LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria

Melbourne — 30 September 2013

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Mr J. Ryan, Chief Executive Officer, Anex.

The CHAIR — Welcome to the first public hearing of the Law Reform, Drugs and Crime Prevention Committee's inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. I thank Mr John Ryan, chief executive officer from Anex, for making his time available to present to the committee this morning. I understand we have media from the Age, the ABC, Channel 10 and the Herald Sun. Welcome to the public hearing. This is the first public hearing today into this inquiry, and this part of the inquiry will run from 9.30 until 10.15. John, for your benefit, we normally allow a presentation and then the committee has a number of questions to ask of you. Perhaps you could present for 10 to 15 minutes, and then we will have a series of questions to raise with you.

All evidence taken at this hearing is protected by parliamentary privilege, as provided by the Constitution Act 1975, and further subject to the provisions of the Parliamentary Committees Act 2003 and the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. Have you read and received the guide for witnesses presenting evidence to parliamentary committees?

Mr RYAN — Yes.

The CHAIR — We are recording the evidence, and we will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. I now invite you to make a verbal submission and, as I advised, we will ask questions as appropriate. Thank you.

Mr RYAN — Thank you very much for the opportunity to present today, and congratulations on taking this issue seriously. It is a significant issue in the community. We have got a history of managing drug problems in Australia since the 1980s which includes a law enforcement approach, a drug treatment approach and a safety approach, which is to reduce the damage from ongoing drug use. I think that framework puts us in a good place in relation to amphetamines issues.

In terms of Anex involvement, we have got an organisational commitment to evidence based practice and policy, and through policy and workforce development we are supporting front line services across Victoria in relation to these and other drug use issues. We are also providing advice to government and other interested parties, such as through our Lucid program, which looks at drug and alcohol use in the workplace, because ice use particularly and general drug use are not concentrated only amongst what might be considered the old stereotypes of the 1990s. It is not people on social welfare only; it is people in employment and people across the economic spectrum, from manual labourers to white collar professionals. Also ice — or methamphetamine, I think more appropriately titled — is now not just a city problem but also a rural and regional problem, so we have a drug issue that is affecting small communities in country Victoria as well as the large metropolitan centre.

In relation to our interest in this issue, we convened the first Australasian Amphetamine Conference in 2007, which was supported by the then Howard government. Amphetamine use is not a new problem. I think it was first manufactured in 1897, so we have got more than 100 years of amphetamine use. It was used during the Second World War as a way of keeping pilots going during conflict, and a form of amphetamines is still used in medical practice — for example, in relation to ADHD. It is both a blessing in terms of its medical prescription and a curse for some people, particularly those who are addicted or the families thereof or the people in their vicinity.

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. For example, in a country hospital emergency

department there might be a psychotic episode, which is a sign of amphetamine overdose. It may not be recorded as a methamphetamine overdose; it may be recorded as a psychotic episode.

The data is not clear, but certainly from talking to literally thousands of people through our training programs we know that it has significantly increased in the last 24 months. There is, I guess, a traditional instinct that we can arrest our way out of this problem, that a policing solution might be our best bet. The difficulty with methamphetamine is that the recipes are on the internet, the manufacture is actually quite easy — it is much easier than, for example, ecstasy — and it is a shift away from traditional drug use, such as things that require cropping: cannabis, cocaine via coca leaves or heroin via opium poppies. Methamphetamine is much easier to produce than any of those sorts of drugs, and it does reflect a change in the drug market.

Whilst the manufacture can be decentralised, the detection is much more difficult and the recipes are available on the internet. We do need to have a linked up approach to this issue, which is to combine policing with drug treatment, community safety messages and, I think importantly, empowering families and communities to be more alert around these issues and more able to intervene in their own family situation. We cannot expect government to solve this problem on its own. It is very much about government empowering the community, and the community includes people who use methamphetamine but also, very importantly, the people around them — their parents, their partners.

I think the challenge that we have yet to really face is how little knowledge there is in the community about methamphetamine. Whilst the myth that you use it once and you will be addicted is mostly a myth, there are people who use it once and, because of the significant down period after use, the temptation to use again is very high, and so people do become quite tempted to use again and again. So the trajectory of use into addiction is much shorter than with other drugs such as alcohol or heroin, and therefore we see people going from their first use to potentially having a significant problem within 6 to 12 months of their first use. That is not to say that all people who use methamphetamines are addicted, and certainly not addicted automatically. It is a drug like any other, which means that some people are particularly vulnerable. For example, if part of the experience of using methamphetamine is that you feel 10 feet tall and very confident and you have previously not felt 10 feet tall and very confident, the temptation because of that vulnerability is high to use again and again.

The problem is that high use creates a number of issues for the individual but just as importantly for the community. I think we have seen some data on the scale of methamphetamine use. The Australian Bureau of Statistics has data from 2010 suggesting that there might be 23 000 people into methamphetamine consumption in Victoria. That is interesting because it is most likely an underestimate from that time. People are obviously very reluctant to admit methamphetamine use. It is based on Australian Institute of Health and Welfare studies and others. But the temptation to hide your meth use is obviously very high, particularly if you are a professional or if you have a family member in the vicinity when you are answering the questions.

That figure of 23 000 is obviously before the significant increase that we have seen in the last two years, so we are talking about a quite large population directly consuming, some of whom will be addicted, some of whom will be using on the weekend or once a month or once every three months, but all of whom will be connected with many more people. So the scale of the impact across the community is not only that first 23 000, which has increased significantly, but also all the people they are dealing with, as in with whom they are living or interacting through work.

One of the problems for people around methamphetamine is safety issues — that is, safety in relation to, for example, domestic violence. If you feel 10 feet tall, the positive way of looking at that is that you are feeling more confident. The way that you are experienced by the people in your vicinity is possibly as being extremely arrogant. Part of the fight or flight response that is a biological result of methamphetamines is (a) increasing paranoia and (b) an increase effectively in short temperedness. We can see that domestic violence, for example, is likely to be significantly impacted on by methamphetamine use, but if the police are called to a domestic violence situation, do they record it as methamphetamine driven? I am sure that often they do not because people are reluctant to admit that methamphetamine use is one of the factors in that domestic situation.

Similarly, when they are admitted to an emergency department it might be for a psychotic episode, but they are most likely to not want to admit to methamphetamine use.

I think we have several key challenges in relation to methamphetamine. One is to stay sober in our approach, which is to stick with the evidence; we need a linked up approach between law enforcement and public health. Secondly, we need to be honest with the community about the issues in relation to methamphetamines. It is not necessarily a road to ruin, but it often is significantly problematic for some people. The impact in terms of mental health is significant, also in terms of employment and in terms of violence. All of these are key issues, but we need to have an informed community as well as workforce to deal with the issues, and I think we have a long way to go until we have a community that is well equipped to deal with the issues in their setting, and also front line services.

Part of that challenge, which I hope we at Anex will be able to meet via some funding from the Department of Health, is to undertake a rapid situational assessment in relation to methamphetamine use across Victoria. That will involve speaking with people who use methamphetamines, as well as with service providers, police, health workers et cetera, but also, importantly, looking at the data to try to investigate how much underreporting of methamphetamine use there is.

The CHAIR — Thank you. I will ask the first question, then I will invite Mr Scheffer to ask a question and committee members to also participate. We have a number of questions to pose to you, John. In previous inquiries we have come across the misuse of alcohol as being one of the causes of family violence and other things that you have mentioned in respect of ice. What we would like to know is how seriously you view the issue of crystal methamphetamine use in Victoria. Do you think it has been exaggerated in the media? They have talked about a crisis in regional areas. They have talked about a crisis in the use and some of the impacts that it has, as you have indicated, compared to the misuse of alcohol, which creates a lot of antisocial behaviour and domestic violence and other things that you have stated. We are just trying to box in where it fits in relation to other drugs and the misuse of drugs and the impacts they have on communities. Where do you think ice fits into that?

Mr RYAN — The difference between alcohol and methamphetamine is that alcohol is legal, and that provides a much more obvious way of dealing with the issues. The challenge in relation to methamphetamine is that it is illegal and often secret, and we do not have honest and frank conversations about it. That makes it difficult to accurately understand how prevalent its use is, but also it makes it difficult for people to be honest about their use. It makes it easier to be fearful of an illegal drug, particularly if you do not know much about it, and I think it is fair to say that some of our reaction to methamphetamine is based on the combination of not knowing plus myths in relation to methamphetamine use.

There is no doubt about it, it is a problem, but I think part of the problem is that we do not know enough about it and the community does not feel empowered enough in terms of how they can deal with it. Therefore there have been some occasions of, I think, dramatic media reporting, which actually fuels that fear within the community. Is it a crisis? I do not think it is a crisis if you compare it to other crises around the world. We have a good system in Victoria to deal with these issues. We can certainly improve, but I think keeping a level head is actually very important, so I would not use the word 'crisis'.

Mr SCHEFFER — Thanks, John, for your presentation. You talked about how the production and distribution of amphetamines and ice is very different to some other drugs, but it is not a centralised production. It can be done in various locations, and recipes are available on the internet and so forth. Then you said that the problem with this is that the community is really not well equipped to deal with that. What I would just ask you to reflect on for a minute is: what do you think that a community that is well equipped to deal with these issues would look like?

Mr RYAN — I think at the most immediate level people who are using methamphetamine actually need to be much better educated about the risks they are taking — about the toxic content of the drug. But we 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.

Australia had a great triumph in terms of preventing HIV in the Australian population via needle exchanges, which has always had bipartisan support around Australia. That is the kind of model that I think should apply to methamphetamine — which is, innovative and realistic approaches to people who are using. Part of that, I think, includes trying to discourage a transition from the most common route of administration now, which is inhalation via smoking, to injecting. If we had a shift towards injecting in Victoria's methamphetamine population, we would have a very much more severe addiction and also a risk of other negative consequences from injecting. Protecting those people, I think, is very important. Reducing their period of addiction is also very important. Having well engaged local level services and a skilled up workforce is very important, because that workforce is in the community.

Just as importantly, I think, 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.

Further away from that, I think we need to be dealing with the fact that there is likely to be an ever increasing prison population, and the evidence is that the offspring of people who are incarcerated are more likely to be incarcerated. We need to really ramp up the way we deal with health problems in the prison system, the way we deal with recidivism within the criminal justice system and also, importantly, how we support families who have somebody within the prison system, because they are the nucleus of the more broad community problem.

Mr SCHEFFER — Just quickly, I presume the skill level of the 23 000 front line workers across a range of areas that you mentioned is necessarily not uniform, but are they pretty well skilled up or do they need a lot more work done?

Mr RYAN — Sorry, just to clarify, we have trained about 2500 front line workers since late last year, and the ABS estimates 23 000 people in the community in Victoria consuming methamphetamine.

Mr SCHEFFER — I see. Sorry.

Mr RYAN — In terms of the workforce skill in this area, a similar thing happened in relation to heroin in the 90s. We had a significant and fairly rapid increase in heroin use. There was heroin in the 70s and in the 60s in Victoria, and so there was in the 80s. Amphetamine was actually quite popular in the 80s. There was a small cohort of people who were using heroin. That increased significantly in the 90s. There was a lot of work to skill up the system and to be more flexible and adaptable in relation to the change in the drug market in the 90s. I think the challenge this time around is to shorten that period of being under skill and under capacity in order to move the system to be more responsive to the change in the drug market. The drug market is dynamic. We saw heroin in the 90s. We saw a significant amount of pharmaceutical misuse in the last 15 years, and now we are seeing a significant increase in methamphetamine use. That requires change at all levels.

Mr SCHEFFER — Thank you.

Mr SOUTHWICK — John, I wanted to explore further the change of dynamics of the market. You mentioned that the drug methamphetamine, or ice, has been around for quite some time, so why are we seeing the current popularity towards that drug, and is it at the expense of others? Is the overall market growing, or is it just changing over from ecstasy, cocaine and heroin to ice?

Mr RYAN — I think it is a very good and very difficult question, and I wish I knew confidently the answer. I think part of it is that in relation to drug use there is a fashion element involved. The fashion of the 90s was that people who are now 40 or 50 — it is an ageing demographic of people — were heroin users. The younger generation look at them and think, 'I don't want to be like those. I want to do something different'. The word 'ice' itself, I think, has an element of coolness to it. The switch from particularly ecstasy, which is more difficult to manufacture, to ice, which is cheaper, provides another incentive. So it is a range of changes, which include the traditional change from one generation to the next plus the fact that it is cheaper than other forms of drug use. Certainly it is the availability. Because it is available within an unregulated system, and there are not many ethical people who are dealing drugs, some of the age restrictions do not apply — for example, with the responsible serving of alcohol, where children under 18 cannot access alcohol.

I think honestly part of it is that it is a stimulating drug. The rush is incredibly intense. The high is incredibly intense, which means that people will use it and experience great pleasure. In fact it replaces a lot of the pleasures we would get through other natural means, such as eating delicious food or doing exercise, in which case people who are in menial jobs and are bored and work long shifts think it helps them. People who are trying to increase their confidence in a nightclub setting think it helps them. The drivers for it are similar I guess to all drugs — alcohol or illicit drugs — and various, depending on the individual, but certainly price, availability, intensity and difficulty of detection have to be some of the key factors other than that traditional shift that we see in the drug market over time.

The rise in synthetic drugs on the internet is, I think, part of the story of ice use, which is that we are seeing a shift away from the traditional soil based, organic drugs to something that is chemical. Similarly, we are seeing that in the way that pharmaceutical misuse has increased, which is that there is a shift away from traditional forms of drug consumption to this new dynamic, that is chemical manufacture.

Mr SOUTHWICK — Just further to that, the party drug weekend user — are we seeing a convergence from them into it being used in the workplace and as a more regular full on activity?

Mr RYAN — The tradition of amphetamine use in, for example, the trucking industry goes back a very long way. Truck drivers used to use it in order to drive long distances and to avoid the need to sleep. You cannot actually avoid the need to sleep; it is extremely important. I do not think the community adequately understands the importance of sleep in relation to methamphetamine use. But definitely the age range of people is from teenagers right up to people in their 60s who are using methamphetamines. It is absolutely used by some to increase their productivity. Obviously it does not work in the long term, because people go off the rails, but certainly a false sense of achievement in terms of increased productivity in manual labour but also in white collar, professional positions is significant because of the lack of knowledge that it is not a long term solution.

There is a cohort of people who are using it for work related reasons, a cohort of people who are using it for dance party or hotel or nightclub use, but there are also people who are using it at home to do the cleaning.

Mr CARROLL — Thanks, John, for your presentation. Part of the terms of reference is to analyse the supply and distribution of ice. We have read some briefings that said that outlaw motorcycle gangs control about 90 per cent or above of the supply and distribution of ice. Do you have any analysis through Anex of the cohorts of people who are getting it? The outlaw motorcycle gangs are supplying and distributing it. Is your apprentice tradie getting it from one section of the market versus your nightclub person or your white collar person? The people who

come and see you at Anex, do they give any analysis of how they are actually getting their hands on the drug?

Mr RYAN — The sad fact of the matter is that most people with a severe drug problem, as in an addiction, are also trading drugs themselves. One of the things that the community needs to better understand is that if you supply methamphetamines to a friend, you are actually committing a criminal offence. At the very local level most of it is through friendship networks. It is not some big bad bikie who is providing it, it is somebody who is connected to somebody who is connected to somebody, and the profit incentive is so high — the mark up on the drug is so high — that you can have a number of hands touching it and taking a commission, or a percentage, until it gets to wherever it is going. Whether or not it is 90 per cent bikie driven I do not know; the law enforcement agencies would know better than me. But certainly I think there seems to be very strong anecdotal evidence that that is a key part of the distribution, including in country areas. Whether or not it is 90 per cent I would not know, but certainly people are getting it mostly at the lower level, at the consumer level, through friendship networks.

Mr CARROLL — So they are getting it through friendship networks, but are those networks based on a friendship that was through, say, cannabis or ecstasy, which was the foundation but now ice has been the big thing in the last 24 months that has become the market driver?

Mr RYAN — It is interesting. I use the words 'friendship network' loosely. It would probably be better to call them acquaintances, associates and friends, because there are not many solid friendships in that drug distribution scene. There used to be a belief that there was a kind of gateway drug from one to another, from a softer drug to a harder drug. It was never that well evidenced, and certainly in relation to methamphetamines it does not seem to be the case that people will start with, say, cannabis and move on to ice. Those sorts of continuities are not apparent. Obviously the first drug most people consume is a medicinal drug, and there is an increase in the misuse of medicines, but I would not want to create a causal link between medicinal drugs and methamphetamines. But it is true to say that for a lot of people their first illegal drug consumption is methamphetamine.

The CHAIR — You say there is no crisis as such, as has perhaps been illustrated in the media, yet since the announcement of this inquiry we have been inundated through the secretariat with people in regional Victoria saying there is a crisis in regional Victoria in relation to the use of ice and that in parts of Victoria it is being manufactured — and we can argue the toss whether it is through organised crime or outlaw motorcycle bikie clubs or others. Could you give the committee some idea of why regional Victoria seems to be more impacted by the use of this drug rather than by the traditional drugs of heroin, ecstasy and speed and others that have been typically metro driven? I believe firmly that there is something happening with regional Victoria being engaged much more in the acceleration of the use of the drug ice.

Mr RYAN — I think emotions are running very high, which is why some people will call it a crisis. I am not underplaying the issue; I think is a very significant issue, but I would not want to be unnecessarily alarmist about it. A lot of our work has actually been in country Victoria because it is country Victoria that has most noticed the significant increase. Part of the value of living in the country is that people have better local networks. They know what is going on in their town, and therefore they are more quick to catch on to a significant issue. Because they do not yet have the skills and knowledge to be able to understand how to manage the issue adequately, there is therefore a lot of fear and anxiety. I am confident that can be worked through.

The problem is also in outer metropolitan Melbourne. It is a problem in the new suburbs and in the growth suburbs, and it is also a problem in the inner city. It is a problem across Victoria. The heroin market never really penetrated much outside of Melbourne, Geelong and some of the big regional centres, partly because it was a difficult drug to transport and police were quick to jump on local traffickers. The difference with methamphetamine is that it is much easier to hide and easier to manufacture. There is manufacturing going on in regional and rural Victoria. There are stories of manufacture going on in people's car boots and in motel rooms. In Western Australia we have seen some evidence of manufacture just using, effectively, large plastic bottles that are used

for soft drinks. The decentralisation of manufacture allows for much greater penetration in country Victoria.

Mr SCHEFFER — You talked in response to the chair's question about the regional use and how that is spreading, but in terms of demographics, what is Anex's research on aged profiling, gender profiling, ethnicity and Aboriginality?

Mr RYAN — The curious thing about the diversity of methamphetamine use is one of our great challenges, which is to say that it is from people who are very young — early initiates are in the low teen years — to people in their 60s. There are some communities that are particularly affected. Talking to us, for example, the Aboriginal community has been, I think, very significantly affected. The gay community is very significantly affected. Some of the range includes people who are in post high school study — so, TAFE colleges and universities — being affected and also people who have never really been involved in illicit drug use previously. So whilst we still have the dynamic of that cohort of people who are heroin users et cetera using ice, we now have lots of people who are novices to illicit drug use who are picking up ice use, with very little capacity to actually manage that. So my sense is that the demographic for ice is extremely broad, both across the age range and across different ethnicities.

Mr SCHEFFER — But the groups you instanced, I think, would tend to be the younger cohort — but you did say in passing that there were people in their 60s who are using it. Is it an even distribution or is it bunching at young people?

Mr RYAN — I think it is bunching at young people, but it is a significant problem also for older people. There are lots of stories of people in their 40s using ice, and we are also hearing of people in their 50s and 60s, but I think the biggest challenge is about protecting young people.

Mr McCURDY — Can any interventions be more tailored to specific groups, like rural and regional people or young people or even Indigenous groups?

Mr RYAN — 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 partly 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.

Mr SOUTHWICK — If we could pick up on the use of ice in the workplace and maybe what you think we could be doing to reverse some of these alarming trends, particularly with the communication of the productivity — the fact that it enhances productivity — what key messages do we need to be selling to counteract the sorts of things we are seeing?

Mr RYAN — I think the productivity improvement is a false promise. People mistakenly think it is a solution to productivity, but in the long term the mental health consequences and the financial consequences — because of the increased tolerance, it requires more consumption — are a recipe for spinning out of control. Part of the challenge for employers and employees, I think, is to be more knowledgeable about the fact that it is not a solution to productivity issues and also that drug use problems in the workplace are the opposite of a productivity improvement; they actually generally decrease productivity. They cause work related accidents, and they cause disruption in the workplace.

It is a difficult issue for many employers to talk honestly and frankly about because we traditionally like to sweep the issues under the carpet, which is why I think the committee's work is so important. 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.

The CHAIR — All right. We might have to leave it there; our time has expired. Thank you very much, Mr Ryan, for presenting to the committee this morning. We appreciate it.

Mr RYAN — Thank you.

Witness withdrew.