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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The CHAIR — Welcome to the public hearing of the Law Reform, Drugs and Crime Prevention Committee, and thank you for your time this morning. I welcome Dr Belinda Lloyd, Dr Amy Pennay and Dr Matthew Frei from the Turning Point Alcohol and Drug Centre. I understand you have a laptop presentation. We have allowed from 11.15 a.m. to 12 o'clock for this session. We like the committee to be able to ask questions, so if you could allow time for us to post some questions that are otherwise not covered by your presentation, I would appreciate it.

All evidence taken at this hearing is protected by parliamentary privilege, as provided by the Constitution Act 1975, and is 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? I note you are nodding in agreement. 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. Thank you.

Dr FREI — Thank you for asking us here to speak to you. We have a few slides, and we will be really pleased to answer questions at the end. I will present first and then Belinda will present some slides. If you want to interrupt me and ask questions, and I do not know how you have done it with other speakers, it is fine with me.

Overheads shown.

Dr FREI — We are from Turning Point, which is a statewide alcohol and drug service affiliated with Eastern Health. I am the head of clinical services at Turning Point, so my part of this presentation will be a clinical overview of methamphetamine use. Belinda will have a more epidemiological presentation of emergency services, and Amy will also talk to questions around methamphetamine use and feedback from consumers around methamphetamine use.

We are from the drug and alcohol treatment sector. We know this drug has been around forever. This meeting has been convened, and it has been a big subject of discussion, but amphetamine type drugs have been around for ages. They started being misused in the days when drug misuse took off in the 1960s, and it is only in the last decades when we have started really seeing methamphetamine or ice presentation. It is a relatively recent phenomenon in terms of drug trends, particularly the use of smoke methamphetamine. This is not just in Australia; it is across the world, including the Asian region and the United States.

When we see methamphetamine use we see it in various forms, and we will look at some of the forms. I think a lot of the discussion has been about the crystal form of methamphetamine, which is smoked or injected, although you can still drink it. There are other forms that pop up in clinical presentations such as powder that is snorted and an oily based form that can be drunk or injected. Occasionally we see the diversion — the non medical use of prescription dexamphetamine, which is a drug prescribed for certain paediatric and some adult conditions.

We have a clinic that specialises in methamphetamine users called Access Point at Turning Point. It is located at Fitzroy, up the road in Gertrude Street. It is a really useful clinic — it has been going for a few years — in that it can give us a bit of a profile of what sort of people use methamphetamine, the sort of group that are presenting. The reason it was set up was in part because there was the thinking that it is a different cohort of people who come in with methamphetamine use problems. It is not your so-called mainstream drug user — whoever that is.

I have a couple of slides about our experience at Access Point, the methamphetamine clinic. It is predominantly males, and a lot of young males, but we get people into their late 40s, which is still actually young in my view. 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.

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 methamphetamines. 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.

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. The other finding is that it is often peer based — a lot of peers will use with people that use methamphetamine. 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.

I was told there might be a discussion about pharmacology. A lot of the discussion about methamphetamine is centred around it being an incredibly addictive drug. I guess it is a bit concerning because I think we need to put what addiction is into context when we talk about this being a more addictive drug than alcohol or heroin or whatever. What we do know about methamphetamine is that it is a drug, particularly when smoked or injected, that causes an intense rush or release of brain chemicals that make you feel really intensely good and that are used to mediate mood and happiness. Those drugs get released in a huge burst, and that release of these sorts of feel good chemicals is incredibly reinforcing, so that I guess is the term we would use for addictive potential — it is reinforcing. It means that a user has a tendency to do it again and again to repeat that very pleasurable and intense experience, and that behaviour in drug use leads to repeated dosing, and this is what eventually leads to a change in brain state that leads to probably what we would call addiction — that is, continued use despite a lot of problems and despite a lack of any noticeable enjoyment. At this stage people are often using just to not feel bad, and often this sort of use leads to a lot of fallout — social and medical — and unwanted consequences.

Mr SCHEFFER — Could I just ask there: what is the difference between the function of methamphetamine in the way you have just described it and heroin? It has been put to us that in the case of methamphetamine it does not actually add anything to the body but allows the body to do something.

Dr FREI — Part of it depends on route of administration. There are different delivery systems that cause a more intense sensation. I know I am not directly answering the question.

Mr SCHEFFER — No, that is fine.

Dr FREI — Part of the effect of the drug depends on the delivery system. We know that smoking a drug is a very good delivery system. That is why tobacco smoking is a huge health problem and a huge drug industry. Smoking or injecting methamphetamine or heroin both cause a release of chemicals in the brain that are reinforcing and that people like. I am not sure if you mean repeated use of heroin, which will, in a short period of time, eventually lead to significant sedation and depression of function, whereas repeated use of methamphetamine will lead to excitation and an increase in function. That function may be misdirected or purposeless, but it will lead to an increase in activity. I am not sure if I answered your question.

Mr SCHEFFER — Yes, you have. It is okay.

Dr FREI — Okay. The way the drugs are used is different, and this has implications for treatment, which I will talk about in a minute. The way the other very significant illicit drug of dependence that we see in treatment, which is heroin, is used is quite different to methamphetamine use, and this poses some issues for treatment.

I just wanted to talk about some of the effects. Some of the effects kind of make sense: people get enhanced energy, they get often an increase in sex drive, they feel more talkative and confident and often very powerful and energetic. I mention these effects because we have to keep in mind that people do not start using or frequently using methamphetamine and those related drugs because they want their teeth to fall out or they want to spend all their money or cause great disruption to their social and family life; they use it because it does give some reward. Those are the immediate effects — alertness, increased energy, the ability to dance and stay awake and have sex and all these things that people generally want. The trouble is that it also causes all these unwanted effects, such as agitation, irritability, paranoia and suspiciousness, and sometimes, as I mentioned, the functionality may not be purposeful. Sometimes people talk about repeated purposeless behaviour — so, doing something over and over again without any actual clear picture of what the outcome is going to be. Assembling and disassembling devices or in some cases picking at skin and so forth — these sorts of unwanted repetitive behaviours are often part of intoxication with methamphetamine.

In severe cases — and I will list these — these are things we see in hospitals. The psychiatric I have already alluded to, and psychosis is something we see in presentations to emergency departments. Sometimes we see people getting very overheated, and rhabdomyolysis is a breakdown of muscles which can lead to kidney failure. These are relatively rare but very significant toxic effects of methamphetamine. Occasionally we see cardiac events. You can imagine that a drug that increases your heart rate and increases your blood pressure might bring risk of a cardiac event, like myocardial ischaemia or a heart attack, and occasionally we have seen seizures and actual strokes — so, injuries to the brain. Again, I need to stress that these are relatively rare but do happen and are potentially very serious adverse toxic effects, and they are all complicated when people combine the drug with alcohol or other drugs.

This is just a photo of someone who presented with injection related injuries from methamphetamine injection. Any street drug that is injected by a person who is self injecting or by friends injecting them is going to cause risk of injection related complication, so it can be local, like this — this is a local abscess from self injection — or things like blood borne viruses and other complications with injection that we see with any injected drug.

I might keep moving. I mentioned psychosis, and the psychosis of methamphetamine is characterised usually by suspiciousness. It is not always characterised, I have to say, by aggression. Aggression occurs in this group, but it is perhaps not as common as people might have us believe. I think the thing about emergency department personnel is that when they get an aggressive methamphetamine intoxicated person in the emergency department they remember it because it can be very severe and very difficult to manage. I mentioned stepped sedation. People will give an intoxicated, agitated and aggressive person increasing doses of sedating drugs and might find that the tolerance or amount of sedating drug that the person needs is really quite high, and they remember that. But far more common in severe or acute presentations to emergency departments is suspiciousness rather than violence or aggression.

The other thing that is often asked — I think this is important — is: what are the long term effects? We know what the short term effects are and how to deal with them, but what about the really regular or long term users? What happens to them? There are a number of things, but probably the most concerning to me is the neurological effect on the brain, and that is because we do not have a really good picture of that yet; we do not really know what the effect is of frequent use of a potent psychostimulant drug on the brain. Does it cause a change in brain chemistry that recorrects itself with time and abstinence from the drug, or is it a persisting deficit that you get in your brain chemistry that means that you are at prolonged depression? Is it worse in developing brains — so, are teenagers who take methamphetamine at greater risk? We know that there is greater risk from other drugs when they are used in the critical late adolescent years of brain development.

Mr SCHEFFER — If the drug has been around since 1897, why do we not know that? Why do you not know that? I do not know anything.

Dr FREI — I think it is a really good question. It has been around forever; it is not a new drug to us. The studies of illicit drugs are fraught and difficult to do because the way they are taken

is always changing. Methamphetamine has been around since the 60s as a medicinal drug, but its smoked form is made by illicit chemists, offshore or onshore, and sold in illicit drug markets and used by frequent smoking through a glass pipe, which is the way a lot of this group use this drug. That particular form of use of that particular form of the drug we do not really know much about, because it is only a phenomenon of the last decade. We certainly know, as you say, about the amphetamine group of substances I learnt about in medical school in the 80s. The neurochemists and the pharmacologists know really very well about how these drugs change the brain, and there are a lot of animal studies and so forth, but we do not know about a repeated smoker of methamphetamine, because that really is a phenomenon of about the last 5 to 10 years.

These studies take a long time to do. You can imagine that trying to study someone who uses illicit drugs is very difficult. The drugs are manufactured clandestinely and their use is clandestine, so it is much harder than studying a drug like alcohol or tobacco, which we have very tight and clear regulation around and are able to learn a lot more about. We do not know what the long term neurological changes are. As I mentioned we know you get injection related problems. There is certainly evidence of people getting anxiety and depression with long term use, as you might imagine, and because it discourages eating there are also nutritional problems and because of the dry mouth there is also some record about damage to dental tissue.

The other significant issue is social harm, and again this is from our clinic Access Point. A lot of the work is dealing with very upset families. Even though this drug is relatively inexpensive compared to, say, cocaine, there can be significant financial losses, exposure to crime and exposure to violence.

The other thing I get involved in is the management of detoxification. People come to treatment services and they say, 'I need help', and, 'I need to stop using this drug'. The symptoms are quite difficult to deal with. They are things like people being irritable, being flat, not wanting to do anything and being demotivated. Sometimes this goes on for quite a long time. Our detoxification services are based around a seven day model, so it is quite challenging to manage methamphetamine withdrawal. What we do is usually manage symptoms. We see this group either in our community detoxes that are spotted around the state — these are 12 bed community residential detoxification units — or often also, as you might imagine, in the hospital. Somebody comes into the hospital very sick with intoxication and their detox is managed in a psychiatric ward or a medical ward. Often the management includes, as I mentioned, management of other drug dependencies and management of mental health issues.

As you might imagine, 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. At the moment we do not have effective, well evidenced and proven drugs to manage methamphetamine use. I alluded to this earlier.

For heroin users we have very good drugs. Since the 1960s we have used methadone and buprenorphine with very good outcomes in maintenance treatment with those drugs. We do not have anything like that for methamphetamine. People have tried similar models, like substituting another stimulant for methamphetamine, with mixed but not great results. It is nothing like the results we have got with methadone and buprenorphine. In a way that is understandable. This is a drug that people take in intense bursts and then have a break and crash. A drug that keeps you on a constant level perhaps is not the ideal model for methamphetamine as it is with heroin.

The CHAIR — Dr Frei, I might just have to remind you that we only have about 15 minutes left. You have two speakers and we have not asked a question yet.

Dr FREI — I might just stop there. I have mentioned Access Point, and I will hand over to Belinda.

Dr LLOYD — I will try to be mercifully brief with the data. Just to give you a bit of an overview, this gives an indication over time of stimulant related arrests. This is not just going to be crystal methamphetamine, although it is largely driven by methamphetamine related arrests. It is important to remember that methamphetamine is not just crystal methamphetamine; we also see it in the form of speed — so a powder form — or in base, which can be powdery or waxy or, as Matt was saying, the other different forms that it comes in. We see all of those. We often see people self report that they are using ice, but it may not necessarily be a purer form than the other forms of methamphetamine we see. Sometimes it is actually sold to look like crystalline methamphetamine but the purity is actually fairly low. There is a lot of variability in purity — it can go anywhere from 10 per cent to purity of 80 or 90 per cent. We are seeing an upturn in arrests.

There is a lot of information here. This information is available more broadly. These are the numbers and rates of attendances for a range of different drugs across Victoria. This shows data for metropolitan and regional Victoria. These are acute presentations to ambulances. These are people who are being attended by ambulance for use of these drugs. It is the immediate or very recent overuse or inappropriate use of the drug that has directly contributed to the ambulance attendance. If they have had a long term use issue and they are seeking treatment but they have not been using in the last few days, we would not have them in the data; they need to have recently consumed the drug and it be directly relevant to their presentation.

It is important to note a couple of things here. Firstly, the rates of attendances are much higher in metropolitan areas than in regional areas for crystal methamphetamine. This is one of the few datasets where we can look specifically at crystal methamphetamine as opposed to all amphetamines together or methamphetamine overall. It is also important to recognise that it is not the most common drug that we see at ambulance attendances. We see more cannabis related attendances. We see more cannabis related attendances in regional areas than we do in metropolitan Melbourne as well. Heroin related attendances are still higher than what we see for crystal methamphetamine.

Just to give you an indication, I think it is really important to be thinking about the rising harms that we are seeing for crystal methamphetamine and the concern around it in the context of the other drugs that we also see and which represent a significant burden on the community. We can see here that alcohol is far and away what we see most of in ambulance attendances and across treatment settings as well. Alcohol is the most common drug that people seek treatment for in the specialist alcohol and drug sector. Behind tobacco it is the most common reason for hospitalisation for both acute harm and also chronic harm. We also see substantial numbers for pharmaceutical drugs. Particularly in regional Victoria, pharmaceutical drugs represent a really significant issue, and by population size they are a much greater issue then in metropolitan Melbourne, where we see more illicit drug use.

Just to give you an indication of what we have seen over the last decade in terms of ambulance attendances, the line that is going up and up is alcohol intoxication. That is what we see the most of. That is what we see the most of across settings in emergency departments, and it is what police see the most of. The second most common reason for attendance, and consistently so for a very long period of time, is benzodiazepines. We are talking about a pharmaceutical drug that is very readily available, but it is available by prescription. We are seeing substantial numbers of those cases every year. Heroin is the third most common and has continued to be so over a number of years after it peaked at the beginning of 2000. We have seen an increase in amphetamine related attendances.

These are attendances for illicit drugs. When we have alcohol and benzodiazepines on the slide it is very hard to see what is going on for some of the illicit drugs, but what we can see are some increases. Over time we still see an increase in harm in relation to cannabis and to other drugs like GHB as well. Crystal methamphetamine is an issue, but it is an issue in the context of a number of other drug issues that we have and changing patterns of drug use.

These slides give an indication of the distribution of cases across Victoria — that is the large map. The insert is metropolitan Melbourne. Crystal methamphetamine and amphetamines overall are predominantly in metropolitan areas. We need this kind of information because we know those

patterns change over time. Other research we do, particularly with drug and alcohol agencies in regional areas, indicates that there is growing concern around crystal methamphetamine availability and quite active marketing in regional areas. That just gives an idea at a more local level; that is at a postcode level.

In terms of the change that we have been seeing over the past couple of years — and again these are illicit drugs and this is just metropolitan Melbourne because we have not had data for a long time coming from regional areas, but thankfully we are getting a lot more now — what is important to note is that we have seen a bit of shifting of a whole range of different drugs. We have other drugs that are more common than crystal methamphetamine, but we have seen the largest increase over the past two years in crystal methamphetamine related ambulance attendances. These attendances will be for psychiatric issues. We will see people who are experiencing symptoms of psychosis or who are highly anxious; they are experiencing palpitations or they are having a panic attack partly because of the pharmacological effects of the drug but also because of the broader issues around their drug use and the situation they may be in when they are using that drug.

We see people who have experienced injuries, either as a result of violence, motor vehicle accidents or risk taking behaviour — they might have fallen or have jumped from a height. We see a range of different harms. We very rarely see acute toxicity; we very rarely see people who are in a life threatening situation because of the drug and nothing else. We will very rarely see an overdose where there is an issue around temperature regulation or cardiovascular issues. They are very uncommon, but we have certainly seen a sizeable increase.

As I mentioned before, while we have seen that increase — and it is certainly the largest increase we have seen across the drug groups — it is really important to note that we are seeing increases in other drug categories as well. As you can see very clearly there, the number of alcohol related attendances where the patients are acutely intoxicated are substantially greater and represent a really significant burden on services.

It is also important to note that we have not seen a substantial difference in the characteristics of patients attended for crystal methamphetamine related harm in metropolitan and regional areas; they are broadly similar. We are not talking about necessarily very different populations who are using the drug and getting into trouble with using that drug in different geographic locations; they are broadly similar populations.

In terms of the change over time in that population, even though we are seeing more harm and we are seeing more people experiencing harm, we are not seeing a huge shift in the populations that are presenting to the ambulance with crystal methamphetamine related harm. I think it is also important to note, as Matthew mentioned, that the use of multiple drugs complicating people's use and the harms that they experience is a significant issue. Alcohol is involved in a substantial proportion of these cases; 10 or 15 years ago it was pretty uncommon to see people mixing stimulants with alcohol or with other CNS depressants, but we are seeing that more and more. People are using more alcohol and then more stimulants — so more crystal methamphetamine — and experiencing a whole range of harms associated with intoxication with a number of different substances and then the higher risk of harm associated with that.

This just pulls out specifically crystal methamphetamine related attendances since 2002–03 in metropolitan Melbourne. We have seen a substantial increase, and that is a cause for concern in the context of all those caveats we have been talking about. These cases really represent an issue for emergency services as they struggle to deal with them.

I will just quickly mention a couple of other pieces of information or pieces of the puzzle around what we are seeing at a population level in terms of methamphetamine related harm. These are calls to DirectLine, which is a 24 hour a day, 7 day a week statewide telephone service run through Turning Point. 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.

We have also seen an increase in hospitalisations. It is important to note that these are stimulant related hospitalisations. It is very hard to identify these substances. This will also include cocaine and other stimulants. We know from our other data that crystal methamphetamine has been driving a lot of the harms that we are seeing, particularly in terms of acute harm. We have seen a real increase in hospitalisations after relative stability over a number of years. The levels of harm we are seeing now are higher than the levels of harm we were seeing five or six years ago when there was significant concern around crystal methamphetamine particularly, and there was a lot of attention paid to it around 2006 to 2008.

The CHAIR — Dr Pennay, do you have anything else?

Dr PENNAY — I do not have any slides to present, but I worked on a lot of the methamphetamine related projects we have done at Turning Point over time, so I thought it might be useful for me to be here in case I could answer some questions. There are one or two points that might be worth noting. 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. It is important to note that methamphetamine powder or speed, as it is sometimes called, is a more frequently used drug than crystal methamphetamine — much more frequently used. However, we are seeing increases in ice smoking — there is no doubt about that — and I think that is reflected in Belinda's slides, where we can see an increase especially over the last two years.

The other thing that I think is worth mentioning in terms of treatment relating to methamphetamine is that methamphetamine users generally seek treatment in very low numbers compared to the number of people using it. This is because they feel that the current treatment system, and the way that it is set up, will not respond well to their needs. As Dr Frei said, it is short term treatment; methamphetamine withdrawal lasts for a month and then the problems still continue after 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. That is why Access Point, as a specialist methamphetamine treatment centre, is a good option. However, currently it is the only one of its kind, as far as I know.

The CHAIR — Thank you. I will open up questions to the committee in the time that we have left. I will start off, if I may. I am just trying to understand the differentiation between traditional drugs, such as heroin, ecstasy and speed, and methamphetamine. We have witnesses from Ambulance Victoria coming in this afternoon, and they will probably cover some of the statistics you gave us this morning. We have yet to have a submission from Victoria Police, but my understanding is that there is an increased incidence in aggressive antisocial behaviour by users of ice, just because, as you have said, its usage creates almost an invincible attitude in those who are taking the drug. It is a sexual stimulant, and depending on how many times they take it — and I am not a clinician, so I do not know what impact it has — there is a high and a low.

The sort of advice we are getting is that it creates a problem for communities in regional areas particularly because of the incidence of quite aggressive behaviour in respondents. The police or ambulance have to go to deal with someone who is being physical or who is engaged in criminal or sexual activity or armed robbery. This is apart from the self harm. I am just trying to move away from self harm to harming communities.

We just find that this drug seems to be inciting a much more aggressive response by those takers to other people within the community — and quite harmful responses. I am just wondering what your take on that is because it is a bit different to the other drugs, where the response has been more passive. This drug seems to be creating a lot of problems in communities because of the quite aggressive nature of the people taking it, whether it be simple things such as bumping into someone in the street and suddenly there is a fistfight with quite catastrophic impacts on the people involved. Armed robberies are becoming much more vicious, domestic violence is becoming more aggressive et cetera. Can you comment on that?

Dr FREI — I would just like to say that I think we need to probably look at the evidence to see whether there is a direct association — and it may well be the case — between the use of methamphetamines and violence, or whether it is that we already have a drug out there which is known to make people violent, has a long history of causing violence and is probably the most violence inducing drug ever known to humankind — it is called alcohol. We know that alcohol is often used with methamphetamines. It is possible that we are having 'wide awake' drunks, so people who have all the disinhibition of alcohol but who are not sleeping it off, and that is part of the issue. I think it might be a combination of drugs. We need to look at some of the evidence for this, and whether it is violent people who happen to take amphetamine, or whether it is methamphetamine and its pharmacological effects causing violent behaviour.

Mr SCHEFFER — But we do not have the evidence at the moment; is that what you are saying?

Dr FREI — It would be a very hard thing to study. I am not aware of how much evidence we have about violent offending behaviour particularly and its association with methamphetamine. There is no doubt that there is strong anecdotal evidence for that. As I mentioned before, part of it is that, when one encounters one of these people who happen to be violent and using methamphetamine, they are very memorable. The clinicians do not forget them; they really leave an imprint. But I am unsure of how prevalent it is.

Dr LLOYD — I would agree with that. Far and away, when we are talking about drug related violence, it is alcohol that absolutely leads and has consistently led, and that goes across violence against strangers, family violence, intimate partner violence and sexual violence. Alcohol absolutely outstrips crystal methamphetamine and all other illicit drugs put together. It has consistently been an issue, and it will consistently be an issue.

I would echo Matthew's comments that these cases are very memorable and they are very visible, and they can be very complex when they do occur. That then becomes the truth — that everybody who uses this drug is violent and every case you attend or you see in the ED that is crystal methamphetamine related is going to be like this. We see a lot of that generalisation as well around heroin use and other drugs as well; there is the perception that every person who uses this drug is going to behave in this way.

It is really important to be aware that there are a whole range of risks and harms. People may engage in violent behaviour, and we are talking about people who are often very sleep deprived, withdrawing from a drug and having a whole range of physical and psychological responses to the use of that drug and a range of other things too if they are having social issues, because if they are having financial issues they are going to be more easily upset and agitated.

We also need to take into account that, if that is the focus and if we give the impression that everybody who uses this drug is violent, antisocial and unable to be managed, that will actually reduce the likelihood of people accessing help if they feel they need it, but also reduce the likelihood of their listening to the public health messages around the harms associated with it, because it is not most people's experience of using that drug themselves or with their friends. They do not see those kind of harms, so then they do not engage with a discussion if they start to experience problems. They do not want to be labelled as a violent offender when they may not necessarily be so. So we need to take all of that evidence and weigh it up to make sure that what we are presenting in terms of the harms associated with the use and patterns of use is actually a good representation of what happens in the community.

Mr SOUTHWICK — I just wonder about how many people you see presenting at your agency versus those who may not necessarily want to seek help. You mentioned earlier on, Dr Frei, the fact that the repetitive positive feeling effectively gets people wanting to repeat use, which may lead to addiction. How many of those people who have got to that point would consider themselves addicted to the drug in the first place if they were continually getting a positive outcome, and how big is the problem amongst the silent group that continues to be out there?

Dr FREI — I think we do not know what we do not know. We were talking about this earlier. The silent group is silent, and there have been some good anonymous surveys about this sort of group. With all illicit drug users, not necessarily only with methamphetamine, there is a large proportion who are silent, and web based anonymous surveys are often a good way to investigate that.

In answer to your question, we recognise that in all illicit drug use and in fact in illicit drug populations, most do not get treatment, and that is for a number of reasons. One of them is accessibility and availability of treatment services, and the other is, as we have alluded to, the fact that, as Belinda was saying, they might feel uncomfortable or they do not fit in a treatment service. So part of your question is: do these people know they have a problem, and are they not seeking treatment because they are unaware that they have serious consequences from their drug use? I think a part of addiction is that people continue to use and often do not have insight. I think that is the case, though, across the board with all illicit drugs, and I think we acknowledge that among people who use substances or have addiction issues not as many as we would like get to treatment, and that includes methamphetamine users.

Mr SOUTHWICK — But we are seeing the largest amount of criminal activity and arrests in the last 12 months that we have in the drug's activity. What is causing that sort of focus on this drug at the current time? This drug has been evident since the 1960s. Why all of a sudden now are we getting the sorts of presentations that we have not had before?

Dr FREI — I do not know, but if you look at the history of illicit drug use, we had a heroin boom on the east coast of Australia in the 1990s, and heroin became abundant, potent, cheap and plentiful. Things changed around late 2001, and we had the so called heroin drought. It seems that since then things have changed a bit, so it might be market driven. At the same time, we had a boom in online communications, and the world become a global community with social networks, and so people were able to exchange information very effectively about the manufacture and use of drugs. I think there are a lot of factors that have made this a 21st century phenomenon, but it is a very difficult question to know why we are talking about it now and why we were not talking about it in 1993, for example. The technology was probably there in 1993. I think it is multifactorial that we have this boom now.

Dr PENNAY — Just to add to that, we see in drug trends peaks and troughs, and in the mid 2000s there was a big peak in ecstasy use. It was really good quality, it was cheap and it was available. According to the punters I am talking to at the moment, methamphetamine, particularly crystal methamphetamine, is affordable, really easily available and good quality. It can take just a few changes in supply and demand for those kinds of trends to shift over time.

Mr CARROLL — Belinda, I was interested in the statistics you put up about the ambulance call outs. We have not seen any sort of evidence like that before, and Ambulance Victoria will be presenting to us shortly. It is the night time economy where people are using it, so is it someone who sees someone who has taken it who is in some serious trouble, and then is it a friend who is doing the phone call? Do you know?

Dr LLOYD — We get a mix, so we have patients who call for an ambulance themselves, it could be someone who is a stranger and sees someone in trouble, it could be a family member or it could be a friend. Sometimes it is the police, so the police are co attending the case, although it is in the minority of cases that police are either on the scene already or need to be called to the scene. That really gets to that issue of drug related violence where police are called to the scene if someone is agitated or if someone is aggressive, and we do not see that in most cases. It is a range of different things, and it will depend on the kind of harm people have experienced, so people may

be feeling highly anxious as a result of the effects of the drug and call an ambulance themselves because they do not know how to handle it, and it may be a family member who is concerned about psychotic behaviour and call an ambulance. There may be a motor vehicle accident, and so it is someone on the scene. It is really quite a mix.

Mr CARROLL — Okay. The committee is looking at best practice in how to deal with crystal meth. If an ambulance comes out and treats someone, where does it go from there?

Dr LLOYD — It depends on the circumstances. The patient may be transported to hospital, and that is dependent on the paramedics' assessment of whether they actually need further treatment, but also on whether the patient is willing to or not. We see a fairly high transport to hospital rate, but it depends on why they are presenting and what their issues are. For things like heroin, we see a really low transport rate, so it really varies by drug. Often patients will refuse to be transported even if the paramedics feel that they should be reviewed in an emergency department. So we do see a substantial proportion going on to an emergency department and being reviewed there. Very few actually get admitted to hospital. They are seen by an ambulance, they are seen in the ED and then that is it.

Mr McCURDY — It appears to me that you still have some reservations about the effectiveness of some of the current treatment programs. Is there anywhere else in Australia or even internationally that you know of or have seen to be doing it better in terms of treatment programs that you can put your finger on?

Dr FREI — I do not. I think in New South Wales, for example, they have had a larger magnitude boom in methamphetamine use, and I believe they have done similar things. It is a completely different health service system in drug and alcohol in New South Wales and Victoria. I think they have made similar endeavours towards methamphetamine specific clinics. In fact one of my colleagues has done some work with substitution therapy, so using prescribed amphetamine forms — dexamphetamine forms, which you can get under prescription for certain conditions — as a treatment for methamphetamine dependence. That is where I am interested and where I think some of the most exciting work is — embedding psychosocial interventions with medication treatments. I think that is where the future is. But I am not aware of anyone who is doing it a lot better, and I think because of this boom in the last 5 to 10 years everyone is looking at a way to do it better in this country.

Dr PENNAY — One quick thing to add on that is the high rates of mental health problems associated with methamphetamine use, which is perhaps a little bit distinct from other drugs. It means that having a drug use counsellor along with a mental health practitioner is a really useful way of doing it along with a medical doctor. The current system is set up where you see mental health treatment separate to your drug use treatment, but it is not a drug where you can deal with those issues like that. I think that is important.

The CHAIR — All right. Thank you for your time this morning, Dr Frei, Dr Pennay and Dr Lloyd.

Witnesses withdrew.