among young people in northern Thailand', *Addiction*, vol. 101, no. 8, pp. 1143–1152.

- Gizzi, MC & Gerkin, P 2010, 'Methamphetamine use and criminal behaviour', *International Journal of Offender Therapy and Comparative Criminology*, vol. 54, no. 6, pp. 915–36.
- Gliddon, J 2002, 'Agony and ecstasy', *Bulletin*, 3 September, pp. 14–15.
- Global Commission on Drug Policy (GCDP) 2011, *War on Drugs; Report of Global Commission on Drug Policy*, GCDP, Rio de Janeiro.
- Godfrey, D & Phillips, M 2003, 'Driving under the influence of drugs', *Policing Issues and Practice Journal*, January, pp. 16–27.
- Goldsmith, A, Gray, D & Smith, RG, 2014, 'Criminal asset recovery in Australia', in King, C & Walker, C (eds.), *Dirty Assets: Emerging Issues in the Regulation of Criminal and Terrorist Assets*, pp. 115–39, Ashgate Publishing Limited, Farnham.
- Goldstein, PJ 1985, 'The drugs/violence nexus: A tripartite conceptual framework', *Journal of Drug Issues*, vol. 39, pp. 143–74. <http://www.drugpolicy.org/docUploads/nexus.pdf>.
- Golub, M, Costa, L, Crofton K, Frank, D, Fried P & Gladen B 2005, 'Expert Panel Report on the reproductive and developmental toxicity of amphetamine and methamphetamine', *Birth Defects Research Part B: Developmental and Reproductive Toxicology*, vol. 74, no. 6, pp. 471–584.
- Gomez, M & Ritter, A 2014, *Hard to count or unrecorded treatment utilisation for alcohol and other drugs*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW, Sydney.
- Gonzales, R, Ang, A, Murphy, DA, Glik, DC, & Anglin, MD 2014, 'Substance use recovery outcomes among a cohort of youth participating in a mobile-based texting aftercare pilot program', *Journal of Substance Abuse Treatment*, vol. 47, no. 1, pp. 20–26.
- Grabosky, P 1995, 'Fear of crime and fear reduction strategies', *Trends and Issues in Crime and Criminal Justice*, No. 44, Australian Institute of Criminology, Canberra.
- Gray, D, Saggars, S, Atkinson, D, Carter, M, Loxley, W & Hayward, D 2001, *The Harm Reduction Needs of Aboriginal People Who Inject Drugs*, National Drug Research Institute, Curtin University, Perth.
- Gray, S, Fatovich, D, McCoubrie, D & Daly, F 2007, 'Amphetamine-related presentations to an inner-city tertiary emergency department: a prospective evaluation', *Medical Journal of Australia*, vol. 186, no. 7, pp. 336–338.
- Grant, P 2008, 'Interventions that work: Dealing with young people in conflict with the law', Paper given at the Young People, Crime and Community Safety Conference, Australian Institute of Criminology, Melbourne, 25–26 February.
- Green, A & Halkitis, PN 2006, 'Crystal methamphetamine and sexual sociality in an urban gay subculture: An elective affinity', *Culture, Health and Sexuality*, vol. 8, no. 4, pp.317–333.
- Grinspoon, L & Hedblom, P 1975, *The speed culture: Amphetamine use in America*, Harvard University Press, Cambridge.
- Groves, A & Marmo, M 2009, 'How to 'melt the ice' on the streets: A social-control analysis on the rise of methamphetamine within Australia and the need to reduce demand', *Current Issues in Criminal Justice*, vol. 20, no. 3, pp. 413–432.
- Grund, JP, Coffin, P, Jauffret-Roustide, M, Dijkstra M 2010, *The fast and furious — cocaine, amphetamines and harm reduction*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon.
- Halkitis, P, Fischgrund, B & Parsons, J 2005, 'Explanations for methamphetamine use among gay and bisexual men in New York City', *Substance use & misuse*, vol. 40, no. 9-10, pp. 1331–1345.

- Hall, W & Hando J 1993, 'Patterns of illicit psychostimulant use in Australia', in Burrows, D, Flaherty, B & MacAvoy, M (eds.), *Illicit psychostimulant use in Australia*, Commonwealth Department of Housing and Community Services and Drug and Alcohol Directorate, New South Wales Health Department, Australian Government Printing Service, Canberra, ACT, pp. 53–70.
- Hall, W & Hando, J 1994, 'Route of administration and adverse effects of amphetamine use among young adults in Sydney, Australia', *Drug and Alcohol Review*, vol. 13, no. 3, pp. 277–284.
- Hall, W & Hando, J 1997, 'Patterns of amphetamine use in Australia', in *Amphetamine Misuse: International Perspectives on Current Trends*, H. Klee (ed.), Harwood Academic Publishers, The Netherlands, pp. 81–110.
- Hall, W, Hando, J, Darke, S & Ross, J 1996, 'Psychological morbidity and route of administration among amphetamine users in Sydney, Australia', *Addiction*, vol. 91, no. 1, pp. 81–87.
- Hall, W & Homel, R 2007, 'Cannabis-impaired driving: Is there sufficient evidence for drug testing of drivers?', *Addiction*, vol. 102, no. 12, pp. 1918–1919.
- Hamilton, M, King, T & Ritter, A 2004, *Drug Use in Australia: Preventing Harm*, 2nd edn, Oxford University Press, South Melbourne.
- Harris, D & Batki, S 2000, 'Stimulant psychosis: Symptom profile and acute clinical course', *American Journal on Addictions*, vol. 9, pp. 28–37.
- Harris, M 2012, 'The Koori Court and the Promise of Therapeutic Jurisprudence' (2006), *eLaw Journal*, Special Series 1, pp. 129–139, accessed 3 June 2014 at https://elaw.murdoch.edu.au/archives/issues/special/the_koori_court.pdf.
- Harris, R 2006, 'Embracing your demons: An overview of acceptance and commitment therapy', *Psychotherapy in Australia*, vol. 12, no. 4, p. 70.
- Harvard University 2013, *Top 25 Programs: In Detail*, Harvard Kennedy School of Government, accessed at <http://www.ash.harvard.edu/Home/News-Events/Press-Releases/Innovations/Top-25-Innovations-in-Government-Announced2/Top-25-Programs>
- Haug, NA, Shopshire, M, Tajima, B, Gruber, V & Guydish, J 2008, 'Adoption of evidence-based practices among substance abuse treatment providers', *Journal of Drug Education*, vol. 38, no. 2, pp. 181–192.
- Hawken, A & Kleiman, M 2009, *Managing drug involved probationers with swift and certain sanctions*, National Institute of Justice, accessed 20 June 2014 at <https://www.ncjrs.gov/pdffiles1/nij/grants/229023.pdf>.
- Hawken, A 2010, 'Behavioral triage: A new model for identifying and treating substance-abusing offenders', *Journal of Drug Policy Analysis*, vol. 3, no. 1.
- Hayes, S 2004, 'Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies', *Behavior therapy*, vol. 35, no. 4, pp. 639–665.
- Heber, A 2013, 'Healthy mining minds', *Australian Mining*, 4 April. Online at <http://www.miningaustralia.com.au/features/healthy-mining-minds>
- Hemphill, S, Toumbourou, J & Catalano, R 2005, *Predictors of violence — Antisocial behaviour and relational aggression in Australian adolescents: A longitudinal study*, Report for the Criminology Research Council, Centre for Adolescent Health, Melbourne and Social Development Research Group, Seattle, Washington.
- Henry-Edwards, S & Ali, R 2000, 'Amphetamine type stimulants demand reduction issues and future priorities', presented at United Nations Drug Control Programme Conference, Tokyo, 24-27 January.
- Herbeck, D, Brecht, M, Lovinger, K, Raihan, A, Christou, D & Sheaff, P 2013, 'Poly-drug and marijuana use among adult who primarily used methamphetamine', *Journal of Psychoactive Drugs*, vol. 45, no. 2, pp. 132-40.

- Herrera, C, DuBois, D & Grossman, J 2013, *The Role of Risk: Mentoring Experiences and Outcomes for Youth with Varying Risk Profiles*, A Public/Private Ventures Project distributed by MDRC, New York.
- Hillier, L, Turner, A, Mitchell, A 2005, *Writing themselves in again: 6 years on*, Monograph Series no. 50, Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne.
- Hilton BA, Thompson R, Moore-Dempsey L, Janzen RG (2001), 'Harm reduction theories and strategies for control of human immunodeficiency virus: a review of the literature', *Journal of Advanced Nursing*, vol. 33, no. 3, pp. 357–70.
- Hobbs, D 2013, *Lush life: Constructing Organized Crime in the UK*, Oxford University Press, Oxford.
- Hollingworth, S, Nissen, L, Stathis, S, Siskind, D, Varghese, J & Scott, J 2011, 'Australian national trends in stimulant dispensing: 2002--2009', *Australian and New Zealand Journal of Psychiatry*, vol. 45, no. 4, pp. 332–336.
- Holly, C & Shoobridge, J 2003, Responding to the Needs of Indigenous People Who Inject Drugs: investigating the impact of injecting drug use in Indigenous communities in metropolitan Adelaide, Aboriginal Drug and Alcohol Council (SA) Inc, Adelaide.
- Holmes, L 2007, 'Introduction' in Holmes, L (ed.), *Terrorism, Organised Crime and Corruption*, pp. 1–28, Edward Elgar Publishing, Cheltenham.
- Howard, J, Metcalf, A, Beck, S & Matheson, A 2012, 'Working with same-sex attracted, sex and gender diverse persons', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 154–158.
- Howard, S & Johnson, B 2000, 'Resilient and non-resilient behaviour in adolescents', *Trends and Issues in Crime and Criminal Justice*, no. 183, November, pp.1–6.
- Hughes, Caitlin & Stevens, Alex 2010, 'What can we learn from the Portuguese decriminalization of illicit drugs?', *British Journal of Criminology*, vol. 50, pp. 999–1022.
- Hughes, Caitlin 2014, *The Australian (illicit) drug policy timeline: 1985-2014*, Drug Policy Modelling Program. Last updated 16 April 2014. Retrieved from: <http://www.dpmp.unsw.edu.au/resource/drug-policy-timeline>.
- Hughes, C, Ritter, A, Cowdery, N & Phillips, B 2014, "Australian threshold quantities for 'drug trafficking' : Are they placing drug users at risk of unjustified sanction?", *Trends and issues in crime and criminal justice*, no 467, March, Australian Institute of Criminology, Canberra.
- Huisman W & Nelen H 2007, 'Gotham unbound Dutch style: The administrative approach to organized crime in Amsterdam', *Crime, Law and Social Change*, vol. 48, pp. 87–103.
- Humeniuk, R, Dennington, V & Ali, R 2008, *The Effectiveness of a Brief Intervention for Illicit Drugs Linked to the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) in Primary Health Care Settings: A Technical Report of Phase III Findings of the WHO ASSIST Randomized Controlled Trial*, World Health Organization, Geneva.
- Hurley, M & Prestage, G 2009, 'Intensive sex partying amongst gay men in Sydney', *Culture, Health & Sexuality*, vol. 11, no. 6, pp. 597–610.
- Hutchinson, SL and Brooks, E 2011, *Physical Activity, Recreation, Leisure, and Sport: Essential Pieces of the Mental Health and Well-being Puzzle*, Report prepared for Recreation Nova Scotia and Nova Scotia Department of Health and Wellness Physical Activity, Sport and Recreation Responsibility Centre. Prepared by Susan L. Hutchinson PhD, with assistance from Erica Brooks.
- Hyde, Z, Comfort, J, Brown, G, McManus, A & Howat, P 2007, *The health and wellbeing of lesbian and bisexual women in Western Australia*, Western Australian Centre for Health Promotion Research, Curtin University of Technology, Perth.
- Iguchi, MY 2012, 'Taking a reinforcing approach to Treatment Entry and Retention', in Allsop, S & Lee, N (eds.), *Perspectives on Amphetamine-Type Stimulants*, Melbourne, IP Communications, pp. 254–263.

- Illicit Drug Reporting System (IDRS) 2002, *IDRS Drug Trends Bulletin*, prepared by C Breen, L Degenhardt & A Roxborough, National Drug and Alcohol Research Centre, University of New South Wales, Sydney.
- Independent Broad-based Anti-corruption Commission (IBAC) 2013, *Annual Report 2012-13*, IBAC, Melbourne. <http://www.ibac.vic.gov.au/docs/default-source/ibac-annual-reports/ibac-annual-report-2012-13.pdf?sfvrsn=8>.
- Intergovernmental Committee on Drugs (ICD) 2008, *Code of Practice for Supply Diversion into Illicit Drug Manufacture*, Plastics and Chemicals Industries Association (PACIA) and Science Industry Australia (SIA), ICD, Canberra. <http://www.pacia.org.au/Content/drugs.aspx>.
- Intergovernmental Committee on Drugs 2013, *Annual Report 2012-13*, at [http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/7FDE1A1621748A0ACA2571630008405F/\\$File/IGCD%20Annual%20Report%202011-12.pdf](http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/7FDE1A1621748A0ACA2571630008405F/$File/IGCD%20Annual%20Report%202011-12.pdf).
- Isaiah Green, A & Halkitis, P 2006, 'Crystal methamphetamine and sexual sociality in an urban gay subculture: an elective affinity', *Culture, Health & Sexuality*, vol. 8, no. 4, pp. 317–333.
- Iversen, J & Maher, L 2013, *Australian Needle and Syringe Program Survey National Data Report 2008-2012*, The Kirby Institute, Faculty of Medicine, the University of New South Wales, accessed 5 June 2014 at http://www.kirby.unsw.edu.au/sites/default/files/hiv/resources/ANSPS_2008_2012%20KI.pdf.
- Jackson, C, Henderson, M, Frank, JW & Haw, SJ, 2012, 'An overview of prevention of multiple risk behaviour in adolescence and young adulthood', *Public Health*, vol. 34 (suppl 1), pp. i31–i40. Supplement on Multiple Risk Behaviour in Adolescence.
- Jenkins, P 1999, *Synthetic Panics: The Symbolic Politics of Designer Drugs*, New York University Press, New York and London.
- Jenner, L 2012, 'Ups and downs: physical and mental health consequences of amphetamine-type stimulant use', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 83–90.
- Jenner, L, Spain, D, Whyte, I, Baker, A, Carr, VJ & Crilly J 2006, *Management of patients with psychostimulant toxicity: guidelines for ambulance services*, Department of Health and Ageing, Commonwealth of Australia, Canberra.
- Jenner, L & Lee, N 2008, *Responding to Challenging Situations Related to the use of Psychostimulants: A Practical Guide for Frontline Workers*, Department of Health and Ageing, Canberra.
- Juckles, L 2012, 'Working with people affected by co-occurring amphetamine-type stimulant and mental health problems', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, Hawthorn, Vic.
- Kay-Lambkin, FJ 2008, 'Technology and innovation in the psychosocial treatment of methamphetamine use, risk and dependence', *Drug and Alcohol Review*, vol. 27, no. 3, pp. 318–325.
- Kay-Lambkin, FJ, Baker, AL, McKetin, R & Lee, N 2010, 'Stepping through treatment: Reflections on an adaptive treatment strategy among methamphetamine users with depression', *Drug and Alcohol Review*, vol. 29, no. 5, pp. 475–482.
- Kaye, S & Darke, S 2000, 'A comparison of the harms associated with the injection of heroin and amphetamines', *Drug and Alcohol Dependence*, vol. 58, pp.189–195.
- Keane, H 2008, 'Pleasure and discipline in the uses of Ritalin', *International Journal of Drug Policy*, vol. 19, no. 5, pp.401–409.
- Kelsall, J, Higgs, P, Lam, T & Crofts, N 1999, *The Vietnamese injecting drug use and harm reduction study*, Centre for Harm Reduction, Melbourne.
- Kenny, P, Harney, A, Lee, N & Pennay, A 2011, 'Treatment utilization and barriers to treatment: Results of a survey of dependent methamphetamine users', *Substance Abuse Treatment, Prevention, and Policy* 2011, vol. 6, no. 1, p. 3.

- Kim, W 1998, 'Crank', *Time Magazine*, vol. 151, no. 24, 22 June, pp. 24–31.
- Kimber, J, Copeland, L, Hickman, M, Macleod, J, McKenzie, J, De Angelis, D & Robertson, J 2010, 'Survival and cessation in injecting drug users: prospective observational study of outcomes and effect of opiate substitution treatment', *British Medical Journal*, vol. 341.
- King, C 2012, 'Bikie gang "hooking rural youth on ice"', *ABC News Online*, 1 November. <http://www.abc.net.au/news/2012-11-01/bikie-gang-tied-to-rural-drug-spike/4345668>.
- King, J & Hales J 2004, *Cost effectiveness study — Victorian Drug Court Final Report*. Court Diversion Program Evaluation Vol 4, Health Outcomes International in collaboration with Turning Point Alcohol and Drug Centre, Melbourne.
- Kinner, S & Degenhardt, L 2008, 'Crystal methamphetamine smoking among regular ecstasy users in Australia: increases in use and associations with harm', *Drug and Alcohol Review*, vol. 27, no. 3, pp. 292–300.
- Kinner, S, Kinner, S, Degenhardt, L, Kinner, S & Degenhardt, L 2008, 'Crystal methamphetamine smoking among regular ecstasy users in Australia: increases in use and associations with harm', *Drug and alcohol review*, vol. 27, no. 3, pp. 292–300.
- Kinner, S, Preen, D, Kariminia, A, Butler, T, Andrews, J, Stooze, M & Law, M 2011, 'Counting the cost: Estimating the number of deaths among recently released prisoners in Australia', *Medical Journal of Australia*, vol. 195, no. 2, pp. 64–68.
- Kinner, S, Jenkinson, R, Gouillou, M & Milloy, M 2012, 'High-risk drug-use practices among a large sample of Australian prisoners', *Drug and alcohol dependence*, vol. 126, no. 1, pp. 156–160.
- Kinner, S, Forsyth, S & Williams, G 2013, 'Systematic review of record linkage studies of mortality in ex-prisoners: why (good) methods matter', *Addiction*, vol. 108, no. 1, pp. 38–49.
- Kirn, W 1998, 'Crank', *Time Magazine*, vol. 151, no.24, pp. 24–31.
- Klee, H. 1997, 'A typology of amphetamine users in the United Kingdom', in H Klee (ed.), *Amphetamine Misuse: International Perspectives on Current Trends*, Harwood Academic Publishers, The Netherlands, pp.35–68.
- Klee, H 2001a, 'Amphetamine use: Crystal gazing into the millennium: Part one — What is driving demand?', *Journal of Substance Use*, vol. 6, no. 1, pp. 22–35.
- Klee, H. 2001b, 'Amphetamine use: Crystal gazing into the millennium: Part two — Alternative paths', *Journal of Substance Use*, vol. 6, pp.80–95.
- Klee, H & Morris, J 1994, 'Crime and drug misuse: economic and psychological aspects of the criminal activities of heroin and amphetamine injectors', *Addiction Research*, vol. 1, pp. 377–86.
- Klein, B, White, A, Kavanagh, D, Shandley, K, Kay-Lambkin, F, Proudfoot, J, Drennan, J, Connor, J, Baker, A & Young, R 2010, 'Content and functionality of alcohol and other drug websites: Results of an online survey', *Journal of medical Internet research*, vol. 12, no. 5.
- Klein, B, Meyer, D, Austin, D & Kyrios, M 2011, 'Anxiety online — A virtual clinic: Preliminary outcomes following completion of five fully automated treatment programs for anxiety disorders and symptoms', *Journal of medical Internet research*, vol. 13, no. 4.
- Kornell, S 2013, 'Probation That Works', *Slate*, 5 June 2013, accessed 20 June 2014 at http://www.slate.com/articles/health_and_science/science/2013/06/hawaii_hope_probation_program_reduces_crime_drug_use_and_time_in_prison.html.
- Kratzmann M, Mitchell, E, Ware, J, Banach, L, Ward, J & Ryan, J 2011, *Injecting drug use and associated harms among Aboriginal Australians*, Australian National Council on Drugs, Canberra, ACT.
- Lancaster, K, Ritter, A & Colebatch, H 2014, 'Problems, policy and politics: Making sense of Australia's "ice epidemic"', *Policy Studies*, vol. 35, no. 2, pp. 147–171.

- Lapworth, KN 2011, An investigation of aggression in methamphetamine users, PhD thesis, School of Psychology, Griffith University, Brisbane. https://www120.secure.griffith.edu.au/rch/file/4727b810-192b-4ba6-1964-c193f975ef20/1/Lapworth_2011_02Thesis.pdf.
- Lapworth, K, Dawe, S, Davis, P, Kavanagh, D, Young, R & Saunders, J 2009, 'Impulsivity and positive psychotic symptoms influence hostility in methamphetamine users', *Addictive Behaviour*, vol. 34, no. 4, pp. 380–85.
- Le, Vy, KV 2013, Understanding the Operational Structure of Southeast Asian Drug Trafficking Groups in Australia, PhD thesis, School of Justice, Queensland University of Technology. <http://eprints.qut.edu.au/60670/3/60670.pdf>
- Le, Vy KV & Lauchs, M 2012, 'Models of South-East Asian organised crime drug operations in Queensland', *Asian Journal of Criminology*, vol. 8, no. 2, pp. 69–87.
- Leahy, R 2008, 'The therapeutic relationship in cognitive-behavioral therapy', *Behavioural and Cognitive Psychotherapy*, vol. 36, no. 6, p. 769–777.
- Lee, JT 1999, 'Volatile substance abuse within a health education context', *Human Toxicology*, vol. 8, pp.331–334.
- Lee, N & Jenner, L 2012, 'Clinical responses to amphetamine-type stimulant problems', in Allsop S, Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 190–196.
- Lee, N & Rawson, R, 2008, 'A systematic review of cognitive and behavioural therapies for methamphetamine dependence', *Drug and Alcohol Review*, vol. 27, no. 3, pp. 309–317.
- Lee, N, Johns, L, Jenkinson, R, Johnston, J, Connolly, K, Hall, K & Cash, R 2007, *Clinical Treatment Guidelines for Alcohol and Drug Clinicians, No 14: Methamphetamine dependence and treatment*, Turning Point Alcohol and Drug Centre Inc, Fitzroy, Vic.
- Lee, N & Rawson, R 2008, 'A systematic review of cognitive and behavioural therapies for methamphetamine dependence', *Drug and Alcohol Review*, vol. 27, no. 3, pp. 309–317.
- Lee, NK, Harney, AM & Pennay, AE 2012, 'Examining the temporal relationship between methamphetamine use and mental health comorbidity', *Advances in Dual Diagnosis*, vol. 5, no. 1, pp. 23–31.
- Lee, NK, Pennay, A, Hester, R, McKetin, R, Nielsen, S & Ferris, J 2013, 'A pilot randomised controlled trial of modafinil during acute methamphetamine withdrawal: feasibility, tolerability and clinical outcomes', *Drug and Alcohol Review*, vo. 32, no. 1, pp. 88–95.
- Lee, N, Roche, A, Duraisingam, V, Fischer, J, Cameron, J & Pidd, K 2014, 'A Systematic Review of Alcohol Interventions Among Workers in Male-Dominated Industries', *Journal of Men's Health*, vol. 11, no. 2, pp. 53–63.
- Lee, NK, Jenner, L & Nielsen, S (in press), *Medication treatment options for amphetamine-type stimulant users*, Australian National Council on Drugs, Canberra.
- Legal and Constitutional Affairs Legislation Committee (2014), Report on the Crimes Legislation Amendment (Unexplained Wealth and Other Measures) Bill 2014, Department of the Senate, Canberra. [http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Unexplained_Wealth_Bill/Report/~media/Committees/Senate/committee/legcon_ctte/cimes_legislation_amendment_wealth/report/report.pdf](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Unexplained_Wealth_Bill/Report/~/media/Committees/Senate/committee/legcon_ctte/cimes_legislation_amendment_wealth/report/report.pdf).
- Leonard, W, Dowsett, G, Slavin, S, Mitchell, A & Pitts, M 2008, 'Crystal clear: The social determinants of gay men's use of crystal methamphetamine in Victoria', Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne.
- Levy, S, Vaughan, B & Knight, JR 2002, 'Office-based intervention for adolescent substance abuse', *Pediatric Clinics of North America*, vol. 49, no. 2, 329–343.
- Lewis, L & Ross, M W 1995, *A Select Body: The gay dance party subculture and the HIV/AIDS pandemic*, Cassell, London.

- Lineberry, T & Bostwick, J 2006, 'Methamphetamine abuse: A perfect storm of complications', *Mayo Clinic Proceedings*, vol. 81, no. 1, pp. 77–84.
- Lloyd, B 2013, *Trends in alcohol and drug-related ambulance attendances in Victoria: 2011/12*, Turning Point Alcohol and Drug Centre, Fitzroy, Victoria.
- Lloyd B, Matthews, S & Gao, C 2014, *Trends in alcohol and drug-related ambulance attendances in Victoria 2012/2013*, Turning Point Alcohol and Drug Centre, Melbourne, accessed 5 June 2014 at <<http://www.turningpoint.org.au/site/DefaultSite/filesystem/documents/TP.ambocallout.fullreport.080514.pdf>>.
- Loughnan, A 2009, 'The legislation we had to have?: The Crimes (Criminal Organisations Control) Act 2009 (NSW)', *Current Issues in Criminal Justice*, vol. 20, no. 3, pp. 457–465.
- Louie, R, Krouskos, D, Gonzales, M & Crofts, N 1998, 'Vietnamese-speaking injecting drug users in Melbourne: The need for harm reduction programs', *Australian and New Zealand Journal of Public Health*, vol. 22, no. 4, pp. 481–484.
- Loxley, W, Toumbourou, JW, Stockwell, T & Haines, B 2004, *The prevention of substance use, risk and harm in Australia: a review of the evidence*, Commonwealth of Australia, Canberra.
- Lozusic, R 2002, *Gangs in NSW*, Briefing Paper No 16/02, NSW Parliamentary Library Research Service, Sydney.
- Macgregor, S & Payne, J 2011, 'Increase in use of methamphetamine: Findings from the DUMA program', *Research in Practice* no. 22, Australian Institute of Criminology, Canberra.
- Macgregor, S & J Payne 2012, 'Research in Practice 22: Increase in use of methamphetamine. Drug Use Monitoring in Australia: 2009–10 report on drug use among police detainees' (AIC Monitoring Report no. 17), Criminology, Australian Institute of Canberra
- Magistrates Court of Victoria 2014, *Guide to Specialist Courts and Court Support Services*, accessed 3 June 2014 from https://www.magistratescourt.vic.gov.au/sites/default/files/Default/Guide_to_Court_Support_and_Diversion_Services.pdf.
- Magor-Blatch, L & Pitts, J 2009, *Amphetamine-type stimulant use. Treatment Protocol for use by staff & clinicians working with ATS clients of Therapeutic Communities*, Odyssey House McGrath Foundation, Campbelltown, NSW.
- Majumder, I & White, J 2012, 'Pharmacology of amphetamine-type stimulants and implications for harms and responses', in Allsop S, Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, Hawthorn, Vic, pp. 21–32.
- Makkai, T & Beattie, J 2012, 'The impact of amphetamine-type stimulant use on law enforcement: patterns and responses', in Allsop S, Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 161–172.
- Mann, M & Ayling, J 2012, 'Capturing "organised crime" in Australian law', *Briefing Paper*, Issue 19, ARC Centre of Excellence in Policing and Security.
- Manning, M, Ransley, J, Smith C, Mazerolle, L & Cook, A 2013, 'Policing methamphetamine problems: A framework for synthesising expert opinion and evaluating alternate policy options', *Journal of Public Policy*, vol. 33, no. 3, pp. 371–96.
- Manning, M, Smith C & Mazerolle, P 2013, 'The societal costs of alcohol misuse in Australia', *Trends and Issues in Crime and Criminal Justice*, No. 454, Australian Institute of Criminology, Canberra.
- Marlatt, GA, Larimer, ME & Witkiewitz, K 2011, *Harm Reduction, 2nd edn: Pragmatic Strategies for Managing High-Risk Behaviors*, 2011, Guilford, New York.
- Marr, P 1995, 'Outlaw motorcycle gangs — An overview', *Australian Police Journal*, vol. 49, no. 1, pp. 49–56.
- Marsden, J, Ali, R, Adelkan, M, Perngparn, U, Liu, T, Sunga, A, Farrell, M & Monteiro, M 2000, *WHO Multi-Site Project on Functional/Instrumental Use of Amphetamine- Type Stimulants: Study Protocol and Instrumentation*, World Health Organization, Geneva.

- Marshall, M, Friedman, M, Stall, R & King, K 2008, 'Sexual orientation and adolescent substance use: A meta-analysis and methodological review', *Addiction*, vol. 103, no. 4, 546–556.
- Martin, I, Palepu, A, Wood, E, Li, K, Montaner, J & Kerr, T 2009, 'Violence among street-involved youth: The role of methamphetamine', *European Addiction Research*, vol.15, no. 1, pp. 32–8.
- Martin J 2014, *Drugs on the dark net: How cryptomarkets are transforming the global trade in illicit drugs*, Basingstoke, Palgrave Macmillan.
- Matheson, A, Roxburgh, A, Howard, J, Degenhardt, L 2010, 'Regular methamphetamine use and drug treatment access among a sample of gay, lesbian and bisexual Sydneysiders', *Drug and Alcohol Review*, vol. 29, pp. 49–49.
- Matrix Knowledge Group, 2007, *The Illicit Drug Trade in the United Kingdom*, Home Office Online Report no. 20.07, Home Office, London.
- Mayrhauser, C, von Brecht, M & Anglin, M 2002, 'Use ecology and drug use motivations of methamphetamine users admitted to substance abuse treatment facilities in Los Angeles: An emerging profile', *Journal of Addictive Diseases*, vol. 21, no. 1, pp. 45–60.
- McDonald, J 2003, *Peer education from evidence to practice — an alcohol and other drugs primer*, National Centre for Education on Training and Addiction, Adelaide.
- McElrath, K & McEvoy, K 2002, 'Negative experiences on ecstasy: The role of drug, set and setting', *Journal of Psychoactive Drugs*, vol. 34, no. 2, April-June, pp. 199–208.
- McGarrity, N 2012, 'From Terrorism to Bikies — Control orders in Australia', *Alternative Law Journal*, vol. 37, no. 3, pp. 166–170.
- McGregor, C, Srisurapanont, M, Jittiwutikarn, J, Laobhripatr, S, Wongtan, T & White, J 2005, 'The nature, time course and severity of methamphetamine withdrawal', *Addiction*, vol. 100, no. 9, pp. 1320–1329.
- McGregor, C, Srisurapanont, M, Mitchell, A, Wickes, W, & JM, W 2008, 'Symptoms and sleep patterns during inpatient treatment of methamphetamine withdrawal: A comparison of mirtazapine and modafinil with treatment as usual', *Journal of Substance Abuse Treatment*, vol. 35, no. 3, pp. 334–342.
- McIver, C, McGregor, C, Baigent, M, Spain, D, Newcombe, D & Ali, R 2006, *Guidelines for the medical management of patients with methamphetamine-induced psychosis*, Adelaide Drug & Alcohol Services, South Australia.
- McKetin, R 2006, 'Patterns and drug use in Australia', Asian Multi-City Epidemiology Working Group, Taipei.
- McKetin, R & Lubman, D 2011, 'Heavy stimulant use remains a significant health concern for Australia', *Medical Journal of Australia*, vol. 195, no. 10, pp. 565–566.
- McKetin, R, McLaren, J & Kelly, E 2005, *The Sydney methamphetamine market: Patterns of supply, use, personal harms and social consequences*, Monograph Series No. 13, National Drug Law Enforcement Research Fund (NDLERF), Canberra.
- McKetin, R, McLaren, J, Kelly, E, Hall, W & Hickman, M 2005, 'Estimating the number of regular and dependent methamphetamine users in Australia', *NDARC Technical Report no. 230*, National Drug and Alcohol Research Centre, Sydney.
- McKetin, R, Kelly, E & McLaren, J 2006, 'The relationship between crystalline methamphetamine use and methamphetamine dependence', *Drug and Alcohol Dependence*, vol. 85, no. 3, pp. 198–204.
- McKetin, R, McLaren, J, Lubman, D & Hides, L 2006, 'The prevalence of psychotic symptoms among methamphetamine users', *Addiction*, vol. 101, no. 10, pp. 1473–1478.
- McKetin, R, McLaren, J, Riddell, S & Robins, L 2006, 'The relationship between methamphetamine use and violent behaviour', *Contemporary Issues in Crime and Justice*, no. 97, NSW Bureau of Crime Statistics and Research, Sydney. <http://www.bocsar.nsw.gov.au/agdbasev7wr/bocsar/documents/pdf/cjb97.pdf>

- McKetin, R, McLaren, J, Lubman, D & Hides, L 2008, 'Hostility among methamphetamine users experiencing psychotic symptoms', *The American Journal on Addictions*, vol. 17, no. 3, pp. 235–240.
- McKetin, R, Ross, J, Kelly, E, Baker, A, Lee, N, Lubman, DI & Mattick, R 2008, 'Characteristics and harms associated with injecting vs. smoking methamphetamine among methamphetamine treatment entrants', *Drug and Alcohol Review*, vol. 27, pp. 277–285.
- McKetin, R, Sutherland, R, Bright, D & Norberg, M 2011, 'A systematic review of methamphetamine precursor regulations', *Addiction*, vol. 106, no. 11, pp. 1911–1924.
- McKetin, R, Baker, A, Kay-Lambkin, F & Lee, N 2012a, 'Amphetamine-type stimulant use on a global level and implications for responding', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 5–20.
- McKetin R, Najman, J, Baker A, Lubman, D, Dawe, S, Ali, R, Lee, N, Mattick, R & Mamun, A 2012b, 'Evaluating the impact of community-based treatment options on methamphetamine use: Findings from the Methamphetamine Treatment Evaluation Study (MATES)', *Addiction*, vol. 107, no. 11, pp. 1998–2008.
- McKetin, R, Lubman, D, Baker, A, Dawe, S & Ali, R 2013a, 'Dose-related psychotic symptoms in chronic methamphetamine users', *Jama Psychiatry*, vol. 70, no. 3, pp. 319–324, accessed 3 June 2014, from <<http://dx.doi.org/10.1001/jamapsychiatry.2013.283>>.
- McKetin, R, Kaye, S, Clemens, J & Hermens, D 2013b, 'Methamphetamine addiction', in *Principles of Addiction: Comprehensive Addictive Behaviors and Disorders*, Elsevier Academic Press, Amsterdam, pp. 689–698.
- McKetin R, Dunlop, AJ, Holland, RM, Sutherland, RA, Baker, AL, Salmon, AM & Hudson, SL 2013c, 'Treatment outcomes for methamphetamine users receiving outpatient counselling from the Stimulant Treatment Program in Australia', *Drug and Alcohol Review*, vol. 32, no. 1, pp. 80–87.
- McKetin, R, Lubman, D, Najman, J, Dawe, S, Butterworth, P & Baker A 2014, 'Does methamphetamine use increase violent behaviour? Evidence from a prospective longitudinal study', *Addiction*, vol. 109, no. 5, pp. 798–806.
- Measham, F, Newcombe, R & Parker, H 1994, 'The normalisation of recreational drug use amongst young people in North West England', *BJS*, vol. 45, no. 2, June, pp.287–312.
- Measham, F, Aldridge, J & Parker, H 2001, *Dancing on Drugs: Risk, Health and Hedonism in the British Club Scene*, Free Association Books, London.
- Memmott, P, Chambers, C, Go-Sam, C & Thomson, L 2006, *Good practice in Indigenous family violence prevention*, Australian Domestic and Family Violence Clearinghouse, UNSW, Sydney, NSW.
- Mental Health in Rural and Remote Communities 2008, Response — ability, Commonwealth of Australia*, at: www.responseability.org/.../Mental-Health-in-Rural-and-Remote-Com.
- Midford, R 2000, 'Does drug education work?', *Drug And Alcohol Review*, vol. 19, pp. 441–446.
- Midford, R 2009, 'Drug prevention programmes for young people: Where have we been and where should we be going?', *Addiction*, vol. 105, no. 10, pp. 1688–1695.
- Midford, R, McBride, N & Farrington, F 1999, 'Drug education: The need for an evidence based approach', *Centrelines*, A quarterly newsletter from the National Centre for Drug & Alcohol Research, vol. 33, pp.4–7.
- Midford, R & Munro, G (eds.) 2006, *Drug education in schools: Searching for the silver bullet*, IP communications, Melbourne.
- Midford, R, Snow, P & Lenton, S 2001, 'School-based illicit drug education programs: A critical review and analysis', RFT 637, pp. 1-80, Department of Employment, Education, Training and Youth Affairs, Melbourne.

- Midford, R, Mitchell, J, Lester, L, Cahill, H, Foxcroft, D, Ramsden, R, Venning, L & Pose, M 2014, 'Preventing alcohol harm: early results from a cluster randomised, controlled trial in Victoria, Australia of comprehensive harm minimisation school drug education', *International Journal of Drug Policy*, vol. 25, no. 1, pp. 142–50.
- Midford R, Cahill, H, Foxcroft ,D, Lester, L, Venning, L, Ramsden, R & Pose, M 2012, *Drug education in Victorian schools (DEVS): The study protocol for a harm reduction focused school drug education trial*, BMC Public Health, vol. 12, p. 112.
- Miller, M, Siggins, I, Hall, W, Bush, R, McDonald, D, Cleary, G, Lai, S, Ho, B, Fowler, G, O'Conner, M & Sumner, C 2009, *Evaluation and Monitoring of the National Drug Strategy 2004-2009*, Siggins Miller, accessed 23 July at www.ancd.org.au/images/PDF/NationalStrategies/nds2004eval.pdf.
- Miller, P, Pennay, A, Jenkinson, R, Droste, N, Chikritzhs, T, Tomsen, S, Wadds, P, Jones, S, Palmer, D, Barrie, L & Lubman, D, 2013, *Patron offending and intoxication in night-time entertainment districts (POINTED): Executive Summary*, National Drug Law Enforcement Research Fund (NDLERF), Canberra, ACT.
- Miller, W & Rollnick, S 2009, 'Ten things that motivational interviewing is not', *Behavioural and cognitive psychotherapy*, vol. 37, no. 2, pp. 129–140.
- Milloy, M, Kerr, T, Tyndall, M, Montaner, J & Wood, E 2008, 'Estimated drug overdose deaths averted by North America's first medically-supervised safer injection facility', *PLoS One*, vol. 3, no. 10, p. 3351.
- Mills, H, Skodbo, S & Blyth P 2013, *Understanding organised crime: Estimating the scale and the social and economic costs*, Research report no. 73, Home Office, London, accessed 5 June 2014 at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/246390/horr73.pdf.
- Mills, T 2014, 'Drug gang ruled with violence in Victorian country towns', *The Age* (Melbourne), 28 May, p. 9. http://newsstore.fairfax.com.au/apps/viewDocument.ac?sy=nstore&pb=all_ffx&dt=selectRange&dr=1month&so=relevance&sf=text&sf=headline&rc=10&rm=200&sp=brs&cls=1075&clsPage=1&docID=AGE140528E87V54H2FQ4.
- Ministerial Action Group on Drugs 2003, *Methamphetamine Action Plan*, Ministerial Action Group on Drugs, Wellington.
- Ministerial Council on Drug Strategy 1991, *National Action Plan on Problems Associated with Amphetamine Use*, Commonwealth of Australia, Canberra.
- Ministerial Council on Drug Strategy 2006, *National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*, Background paper, Commonwealth of Australia, Canberra.
- Ministerial Council on Drug Strategy (MCDS) 1998, *National Drug Strategic Framework 1998–99 to 2002–03. Building Partnerships: A way to reduce the harm caused by drugs in our community*, MCDS, Canberra.
- Ministerial Council on Drug Strategy 2011, *National Drug Strategy 2010–2015. A framework for action on alcohol, tobacco and other drugs*, Commonwealth of Australia, Canberra.
- Ministerial Council on Drug Strategy 2014, *National Drug Strategy*, Australian Government, Canberra, accessed 23 July 2014 at www.nationaldrugstrategy.gov.au.
- Ministry of Health (NZ) 2010, *Drug Use in New Zealand*, Ministry of Health, accessed 1 August 2014 at <http://www.health.govt.nz/system/files/documents/publications/drug-use-in-nz-v2-jan2010.pdf>.
- Ministry of Health (NZ) 2013, *A New National Drug Policy for New Zealand: Discussion document*, Ministry of Health, Wellington.
- Mitchell, J 2007, 'History', in B Carson, T Dunbar, RD Chenhall & R Bailie (eds.), *Social Determinants of Indigenous Health*, Allen & Unwin, Crows Nest, NSW.

- Moore, D 1992, *Recreational Drug Use, with Particular Reference to Amphetamines, Ecstasy and LSD, Amongst a Social Network of Young People in Perth, Western Australia*, National Centre for Research into the Prevention of Drug Abuse, Curtin University of Technology, Perth, WA.
- Moore, D 2002, 'Ethnography and the Australian drug field: Emaciation, appropriation and multidisciplinary myopia', *International Journal of Drug Policy*, no. 13, pp. 271–284.
- Moore, E, Winter, R, Indig, D, Greenberg, D & Kinner, S 2013, 'Non-fatal overdose among adult prisoners with a history of injecting drug use in two Australian states', *Drug and alcohol dependence*, vol. 133, no. 1, pp. 45–51.
- Morgan, P & Beck, J 1997, 'Hidden contexts of methamphetamine use in the United States', in Klee, H (ed.), *Amphetamine Misuse: International Perspectives on Current Trends*, Harwood Academic Publishers, The Netherlands, pp. 135–162.
- Morris, L, Sallybanks, J, Willis, K & Makkai, T 2003, 'Sport, physical activity and antisocial behaviour in youth', *Trends & issues in crime and criminal justice*, no. 249, Canberra/ACT: Australian Institute of Criminology.
- Morrison, S 2002, 'Approaching organised crime: Where are we now and where are we going?', *Trends and Issues in Crime and Criminal Justice*, no. 231, Australian Institute of Criminology, Canberra, ACT.
- Morselli, C 2009, *Inside Criminal Networks*, Springer, New York.
- Muller, D 2009, *Parental Engagement: Social and economic effects*, The Australian Parents Council, at <http://www.deewr.gov.au/Schooling/Resources/Documents/EffectivePartnershipsInPractice08-09.pdf>
- Mundy, J 2001, 'Methamphetamine: A growing epidemic?', *Connections*, April/May, pp. 2–6.
- Murray, S 2009, 'Keeping it in the Neighbourhood? Neighbourhood Courts in the Australian Context', *Monash University Law Review*, vol. 35, no. 1, pp. 74–95.
- Nancy, N, Pacula, R & Beau, K 2009, *The economic cost of Methamphetamine Use in the United States in 2005*. The RAND Corporation, accessed 5 June 2014 at http://www.rand.org/content/dam/rand/pubs/monographs/2009/RAND_MG829.pdf.
- National Association of Community Legal Centres 2013, *Submission of National Association of Community Legal Centres to the Senate Standing Committee on Legal and Constitutional Affairs*, Inquiry into the value of a justice reinvestment approach to criminal justice in Australia.
- National Centre for Education and Training on Addictions (NCETA) 2006, *Amphetamines and Work*, NCETA, Adelaide, SA.
- National Drug and Alcohol Research Centre (NDARC) 2002a, *Victorian Drug Trends 2001: Findings from the Illicit Drug Reporting System (IDRS)*, NDARC Technical Report No. 129, NDARC, University of New South Wales, Sydney, NSW.
- National Drug and Alcohol Research Centre (NDARC) 2002b, *Australian Drug Trends 2001: Findings of the Illicit Drug Reporting System (IDRS)*, NDARC Monograph No. 48, NDARC, University of New South Wales, Sydney.
- National Drug and Alcohol Research Centre (NDARC) 2003, 'Fact Sheet — Amphetamines', <http://ndarc.med.unsw.edu.au/ndarc.nsf>.
- National Drug Strategy (NDS) 2011, *National Pharmaceutical Drug Misuse Framework for Action 2012–2015: A Matter of Balance*, NDS, Canberra. Accessed at <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/drug-mu-frm-action>.
- National Indigenous Drug and Alcohol Committee 2014, *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples*, Australian National Council on Drugs, Canberra.
- National Institute on Drug Abuse (NIDA) (US) 2009, *Principles of drug addiction treatment: A research-based guide*, 3rd edn, National Institute of Health, U.S. Department of Health and Human Services, Maryland.

- National Institute on Drug Abuse (NIDA) (US) 2013, *Methamphetamine: Abuse and Addiction*, Research Report Series no. 13-4210, Office of Science Policy and Communications, Public Information and Liaison Branch, U.S. Department of Health and Human Services, Maryland, accessed 5 June 2014 at http://www.drugabuse.gov/sites/default/files/methrrs_web.pdf.
- National Institute of Justice (US) 2012, "'Swift and certain" sanctions in probation are highly effective: Evaluation of the HOPE Program', National Institute of Justice, accessed 20 June 2014 at <http://www.nij.gov/topics/corrections/community/drug-offenders/Pages/hawaii-hope.aspx>.
- National Treatment Agency for Substance Misuse 2009, *Young people's specialist substance misuse treatment: Exploring the evidence*, NTA, London. National Treatment Agency for Substance Misuse 2009, *Young people's specialist substance misuse treatment: Exploring the evidence*, NTA, London.
- Neale, J. 2001, 'Driving on recreational drugs: A qualitative investigation of experiences from behind the wheel', *Drugs education, prevention and policy*, vol. 8, no. 4, pp. 315–325.
- Nelson, A, Abbott, R & MacDonald, D 2010, 'Indigenous Australians and physical activity: using a social-ecological model to review the literature', *Health Education. Research*, vol. 25, no. 3, pp. 498–509.
- New South Wales Parliamentary Research Service 2013, 'Anti-gang laws in Australia', *Issues Backgrounder*, no. 5, December, NSW Government, Sydney.
- Newton, A 2007, *2006 Clandestine Drug Laboratory (Clan Lab) Report*, National Drug Intelligence Bureau, New Zealand Police.
- Nguyen, P, Dietze, P & Lloyd, B 2013, 'Victorian trends in ecstasy and related drug markets 2012: Findings from the Ecstasy and related Drugs Reporting System (EDRS)', *Australian Drug Trends no. 103*, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, accessed 5 June 2014 at http://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/VIC_EDRS_2012_FINAL.pdf.
- Nicholas, R 2006, *The current amphetamine situation in Australasia – Impacts for Policing*, Australian Centre for Policing, Adelaide.
- Nicholas, R 2008, *An Environmental Scan on Alcohol and Other Drug Issues Facing Law Enforcement in Australia*, National Drug Law Enforcement Research Fund, Canberra. <http://www.ndlerf.gov.au/publications/reports-discussions/environmental-scan-alcohol-and-other-drug-issues-facing-law>
- Nicosia, N, Pacula, L, Kilmer, B, Lundberg, R & Chiesa, J 2005, *The Economic Cost of Methamphetamine Use in the United States*, RAND Corporation, Santa Monica.
- Nilsen, P, Baird, J, Mello, MJ, Nirenberg, T, Woolard, R, Bendtsen, P & Longabaugh, R 2008, 'A systematic review of emergency care brief alcohol interventions for injury patients', *Journal of Substance Abuse Treatment*, vol. 35, no. 2, pp. 184–201.
- Office of the Commonwealth Director of Public Prosecutions (CDPP), *Annual Report 2012-13*, CDPP, Canberra./ <http://www.cdpp.gov.au/wp-content/uploads/CDPP-Annual-Report-2012-2013.pdf>.
- Ogden, EJD, Morris, C, Fredreikson, T, Boorman, M, King, R & Stough, CKK 2010, 'The relationship between accident culpability and the presence of drugs in blood samples taken from people injured in motor vehicle collisions', paper presented at the Australasian Road Safety Research, Policing & Education Conference, 31 August — 3 September, Canberra, Australian Capital Territory.
- Ogloff, JRP, Patterson, J, Cutajar, M, Adams, K, Thomas, S & Halacas, C 2013, *Koori Prisoner Mental Health and Cognitive Functioning Study: Final report*, Victorian Aboriginal Community Controlled Health Organisation, Melbourne.

- Olmstead, TA, Abraham, AJ, Martino, S & Roman, PM 2012, 'Counselor training in several evidence-based psychosocial addiction treatments in private US substance abuse treatment centers', *Drug Alcohol Depend*, vol. 120, nos. 1–3, pp. 149–154.
- Oppenheimer, E 2012, A Review of research on treatment interventions for ATS users, Paper prepared for the WHO Western Pacific Region Office, WHO/WPRO Manila.
- Organisation for Economic Co-operation and Development (OECD) 1997, *Convention Against the Bribery of Foreign Public Officials in International Business Transactions*, OECD, Paris http://www.oecd.org/daf/anti-bribery/ConvCombatBribery_ENG.pdf.
- Orwin, R, Cadell, D & Chu, A 2006, *Evaluation of the National Youth Anti-Drug Media Campaign: 2004 Report of Findings*, Bethesda, MD, National Institute on Drug Abuse.
- Owens, KP & Boorman, M 2011, *Evaluating the deterrent effect of random breath testing (RBT) and random drug testing (RDT): The driver's perspective*, Monograph series no. 41, National Drug Law Enforcement Research Fund, Canberra. http://www.ndlerf.gov.au/pub/Monograph_41.pdf.
- Papanastasiou C, Dietze P & Lloyd B 2014, 'Victorian Trends in Ecstasy and Related Drug Markets 2013: Findings from the Ecstasy and related Drugs Reporting System (EDRS)', *Australian Drug Trends*, no. 121, National Drug and Alcohol Research Centre, University of New South Wales, Sydney. <https://ndarc.med.unsw.edu.au/resource/victorian-trends-ecstasy-and-related-drug-markets-2013-findings-ecstasy-and-related-drugs>.
- Parliament of Victoria 2012, *Research Brief — Criminal Organisations Control Bill 2012*, Parliamentary Library Research Service.
- Parliamentary Joint Committee on the Australian Crime Commission 2007, *Inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs (AOSD) in Australia*, Parliament of Australia, Canberra, accessed at www.dldocs.stir.ac.uk/documents/australaosd.pdf.
- Parliamentary Joint Committee on the Australian Crime Commission 2009, *Inquiry into the Legislative Arrangements to Outlaw Serious and Organised Crime Groups*, Parliament of Australia, Canberra.
- Parliamentary Joint Committee on Law Enforcement 2011, *Report of the Inquiry into the adequacy of aviation and maritime security measures to combat serious and organised crime*, Parliamentary Joint Committee on Law Enforcement, Canberra. http://www.aph.gov.au/~media/wopapub/senate/committee/le_ctte/completed_inquiries/2010_13/aviation_maritime/report/report_pdf.ashx
- Parliamentary Joint Committee on Law Enforcement 2012, *Inquiry into Commonwealth Unexplained Wealth Legislation and Arrangements*, Parliament of Australia, Canberra.
- Pawsey, B & Hynan, C 2012, 'The impact of amphetamine-type stimulant use on mental health services', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 154–158.
- Payne, J, Kwiatowski, M & Wundersitz, J 2008, *Police drug diversion: A study of criminal offending outcomes*, Australian Institute of Criminology (AIC), Reports — Research and Public Policy Series, No 97, AIC, Canberra.
- PBS 2014, 'A new probation program in Hawaii beats the statistics', NewsHour Weekend, 2 February 2014, accessed 20 June 2014 http://www.pbs.org/newshour/bb/law-july-dec13-hawaiihope_11-24/.
- Pearsall, B 2014, 'Replicating HOPE: Can Others Do It As Well as Hawaii', National Institute of Justice, accessed 20 June 2014 at <http://nij.gov/journals/273/Pages/replicating-hope.aspx>.
- Peleg-Oren, N & Teichman, M 2006, 'Young children of parents with substance use disorders [SUD]: a review of the literature and implications for social work practice', in Straussner SLA & Fewell CH (eds.) *Impact of substance abuse on children and families: research and practice implications*, Haworth Press, New York, pp. 49–62.

- Pennington Institute 2014, *Be Crystal Clear: Integrated action to reduce the toll from methamphetamine and other drug-related harm in Victoria*, Pennington Institute, Melbourne.
- Pennay, A & Lee N, 2008, 'Prevention and early intervention of methamphetamine related harm', *Australian Drug Foundation, Prevention Research Quarterly*, September.
- Pennay, A & Lee, N 2009, 'Barriers to methamphetamine withdrawal treatment in Australia: Findings from a survey of AOD service providers', *Drug and Alcohol Review*, vol. 28, no. 6, pp. 636–640.
- Pennay, A, Ferris, J, Reed, M & Devaney, M 2010, *Evaluation of 'Access Point' Specialist Methamphetamine Clinic*, Turning Point Alcohol and Drug Centre, Fitzroy, Melbourne.
- Pennay, A, Lubman, D & Reichert, T 2012, 'Opportunistic interventions for methamphetamine use: Reducing the risks', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 154–158.
- Penning, R, Veldstra, JL, Daamen, AP, Olivier, B & Verster, JC 2010, 'Drugs of abuse, driving and traffic safety', *Current Drug Abuse Reviews*, vol. 3, no. 1, p. 29.
- Pew Research Centre 2010, 'The Impact of Hawaii's HOPE Program on Drug Use, Crime and Recidivism', The Pew Center on the States/National Institute of Justice, accessed 20 June 2014 at <http://www.pewtrusts.org/~media/Imported-and-Legacy/uploadedfiles/pcs_assets/2010/The20Impact20of20HawaiiE28099s20HOPE20Program20on20Drug20Use20Crime20and20Recidivism.pdf>
- Pidd, K & Roche, A 2009, 'Prevention of alcohol-related harm in the workplace', *Prevention Research Quarterly*, Issues Paper 10, pp. 1–10.
- Potera, C 2005, 'Meth's Pollution Epidemic', *Environmental Health Perspectives*, vol. 113, no. 9, p. 589.
- Pritchard, E, Mugavin, J & Swan, A 2007, *A discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs*, Australian National Council on Drugs, Canberra.
- Proude, E, Lopatko, O, Lintzeris, N, & Haber, P 2009, *The Treatment of Alcohol Problems: A Review of the Evidence*, Department of Health and Ageing, Australian Government, Canberra.
- Queensland Government 2011, *Queensland Drug Action Plan (2011-2012)*, Queensland Government, Brisbane.
- Quinn, B, Stoové, 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.
- Race, K 2009, *Pleasure consuming medicine: The queer politics of drugs*, Duke University Press, Durham.
- Ransley, J, Mazerolle, L, Manning, M, McGuoff, I, Drew, JM & Webster, J 2011, *Reducing the Methamphetamine Problem in Australia: Evaluating Innovative Partnerships Between Police, Pharmacies and Other Third Parties*, Monograph no. 39, National Drug Law Enforcement Research Fund, Canberra. http://www.ndlerf.gov.au/pub/Monograph_39.pdf.
- Rasmussen, N 2008, 'America's first amphetamine epidemic 1929-1971: A quantitative and qualitative retrospective with implications for the present', *American Journal of Public Health*, vol. 98, no. 6, pp. 974–985.
- Rawson, R, Huber, A, Brethen, P, Obert, J, Gulati, V, Shoptaw, S & Ling, W 2001, 'Status of methamphetamine users 2–5 years after outpatient treatment', *Journal of Addictive Diseases*, vol. 21, no. 1, pp. 107–119.
- Rawson, R, Marinelli-Casey, P, Anglin, M, Dickow, A, Frazier, Y, Gallagher, C, Galloway, G, Herrell, J, Huber, A, McCann, M, Obert, J, Pennell S, Reiber, C, Vandersloot D & Zweben, J 2004, 'A multi-site comparison of psychosocial approaches for the treatment of methamphetamine dependence', *Addiction*, vol. 99, no. 6, pp. 708–717.

- Rawson, R & McCann, M 2006, *The Matrix Model of Intensive Outpatient Treatment*, The Matrix Institute on Addictions.
- Reback, C & Grella, C 1999, 'HIV risk behaviors of gay and bisexual male methamphetamine users contacted through street outreach', *Journal of Drug Issues*, vol. 29, no. 1, pp. 155–166.
- Reback, C & Shoptaw, S 2011, 'Development of an evidence-based, gay-specific cognitive behavioral therapy intervention for methamphetamine-abusing gay and bisexual men', *Addictive behaviors*, vol. 39, no. 8, pp. 1286–1291.
- Reid, G, Higgs, P, Beyer, L & Crofts, N 2002, 'Vulnerability among Vietnamese illicit drug users in Australia: Challenges for change', *International Journal of Drug Policy*, vol. 13, pp. 127–136.
- Ritter, A 2007, 'Methamphetamine alarm: Are we forgetting what we know?', *Drug and Alcohol Review*, vol 27, no 3, pp.334–341.
- Ritter, N 2013, '*Cultural Shift' Is Among Findings of Second Chance Act Evaluation*', National Institute of Justice, accessed 20 June 2014 at <http://nij.gov/journals/273/Pages/second-chance-act-evaluation.aspx>.
- Ritter, A, Bright, D & Gong, W 2012, *Evaluating drug law enforcement interventions directed towards methamphetamine in Australia*, Monograph Series No. 44, National Drug Law Enforcement Research Fund (NDLERF), Commonwealth of Australia, Canberra.
- Ritter A & Lancaster K, 2013, 'Policy models and influences on policy processes', in A Ritter, T King & M Hamilton (eds.), *Drug Use in Australian Society*, edn. 1, Oxford University Press, Australia, pp. 99–132, http://www.oup.com.au/titles/higher_ed/health_sciences/9780195518863
- Roche, A & Pidd, K 2010, *Alcohol and Other Drugs Workforce Development Issues and Imperatives: Setting the Scene*, National Centre for Education and Training on Addiction, Adelaide, SA.
- Roche, A, Pidd, K, Bywood, P & Freeman, T 2008, 'Methamphetamine use among Australian workers and its implications for prevention', *Drug and Alcohol Review*, vol. 27, no. 3, pp. 334–341.
- Rollings, K 2008, *Counting the costs of crime in Australia: A 2005 update*, Research and public policy series no. 91, Australian Institute of Criminology, Canberra. Also accessed at <http://www.aic.gov.au/publications/rpp/91/index.html>.
- Rosario, M, Schrimshaw, E & Hunter, J 2009, 'Disclosure of sexual orientation and subsequent substance use and abuse among lesbian, gay, and bisexual youths: critical role of disclosure reactions', *Psychology of Addictive Behaviors*, vol. 23, no. 1, p. 175.
- Rose, ME & Grant JE, 2008, 'Pharmacotherapy for methamphetamine dependence: A review of the pathophysiology of methamphetamine addiction and the theoretical basis and efficacy of pharmacotherapeutic interventions', *Annals of Clinical Psychiatry*, vol. 20, pp. 145–155.
- Ross, P 2012, 'Effects of amphetamine-type stimulant use and problems for the individual, family and community', in Allsop S & Lee N (eds.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 91–103.
- Rowe, E, Akman, T, Smith, RG & Tomison, AM 2013, 'Organised crime and public sector corruption: A crime scripts analysis of tactical displacement risk', in *Trends and Issues in Crime and Criminal Justice*, no. 444, Australian Institute of Criminology, Canberra.
- Rowland, B, Toumbourou, J & Stevens, C 2003, 'Preventing drug-related harm in communities characterised by cultural and linguistic diversity', *DrugInfo Clearinghouse, Prevention research evaluation report*, no. 8, November, Australian Drug Foundation, West Melbourne.
- Russell, K, Dryden, DM, Liang, Y, Friesen, C, O'Gorman, K, Durec, T, Wild, TC & Klassen, TP 2008, 'Risk factors for methamphetamine use in youth: a systematic review', *BMC Pediatrics*, vol. 8, no. 48.
- Ryder, D, Walker, N & Salmon, A 2001, *Drug use and drug-related harm*, IP Communications, East Hawthorn, Vic.

- Saitz, R, Alford, DP, Bernstein, J, Cheng, DM, Samet, J & Palfai, T 2010, 'Screening and brief intervention for unhealthy drug use in primary care Settings: Randomized clinical trials are needed', *Journal of Addiction Medicine*, vol. 4, no. 3, pp. 123–130.
- Salo, R, Nordahl, T, Galloway, G, Moore, C, Waters, C & Leamon, M 2009, 'Drug abstinence and cognitive control in methamphetamine-dependent individuals', *Journal of substance abuse treatment*, vol. 37, no. 3, pp. 292–297.
- Salvation Army 2013, *A unique partnership to combat 'P' addiction*, Salvation Army, Wellington, accessed 1 August at <http://www.salvationarmy.org.nz/our-community/faith-in-life/our-people-our-stories/journeying-together>.
- Sara, G, Burgess, P, Harris, M, Malhi, G & Whiteford, H 2011, 'Stimulant use and stimulant use disorders in Australia: findings from the National Survey of Mental Health and Wellbeing', *Medical Journal of Australia*, vol. 195, no. 10, pp. 607–609.
- Schetter, A 2013, 'More police 'no solution' to drug woes', *The Age*, 11 July. Online at www.theage.com.au/more-police-no-solution-to-drug-woes-20130710-.
- Schloenhardt, A 2007, 'The market for amphetamine-type stimulants and their precursors in Oceania', *Research and Public Policy Series*, no.81, Australian Institute of Criminology, Canberra, accessed 5 June 2014 at <http://www.aic.gov.au/documents/7/F/8/%7B7F8A14E8-D893-4D3F-BFE0-DCAE3B2A035C%7Drpp81.pdf>.
- Schloenhardt, A 2008, 'Mafias and motorbikes: New organised crime offences in Australia', *Current Issues in Criminal Justice*, vol. 19, no. 3, pp. 259–281.
- Schloenhardt, A 2011, 'Banning the bikies: Queensland's Criminal Organisation Act 2009', *Queensland Lawyer*, vol. 31, pt. 2, pp. 100–113.
- Schlosser, E 2002, *Fast food nation*, Houghton Mifflin, Boston.
- Scott, JC, Woods, SP, Matt, GE, Meyer, RA, Heaton, RK, Atkinson, JH & Grant, I 2007, 'Neurocognitive effects of methamphetamine: A critical review and meta-analysis', *Neuropsychology Review*, vol. 17, pp. 275–97.
- Seear, K & Fraser, S 2010, 'The "sorry addict": Ben Cousins and the construction of drug use and addiction in elite sport', *Health Sociology review*, vol. 19, no. 2, p.178.
- Semple, G, Grant, I & Patterson, T 2005, 'Female methamphetamine users: Social characteristics and sexual risk behavior', *Women & Health*, vol. 40, no. 3, pp. 35–50.
- Sexton, RL, Carlson, RG, Leukefeld, CG & Booth, BM 2009, 'An ethnographic exploration of self-reported violence among rural methamphetamine users', *Journal of Ethnicity in Substance Abuse*, vol. 8, no. 1, pp. 35–53. <http://www.tandfonline.com/doi/abs/10.1080/15332640802683409#.U8MhMo2KAY8>.
- Shearer, J, Darke, S, Rodgers, C, Slade, T, van Beek, I, Lewis, J, Wodak, A 2009, 'A double-blind, placebo-controlled trial of modafinil (200 mg/day) for methamphetamine dependence', *Addiction*, vol. 104, no. 2, pp. 224–233.
- Shearer, J, Wodak, A, Mattick, RP, Van Beek, I, Lewis, J, Hall, W, & Dolan, K 2001, 'Pilot randomized controlled study of dexamphetamine substitution for amphetamine dependence', *Addiction*, vol. 96, no. 9, pp. 1289–1296.
- Shoptaw, S, Kao, U, Heinzerling, K & Ling, W 2009, 'Treatment for amphetamine withdrawal', *Cochrane Database Syst Rev*, vol. 2.
- Shoptaw, S, Reback, C & Freese, T 2002, 'Patient characteristics, HIV serostatus, and risk behaviours among gay and bisexual males seeking treatment for methamphetamine abuse and dependence in Los Angeles', *Journal of Addictive Diseases*, vol. 21, no. 1, pp. 91–105.
- Siggins Miller 2009, 'Evaluation and Monitoring of the National Drug Strategy 2004-2009', vol. 2, Case studies, literature reviews, and headline indicators, Unpublished Manuscript.

- Simon, S, Dornier, C, Carnell, J., Brethen, P, Rawson, R & Ling, MD 2000, 'Cognitive impairment in individuals currently using methamphetamine', *American Journal on Addictions*, vol. 9, pp. 222–231.
- Simon, S, Dean, A, Cordova, X, Monterosso, J & London, E 2010, 'Methamphetamine dependence and neuropsychological functioning: evaluating change during early abstinence', *Journal of studies on alcohol and drugs*, vol. 71, no. 3, p. 335–344.
- Simpson, T & Miller, W 2002, 'Concomitance between childhood sexual and physical abuse and substance use problems: A review', *Clinical Psychology Review*, vol. 22, no. 1, pp. 27–77.
- Sindicich, N & Burns, L 2013, 'National trends in ecstasy and related drug markets 2012: Findings from the Ecstasy and related Drugs Reporting System (EDRS)', *Australian Drug Trends*, no. 100, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, accessed 5 June 2014 to <http://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/EDRS%202012%20national%20report%20FINAL.pdf>.
- Sindicich, N & Burns, L 2014, 'National trends in ecstasy and related drug markets 2013: Findings from the ecstasy and related drugs reporting system (EDRS)', *Australian Drug Trends*, no. 118, National Drug and Alcohol Research Centre, University of New South Wales, Sydney. <https://ndarc.med.unsw.edu.au/resource/ecstasy-and-related-drugs-reporting-system-edrs-national-report-2013>.
- Single, E, Christie, P & Ali, R 2000, The impact of cannabis decriminalisation in Australia and the United States, *Journal of Public Health Policy*, vol. 21, no.2 (Summer), pp.157–186.
- Slavin, S 2004, 'Crystal methamphetamine use among gay men in Sydney', *Contemporary Drug Problems*, vol. 31, pp. 425-465.
- Smart Justice 2013, *Fact Sheet: Reducing drug-related crime*, February. Online at http://www.smartjustice.org.au/resources/SMART_Drugs.pdf.
- Smart Justice 2014, *Fact Sheet: Justice reinvestment: investing in communities not prisons*, April. Online at http://www.smartjustice.org.au/cb_pages/files/SMART_Reinvestment.pdf.
- Smith, N & Rodwell, L 2009, 'Does receiving an amphetamine charge increase the likelihood of a future violent charge?', *Contemporary Issues in Crime and Justice* (No.126), Crime and Justice Bulletin, NSW Bureau of Crime, Sydney.
- Smout, MF, Longo, M, Harrison, S, Minniti, R, Cahill, S, Wickes, W & White, JM 2010a, 'The Psychostimulant Check-Up: A pilot study of a brief intervention to reduce illicit stimulant use', *Drug and Alcohol Review*, 29, no. 2, 169–176.
- Smout, M, Longo, M, Harrison, S, Minniti, R, Wickes, W & White, J 2010b, 'Psychosocial treatment for methamphetamine use disorders: A preliminary randomized controlled trial of cognitive behavior therapy and acceptance and commitment therapy', *Substance Abuse*, vol. 31, no. 2, pp. 98–107.
- Sommers, I & Baskin, D 2006, 'Methamphetamine use and violence', *Journal of Drug Issues*, vol. 36, no. 1, pp. 77–96.
- Sommers, A & Sommers, I 2006, 'Methamphetamine use and violence among young adults. *Journal of Criminal Justice*, vol. 34, pp. 661–674.
- Srisurapanont, M, Jarusuraisin, N & Kittirattanapaiboon, P 2001a, 'Treatment for amphetamine withdrawal', *Cochrane Database Syst Rev*, vol. 4, CD003021.
- Srisurapanont, M, Jarusuraisin, N, Kittirattanapaiboon, P 2001b, 'Treatment for amphetamine dependence and abuse (review)', *Cochrane Database Syst Rev*, vol. 4,.
- Stafford, J & Burns, L 2011, *IDRS drug trends bulletin October 2011*, National Drug and Alcohol Research Centre, Sydney, NSW.
- Stafford J & Burns L 2013, 'Australian drug trends 2012: Findings from the Illicit Drugs Reporting System (IDRS)', *Australian Drug Trends Series*, no. 91, National Drug and Alcohol Research

- Centre, University of New South Wales, Sydney, NSW, accessed 3 June 2014, <http://ndarc.med.unsw.edu.au/resource/illicit-drug-reporting-system-idrs-national-report-2012>.
- Stafford, J & Burns, L 2014, 'Australian drug trends 2013: Findings from the illicit drug reporting system (IDRS)', *Australian Drug Trends*, no. 109, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, http://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/National_IDRS_2013.pdf
- Stathopoulou, G, Powers, MB, Berry, AC, Smits, JAJ & Otto, MW 2006, 'Exercise interventions for mental health: a quantitative and qualitative review', *Clinical Psychology*, vol. 13, no. 2, pp. 179–193.
- Stephenson, M, Giller, H & Brown, S 2007, *Effective practice in youth justice*, Willan Publishing, Devon.
- Stockwell, T, Gruenewald, PJ, Toumbourou, JW & Loxley, W (eds.) 2005, *Preventing harmful substance use: The evidence base for policy and practice*, John Wiley and Sons Ltd, Chichester, England.
- Stotts, AL, Green, C, Masuda, A, Grabowski, J, Wilson, K, Northrup, TF & Schmitz, JM 2012, 'A stage I pilot study of acceptance and commitment therapy for methadone detoxification', *Drug and Alcohol Dependence*, vol. 125, no. 3, pp. 215–222.
- Stoutenberg, M, Rethorst, CD, Fuzat, G, Greer, T, Blair, S, Church, T, Marcus, B & Trivedi, Madhukar 2012, 'Stimulant Reduction Intervention using Dosed Exercise (STRIDE) — Description of the exercise intervention and behavioral program to ensure adherence', *Mental Health and Physical Activity*, vol. 5, no. 2, pp.175–182.
- Strona, F, McCright, J, Hjord, H, Ahrens, K, Tierney, S, Shoptaw, S & Klausner, J 2006, 'The acceptability and feasibility of the Positive Reinforcement Opportunity Project, a community-based contingency management methamphetamine treatment program for gay and bisexual men in San Francisco', *Journal of psychoactive drugs*, vol. 38, no. sup 3, pp. 377–383.
- Strong, CA 2003, 'Crimes (Money Laundering) Bill: Second reading speech', *Hansard*, Legislative Council Victoria, 2 December, pp. 2035-2040. <http://tex.parliament.vic.gov.au/bin/texhtml?form=jVicHansard.dumpall&db=hansard91&dodraft=0&house=COUNCIL&speech=29006&activity=Second+Reading&title=CRIMES+%28MONEY+LAUNDERING%29+BILL&date1=2&date2=December&date3=2003&query=true%0a%09and+%28+data+contains+'money'%0a%09and+data+contains+'launder'+%29%0a>
- Stubbs, M, Hides, L, Howard, J. & Arcuri, A 2004, 'Psychostimulants and young people', in A Baker, N Lee & L Jenner (eds.), *Models of intervention and care for psychostimulant users*, 2nd edn, Monograph series no. 51, Department of Health and Ageing, Australian Government, Canberra.
- Substance Abuse and Mental Health Services Administration 2012, *Highlights of the 2010 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits*, The DAWN report, Centre for Behavioural Health Statistics and Quality, Washington, accessed 5 June 2014 at <http://www.samhsa.gov/data/2k12/DAWN096/SR096EDHighlights2010.pdf>.
- Substance Abuse and Mental Health Services Administration (SAMHSA) 2013, *Drug Abuse Warning Network, 2011: National estimates of drug-related emergency department visits*, The DAWN report, Centre for Behavioural Health Statistics and Quality, Maryland. <http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.pdf>
- Successworks 2003, *Evaluation of the National Drug Strategic Framework 1998-99 — 2003-04*, Successworks, Melbourne.
- Swan, A & Tyssen, E 2009, 'Enhancing treatment access: Evaluation of an Australian Web-based alcohol and drug counselling initiative', *Drug and Alcohol Review*, vol. 28, no. 1, pp. 48–53.

- Sweeney, J & Payne, J 2011, 'Poly drug use among police detainees', *Trends and Issues in Crime and Criminal Justice*, no. 425, Australian Institute of Criminology, Canberra. http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi425.pdf.
- Sweeney, J & Payne, J 2012, Magistrates Court of Victoria, *Court Integrated Services Program (CISP)*, accessed 3 June 2014 from <https://www.magistratescourt.vic.gov.au/jurisdictions/specialist-jurisdictions/court-support-services/court-integrated-services-program-cisp>.
- Tait, R, McKetin, R, Kay-Lambkin, F, Bennett, K, Tam, A, Bennett, A, Geddes, J, Garrick, A, Christensen, H & Griffiths, K 2012, 'Breaking-the-ice: A protocol for a randomised controlled trial of an internet-based intervention addressing amphetamine-type stimulant use', *BMC psychiatry*, vol. 12, no. 1, p. 67.
- Tarczon, C 2012, *Mothers with a history of childhood sexual abuse: Key issues for child protection practice and policy*, Australian Centre for the Study of Sexual Assault, Melbourne.
- Tasmanian Government 2013, *Tasmanian Drug Strategy 2013-2018*, Tasmanian Government, Hobart.
- Teasdale, KE, Conigrave, KM, Kiel, KA, Freeburn, B, Long, G, & Becker, K 2008, 'Improving services for prevention and treatment of substance misuse for Aboriginal communities in a Sydney Area Health Service', *Drug and Alcohol Review*, vol. 27, no. 2, 152–159.
- Teter, CJ, McCabe SE, Lagrange, K, Cranford JA & Boyd CJ 2006, 'Illicit use of specific prescription stimulants among college students: prevalence, motives and routes of administration', *Pharmacotherapy*, vol. 26, 1501–1510.
- Thomas, JO, Dunn, M, Swift, W & Burns, L 2010, 'Elite athletes' perceptions of the effects of illicit drug on athletic performance', *Clinical Journal Sport Medicine*, vol. 20, no. 3, May, p. 189.
- Topp L 2001, 'The use of methamphetamine in Australia', *Centre Lines*, Newsletter of the National Centre for Drug and Alcohol Research, February, pp. 3–4.
- Topp, L 2012, 'Amphetamine-type stimulant use and risk-tasking behaviours' in Allsop S, Lee N (ed.), *Perspectives on amphetamine-type stimulants*, IP Communications, East Hawthorn, Vic, pp. 69–82.
- Topp, L & Darke, S 1997, 'The applicability of the dependence syndrome to amphetamine', *Drug and Alcohol Dependence*, vol. 48, no. 2, pp. 113–118.
- Topp, L & Mattick, R 1997, 'Validation of the amphetamine dependence syndrome and the SAMDQ', *Addiction*, vol. 92, no. 2, pp. 151–162.
- Topp, L & Churchill, A 2002a, *Australia's Dynamic Methamphetamine Markets*, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, NSW.
- Topp, L & Churchill, A 2002b, *The Illicit Drug Reporting System Trends Bulletin*, June 2002, National Drug and Alcohol Research Centre, Sydney, NSW.
- Topp, L, Degenhardt, L, Kaye, S & Darke, S 2002, 'The emergence of potent forms of methamphetamine in Sydney, Australia: a case study of the IDRS as a strategic early warning system', *Drug and Alcohol Review*, vol. 21, no. 4, pp. 341–348.
- Torok, M, Darke, S, Kaye, S, Ross, J & McKetin, R 2008, *Comparative Rates of Violent Crime Amongst Methamphetamine and Opioid Users: Victimisation and Offending*, Monograph no. 32, National Drug Law Enforcement Research Fund, Canberra. http://www.ndlerf.gov.au/pub/Monograph_32.pdf.
- Tressider J & Shaddock C 2008, 'Policing and Cannabis use in Australia', *Criminal Justice Bulletin*, Series 1, May 2008, Australian Institute of Criminology, accessed 1 August 2014 at <https://ncpic.org.au/ncpic/publications/aic-bulletins/pdf/policing-and-cannabis-use-in-australia>.
- Tucker, S & Cadora, E 2003, 'Ideas for an open society: Justice Reinvestment', *Open Society Institute*, vol. 3, no. 3.

- Twohig, MP, Shoenberger, D & Hayes, SC 2007, 'A preliminary investigation of Acceptance and Commitment Therapy as a treatment for marijuana dependence in adults', *Journal of Applied Behavior Analysis*, vol. 40, pp. 619–632.
- Ullman, S, Najdowski, C & Filipas, H 2009, 'Child sexual abuse, post-traumatic stress disorder, and substance use: Predictors of revictimization in adult sexual assault survivors', *Journal of child sexual abuse*, vol. 18, no. 4, pp. 367–385.
- United Nations 2004, *United Nations Convention against Transitional Organized Crime and the protocols thereto*, United Nations, New York. <http://www.unodc.org/documents/treaties/UNTOC/Publications/TOC%20Convention/TOCebook-e.pdf>.
- United Nations (UN) 2013, *Precursors and Chemicals Frequently Used in the Illicit Manufacture of Narcotic Drugs and Psychotropic Substances*, International Narcotics Control Board, UN, New York. https://www.incb.org/incb/en/precursors/technical_reports/precursors-technical-reports.html
- United Nations Information Service 2005, *United Nations Convention against Transnational Organised Crime Receives 100th Instrument Ratification*, United Nations, Vienna. <http://www.unis.unvienna.org/unis/en/pressrels/2005/uniscp510.html>
- United Nations Office on Drugs and Crime (UNODC) 1988, *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, UNODC, Vienna. <https://www.unodc.org/unodc/en/commissions/CND/conventions.html>
- United Nations Office on Drugs and Crime 2011 (UNODC), *Estimating illicit financial flows resulting from drug trafficking and other transnational organised crimes - Research Report*, Vienna, accessed 5 June 2014 at <http://www.unodc.org/documents/data-and-analysis/Studies/Illicit_financial_flows_2011_web.pdf>.
- United Nations Office on Drugs and Crime (UNODC) 2013a, *Patterns and Trends of Amphetamine-Type Stimulants (ATS) and other drugs - Challenges for Asia and the Pacific in 2013*. A Report from the Global SMART Programme, Vienna, accessed 5 June 2014 at http://www.unodc.org/documents/scientific/2013_Regional_ATS_Report_web.pdf.
- United Nations Office on Drugs and Crime (UNODC) 2013b, *Transnational Organised Crime in East Asia and the Pacific - A Threat Assessment*, Vienna, accessed 5 June 2014 at http://www.unodc.org/documents/data-and-analysis/Studies/TOCTA_EAP_web.pdf.
- United Nations Office on Drugs and Crime (UNODC) 2013c, *World Drug Report*, UNODC, Vienna, Austria, accessed 5 June at http://www.drugs.ie/resourcesfiles/ResearchDocs/Global/UN_World_Drug_Report_2013.pdf.
- United Nations Office on Drugs and Crime (UNODC) 2014, *United Nations Convention against Corruption*, UNODC, New York. <https://www.unodc.org/unodc/en/treaties/CAC/>.
- United Nations Office on Drugs and Crime (UNODC) 2014a, *Global Synthetic Drugs Assessment: Amphetamine-type stimulants and new psychoactive substances*, Vienna, Austria, accessed 5 June 2014 at <http://hesp-news.org/2014/05/20/2014-global-synthetic-drugs-assessment-amphetamine-type-stimulants-and-new-psychoactive-substances/>.
- United Nations Office on Drugs and Crime (UNODC) 2014b, *World Drug Report 2014*, UNODC, Vienna. [http://www.unodc.org/documents/wdr2014/World Drug Report 2014 web.pdf](http://www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf).
- United States Department of Justice, Drug Law Enforcement Administration 2013, *National Drug Threat Assessment Summary 2013*, DEA Office of Intelligence Warning, Plans and Program, Department of Justice, Washington, accessed 5 June 2014 at <http://www.justice.gov/dea/resource-center/DIR-017-13%20NDTA%20Summary%20final.pdf>.
- United States Department of Justice, 2004, *Defining Drug Courts: The Key Components*, US Department of Justice, Washington DC.
- Van de Bunt, H 2004, 'Organised crime policies in the Netherlands', in Fijnaut, C & Paoli, L (eds.), *Organised Crime in Europe: Concepts, Patterns and Control Policies in the European Union and Beyond*, pp. 677–716, Springer, Dordrecht.

- Vanderplasschen, W, Colpaert, K, Autrique, M, Rapp, R, Pearce, S, Broekaert, E & Vandeveld, S 2013, 'Therapeutic communities for addictions: a review of their effectiveness from a recovery-oriented perspective', *The Scientific World Journal*, vol. 2013.
- Van der Sterren, A, Anderson, I & Thorpe, L 2006, "'Individual' harms, community 'harms': reconciling Indigenous values with drug harm minimisation policy', *Drug and Alcohol Review*, vol. 25, pp. 219–225.
- Van der Westhuizen, M, Alpaslan, AHN, & De Jager, M 2013, 'Aftercare to chemically addicted adolescents: An exploration of their needs', *Health SA Gesondheid*, vol. 18, no. 1, pp. 1–11.
- Vearrier, D, Greenberg, M, Miller S, Okaneku, J & Haggerty, D 2012, 'Methamphetamine: History, pathophysiology, adverse health effects, current trends, and hazards associated with the clandestine manufacture of methamphetamine', *Disease-a-Month*, vol. 58, no.2, pp. 38–89.
- Victoria Police 2013, *Annual Report 2012-13*, Victoria Police, Melbourne. http://www.police.vic.gov.au/content.asp?a=internetBridgingPage&Media_ID=97049.
- Victoria Police 2014, 'About Victoria Police', VicPol website. http://www.police.vic.gov.au/content.asp?Document_ID=3.
- Victorian Auditor-General's Office (VAGO) 2011, *Report into Problem Solving Approaches to Justice*, April, VAGO, Melbourne.
- Victorian Auditor-General's Office (VAGO) 2013, *Prevention and Management of Drug Use in Prisons*, VAGO, Melbourne, Vic.
- Victorian Auditor-General's Office (VAGO) 2014, *Report on Accessibility of Mainstream Services for Aboriginal Victorians*, VAGO, Melbourne.
- Victorian Drug and Alcohol Prevention Council 2010, *Victorian Youth Alcohol and Drug Survey 2009*, Social Research Centre, Department of Health, Melbourne, accessed 5 June 2014 at <http://www.health.vic.gov.au/vdapc/downloads/vyads-report-01092010.pdf>.
- Victorian Ombudsman 2014, *Investigation into deaths and harms in custody*, Victorian Ombudsman, Melbourne. Online at <https://www.ombudsman.vic.gov.au/getattachment/2998b6e6-491a-4dfe-b081-9d86fe4d4921>.
- Vincent, N, Shoobridge, J, Ask, A, Allsop, S & Ali, R 1999, 'Characteristics of amphetamine users seeking information, help and treatment in Adelaide, South Australia', *Drug and Alcohol Review*, vol. 18, no. 1, pp. 63–73.
- Volkow, N, Chang, L, Wang, G, Fowler, J, Ding, Y, Sedler, M, Logan, J, Franceschi, D, Gatley, J, Hitzemann, R & others, 2001, 'Low level of brain dopamine D2 receptors in methamphetamine abusers: association with metabolism in the orbitofrontal cortex', *FOCUS: The Journal of Lifelong Learning in Psychiatry*, vol. 1, no. 2, pp. 150–157.
- Volkow, N & Li, T 2004, 'Drug addiction: The neurobiology of behaviour gone awry', *Nature Reviews Neuroscience*, vol. 5, no. 12, pp. 963–970.
- Vos, T 2010, *Random Roadside Drug Testing Program in Victoria*, Briefing Paper, at: http://www.sph.uq.edu.au/docs/BODCE/ACE-P/ACE-P_briefing_Roadside_drugtest.pdf.
- WA Drug and Alcohol Office 2011, *Drug and alcohol interagency strategic framework for Western Australia 2011-2015: illicit drug support plan 2012-2015*, WA Drug and Alcohol Office, Perth.
- Wakefield, M, Loken, B & Hornik, R 2010, 'Use of mass media campaigns to change health behaviour', *The Lancet*, vol. 376, October, pp.1261–1271.
- Walker, D 2013, 'Breaking bad: Why doesn't the UK have a crystal meth problem?', *BBC News Magazine*, 6 August, accessed 5 June 2014 at <http://www.bbc.co.uk/news/magazine-23453028>.
- Walker, J & Donaldson, C. 2010, *Intervening to improve outcomes for vulnerable young people: a review of the evidence*, UK Dept of Education Research Report DFE-RR078, October, Department of Education, London.

- Wallace, C, Galloway, T, McKetin, R, Kelly, E, & Leary, J 2009, 'Methamphetamine use, dependence and treatment access in rural and regional North Coast of New South Wales', *Australia. Drug and Alcohol Review*, vol. 28, no. 6, pp. 592–599.
- Walters, A 2014, 'Could this be the solution to America's probation problem', Aljazeera America, 6 Feb 2014, accessed 20 June 2014 at <http://america.aljazeera.com/watch/shows/america-tonight/america-tonight-blog/2014/2/6/probation-hawaiihope.html>.
- Watanabe-Galloway, S, Ryan S, Hansen K and Hullisek B, 2009, 'Effects of methamphetamine abuse beyond individual users', *Journal of Psychoactive Drugs*, vol. 41, no. 3, pp. 241–248.
- Ward et al. 2013, 'Findings from the GOANNA study', by James Ward, Joanne Bryant, Heather Worth, John Kaldor, Dea Delaney-Thiele, Marian Pitts, Dy Kelaart, Elizabeth Moore, Sallie Cairnduff, Sidney Williams, Peter Waples-Crowe, Kat Byron, Andrew Bamblett, Sarah Betts and Tony Coburn on behalf of the GOANNA study team, *HIV Australia*, vol. 11, no. 3. October 2013. Accessed online at <http://www.afao.org.au/library/hiv-australia/volume-11/vol.-11-number-3/findings-from-the-goanna-study>
- Ware, V 2013, *Mentoring Programs for Indigenous Youth at Risk*, Resource Sheet No. 22, Closing the Gap Clearing House, Australian institute of Health and Welfare, Canberra.
- Weatherburn, D, Jones, C, Snowball L & Hua J 2008, 'The NSW Drug Court: A re-evaluation of its effectiveness', *Crime and Justice Bulletin*, No. 121, Bureau of Crime Statistics and Research (NSW), Sydney.
- Ian Webster 1995, NCADA and NDS — looking forward while looking back, in Paul Dillon (ed.), *NDARC Monograph No. 27, The National Drug Strategy: The first 10 years and beyond: Proceedings from the Eighth National Drug and Alcohol Research Centre Annual Symposium, November 1995*, National Drug and Alcohol Research Centre, Sydney.
- Wermuth, L. 2000, 'Methamphetamine use: Hazards and social influences', *Journal of Drug Education*, vol. 30, no. 4, pp.423–433.
- Western Australia Drug and Alcohol Office 2007, *Western Australia Illicit Amphetamine Summit*, Background paper, Drug and Alcohol Office, Perth.
- White, A, Kavanagh, D, Stallman, H, Klein, B, Kay-Lambkin, F, Proudfoot, J, Drennan, J, Connor, J, Baker, A, Hines, E & Young, R 2010, 'Online alcohol interventions: a systematic review', *Journal of medical Internet research*, vol. 12, no. 5.
- White, V & Bariola, E 2012, *Australian Secondary School Student's Use of Tobacco, Alcohol, and Over-the-counter and Illicit Substances in 2011*, Centre of Behavioural Research in Cancer, Cancer Council Victoria, Melbourne. [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/BCBF6B2C638E1202CA257ACD0020E35C/\\$File/National%20Report_FINAL_ASSAD_7.12.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/BCBF6B2C638E1202CA257ACD0020E35C/$File/National%20Report_FINAL_ASSAD_7.12.pdf).
- Wickes, W 1993, 'Medical aspects of psychostimulant use', in D Burrows, B Flaherty & M MacAvoy (eds.), *Illicit psychostimulant use in Australia*, Commonwealth Department of Housing and Community Services and Drug and Alcohol Directorate, New South Wales Health Department, Australian Government Printing Service, Canberra, pp. 31–52.
- Williams, L & Parker, H 2001, 'Alcohol, cannabis, ecstasy and cocaine: drugs of reasoned choice amongst young adult recreational drug users in England', *International Journal of Drug Policy*, vol. 12, no. 5, pp. 397–413.
- Winford, S 2014, 'Drug Offences', *The law Handbook*, Fitzroy Legal Service, Melbourne. Online at <http://www.lawhandbook.org.au/handbook/ch04s01.php>.
- Withey, A 2014, 'Motorcycle Council to lodge High Court challenge against Queensland's anti-bikie laws', *ABC News Online*, 19 March. <http://www.abc.net.au/news/2014-03-19/motorcycle-council-lodge-high-court-challenge-against-bikie-laws/5330796>.
- Wodak, A, 2006, Responding to the growing threat to HIV control among injecting drug users in Asia from increasing use of amphetamine, Unpublished paper, Dr Alex Wodak, St Vincent's Hospital Darlinghurst, 17 October 2006.

- Wood, C 1998, 'Speed: A matter of treatment', *Connexions*, vol. 17, no. 6, December 1997/January, pp. 19–22.
- Woodruff, SI, Clapp, JD, Eisenberg, K, McCabe, C, Hohman, M, Shillington, AM, Sise, CB, Castillo, EM, Chan, TC & Sise, MJ 2014, 'Randomized clinical trial of the effects of screening and brief intervention for illicit drug use: the life shift/shift gears study', *Addiction Science & Clinical Practice*, vol. 9, no. 1, pp. 1–11.
- World Health Organization (WHO) 1996, *Promoting Health through Schools. The World Health Organization's Global School Health Initiative*, Prepared for WHO/HPR/HEP by S Cohen & C Vince-Whitman, Education Development Center Inc., Newton, Mass., USA, Geneva: WHO.
- World Health Organization (WHO) 2011, *Patterns and consequences of the use of amphetamine type stimulants (ATS)*, Technical brief on ATS 1, WHO, Western Pacific Region Office, Manila.
- Wundersitz, J 2007, *Criminal justice responses to drug and drug-related offending: Are they working?*, Technical and Background Paper No 25, Australian Institute of Criminology, Canberra.
- Zabransky T 2007, 'Methamphetamine in the Czech Republic', *Journal of Drug Issues*, vol. 37, no. 1, pp. 115–80.
- Ziersch, E & Marshall, J 2012, *The South Australian Drug Court: A Recidivism Study*, Office of Crime Statistics and Research, South Australian Attorney-General's Department, Adelaide.
- Zinberg, NE 1979, 'Social interactions, drug use, and drug research', in JH Lowinson & P Ruiz (eds.), *Substance abuse: Clinical problems and perspectives*, Williams and Wilkins, Baltimore, pp. 91–108.
- Zinberg, NE 1984, *Drug, set and setting: The basis for controlled intoxicant use*, Yale University Press, New Haven.
- Zorick, T, Nestor, L, Miotto, K, Sugar, C, Hellemann, G, Scanlon, G, Rawson, R & London, ED 2010, 'Withdrawal symptoms in abstinent methamphetamine-dependent subjects', *Addiction*, vol. 105, no. 10, pp. 1809–1818.
- Zule, W, Poulton, W, Coomes, C, Mansergh, G, Charania, M, Wechsberg, W & Jones, H 2012, 'Results of a pilot study to reduce methamphetamine use and sexual risk behaviors among methamphetamine-using men who have sex with men (MSM) not currently in treatment', *Journal of psychoactive drugs*, vol. 44, no. 5, pp. 351–358.

Extract of the Proceedings

The Committee divided on the following question during consideration of this Report, with the result of the division detailed below. Questions agreed to without division are not recorded in these extracts.

27 August 2014

Executive Summary, page xv

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).

Mr Scheffer moved, That the recommendation be amended as follows:

'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 Alcohol and Drugs (MCAD).

'And that consequential amendments be made to the text throughout the report to ensure consistency.'

Question put.

The Committee divided.

Ayes 1

Mr Scheffer

Noes 3

Mr Carroll

Mr Ramsay

Mr Southwick

Question negatived.

Chapter 31, page 740

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).

Mr Scheffer moved, That the recommendation be amended as follows:

‘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 Alcohol and Drugs (MCAD).

‘And that consequential amendments be made to the text throughout the report to ensure consistency.’

Question put.

The Committee divided.

Ayes 1

Mr Scheffer

Noes 3

Mr Carroll

Mr Ramsay

Mr Southwick

Question negatived.

Minority Report

This Minority Report is only concerned with Recommendation 1, namely, that the work of the Ministerial Council on Methamphetamine (MCM) should largely confine itself to issues related to methamphetamine misuse. Focusing the role of the Ministerial Council on methamphetamine, as its name indicates, is too restrictive and will limit its effectiveness.

While methamphetamine can be a dangerous drug, it actually affects a very small percentage of Victorians. Establishing a council at Ministerial level, indeed chaired by the Premier, to focus on a single drug is inconsistent with the evidence in the report itself. The evidence clearly shows that there has been a move away from strategies that focus on specific policies about particular drugs and yet the majority of the members of the Committee have supported exactly this approach for the proposed Ministerial Council on Methamphetamine (MCM).

To be fair, the report does say that the MCM should be capable of adapting its focus so it can address other problematic drug use should the situation arise. But this so called flexibility simply serves to underline the inherent limitation of restricting the focus of the Ministerial Council to one drug, methamphetamine. The link between methamphetamine use and other problematic drug use is a fact on the ground that should be recognised in a broader role for the Council.

At an organisational level, it is inconsistent for the Alcohol and Drugs Executive Group – the inter-departmental level - to have assigned to it a brief that includes all drugs, licit and illicit, while the MCM, whose job it is to direct the work of the Executive Group, has a focus largely restricted to methamphetamine use.

A ministerial council chaired by the Premier is an assembly of the highest standing and its task should be commensurate with its authority. To establish such a high level body to work for the most part solely on methamphetamine to the general exclusion of other licit and illicit drugs is disproportionate in that it elevates the problems associated with methamphetamine use beyond what the evidence supports.

According to the Australian Institute of Health and Welfare National Drugs Strategy Household Survey 2014, the use of a number of illegal drugs such as ecstasy, heroin and GHB have declined, whereas the misuse of pharmaceuticals has increased. According to the current Household Survey there has been no significant increase in methamphetamine use. But the data suggests that the use of powder form of the drug has decreased significantly, whereas the use of the more potent crystal methamphetamine form has more than doubled. Of the 2 per cent of the population that use methamphetamine, approximately 14.5 per cent have a dependency. It is inferred, therefore, that approximately 84 per cent of users are recreational users. This does not mean that this cohort has no issues using the drug 'recreationally', but the information helps to put methamphetamine use into perspective.

Given the low prevalence of methamphetamine use, a ministerial council chaired by the Premier to deal with it seems out of proportion to the problem. By contrast, a high level ministerial council could usefully assume prime responsibility for alcohol and other drugs, perhaps focussing in the first instance on clarifying the issues concerning methamphetamine use within the wider reality of drugs and crime in the community.

In summary, it is disappointing that the recommended Ministerial Council on Methamphetamine is restricted to working on issues relating to methamphetamine and is unable as a matter of course to focus on the larger problems caused by harmful alcohol consumption and the misuse of pharmaceutical drugs; nor can it instigate research or make recommendations that take into account polydrug use, for example, or how other licit or illicit drugs used in conjunction with methamphetamine can increase harm.

Mr Scheffer