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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Witnesses

Ms J. Kelsall, Executive Officer, Harm Reduction Victoria.

The CHAIR — I welcome Ms Kelsall to the Law Reform, Drugs and Crime Prevention Committee on the first day of the public inquiry into the supply and use of methamphetamines in Victoria. In doing so I am obliged to provide you with the rules of engagement in relation to this hearing. If you will just bear with me for a moment, I will read it out. 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 of other states and territories. Any comments you make outside the hearing may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Ms KELSALL — Yes.

The CHAIR — We are recording the evidence and will provide a proof version of the Hansard transcript at the earliest opportunity so that you can correct it as appropriate. We have allotted until 3 o'clock for this session, but given we are a little bit late starting we will allow some flexibility. However, we will try to keep as close to the time as we can. What we have done with other witnesses is allow them to give a brief presentation and then the committee has asked a number of questions on that presentation. Are you happy with that arrangement?

Ms KELSALL — Yes, that is fine.

The CHAIR — Welcome. We look forward to hearing your submission.

Overheads shown.

Ms KELSALL — Thanks, Simon. I would like to thank the committee for inviting Harm Reduction Victoria to make a submission to you today as part of this inquiry. It is great to have the opportunity to meet with you in person and to present the issues as we see them from a drug user and consumer perspective.

I am currently the executive officer at Harm Reduction Victoria, and I would like to spend just a bit of time talking to you about this organisation. Who are we and what do we do? Some of you will be aware of our existence. Certainly I have met Dr Sandy Cook in the past, but many of you probably will not have heard of Harm Reduction Victoria. We were formerly known as VIVAIDS. We are the drug user organisation for the state of Victoria, and there is an equivalent drug user organisation in most states and territories across Australia. We are part of a national network of such organisations, headed up by our peak body, AIVL, which is located in the ACT.

Amazingly really, Harm Reduction Victoria was established in 1987 as part of the community response to the threat of an HIV epidemic among drug users, hence our former name, VIVAIDS. It is a name that has tended to stick, I think. As one of the affected communities in relation to HIV/AIDS, drug users and drug user organisations played a key role in preventing the realisation of an HIV epidemic among drug users in this country. Happily rates of HIV remain extremely low among people who inject drugs.

We have survived, albeit tenuously at times, for 25 years. We had a celebration last year to celebrate this milestone. Today, in 2013, we work across a much broader front in order to address a wider range of issues and concerns. However, blood borne virus prevention and education, in particular hepatitis C, remain a key focus of our work. Harm Reduction Victoria is a membership based organisation. We currently have a few thousand individual as well as organisational members, and membership is open to anyone who has a history of illicit drug use, past or present, and their families and friends as well as people who support our aims and objectives. We are funded primarily by the Victorian Department of Health.

Our mission, as you can see, is a world free of stigma and discrimination where a person's drug of choice will not be used to define and/or vilify them. Our mission is to simply advance the health and human rights of all people who use drugs. While we regard all people who use drugs as our primary constituency, we maintain a priority focus on the most marginalised and disadvantaged sections of the drug using community and, in particular, on people who inject drugs, due to the increased risks and harms associated with injecting drug use, including the transmission of blood

borne viruses. Our limited resources also dictate that we are strategic and that our programs target those at greatest risk of drug related harm. While people who use drugs are our primary constituency and our priority target groups, we also work closely with other staff in other agencies who work with these target groups.

One of our key functions, I think, is to provide a voice for people who use drugs. This is one of the unique aspects of the organisation — we are the voice of and for people who use and inject drugs. In order to make this claim and to speak with authenticity and authority, we need to be well networked and grounded in our community or communities. We need to keep our collective ear to the ground, and we need to listen to our members and constituents. We encourage our members to participate at all levels of the organisation, and when it comes to illicit drug use we 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, and it is great that we have a voice today as part of this inquiry. These are matters that will impact on their day to day lives.

We promote consumer representation and participation wherever possible. Harm Reduction Victoria can bring the drug user perspective and the reality of what people who use drugs actually do into all our harm reduction initiatives. We stress the consumer perspective and consumer participation in all our partnerships with other organisations and in our advice to governments.

We work within a health promotion and community development framework, and harm reduction as an approach underpins all our work. Essentially this is what we do: we try to ensure that people can use drugs as safely as possible and with minimal harm to themselves and others. Our focus is safety and safer drug use in trying to keep people alive and well during their drug using years.

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 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. However, our work is also informed by the available research and the evidence base, best practice policies and programs from around the world as well as our valuable partnerships with research, other community organisations and governments.

We are not a treatment agency, and these are not redemption narratives; however, if that is what a client or constituent wants, of course we will assist them and point them in the right direction. Our agenda is not getting people off drugs. In fact we are one of the few organisations that works with people during the drug using years, which is when people are most in need of help and support. Our objectives are safer drug use and assisting people to make informed choices. We encourage people to do whatever they can to move their drug use in a safer direction.

How do we engage with our constituents and our target groups? In a variety of ways. Historically, our preferred model of engagement is peer education and its various incarnations. Much of the peer education we do is in the form of interactive workshops that are designed specifically for groups of people who use drugs. But much of our engagement happens in an entirely opportunistic way in the form of brief one on one interventions.

Our magazine, Whack!, has also been 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 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.

What do we do exactly? As I mentioned, the prevention of HIV and viral hepatitis are a key area of activity for us, and much of our funding is tied specifically to Blood Borne Virus prevention and

education. However, I have also mentioned that we are active across a much broader range of program areas, and you can see from this slide some of our current programs. DanceWize, for instance, is a peer education program that has grown up within the dance party scene — it used to be called the rave scene. It is young people who attend music festivals and dance parties in urban and more regional or rural locations. We have an overdose peer education and prevention program. One of the few ways in which we actually actively engage in treatment is our pharmacotherapy advocacy, mediation and support service, which supports consumers of pharmacotherapy, including methadone and buprenorphine. Each of these program areas works with quite different and discrete groups, and they provide us with a range of sources of information and snapshots of the world out there.

That is probably enough about Harm Reduction Victoria for now. I want to get to the reason you have invited me here today and to give you some of our thoughts about methamphetamine and the current state of play in Victoria.

The CHAIR — Jenny, sorry to interrupt. We have limited time here. The committee, to get the best out of the session, would like to ask questions. Perhaps if I could just ask you to briefly outline the specific inquiry into methamphetamine, which I understand you are heading to now, and then we can ask some questions of you. Thank you.

Ms KELSALL — Sure. What I am about to say is anecdotal and based on the information provided to us — to staff — by members of the various networks we work closely with, but it is largely borne out by information gleaned from other sources and some of the recent research that has been conducted by Burnet. In answer to your first question, yes, all the signs point to a dramatic increase or escalation in methamphetamine use in Victoria. For this reason we recently devoted an entire edition of our magazine to stimulants. I do not know if you can tell from that, but that is meant to be a largely dilated pupil — an eye with a dilated pupil. I brought a couple of copies of the edition [of Whack! magazine], and it is also available on our website for your interest.

Feedback from a number of our programs clearly indicates increased use of ice, or methamphetamine. DanceWize, which, as I mentioned, involves a large team of trained volunteers who attend dance party events and music festivals, consistently reports increased use of ice, particularly during periods where MDMA, or ecstasy, has been hard to get or is of lesser quality. This is a very specific group; it is a very young cohort of partygoers. They tend to use a wide range of illicits in a very social and sociable sort of way. As a group they tend to be extremely well informed and eager for information about the cocktail of illicit drugs available at these sorts of events. However, I should also add that alcohol is by far the most problematic drug reported by the DanceWize team from their perspective, especially among the very young patrons and in particular young female patrons. The team report that alcohol is marketed so aggressively at these big commercial music festivals in the city that it is hard to avoid; meanwhile it is very difficult to find a water tap.

Similarly our team of health promotion educators consistently report larger numbers of methamphetamine and ice users in attendance at our peer education workshops about safer using and overdose. Participants are asked to identify the last drug they used prior to the workshop to determine the actual workshop content, and for the last 24 months or so methamphetamine users have outnumbered opiate users for the first time ever in the history of this organisation, which is an indication to us of the prevalence of methamphetamine use.

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. Injecting of methamphetamine is also frowned on in the DanceWize community and shrouded in the same sort of secrecy we observe in the gay community.

As far as we can tell and from our perspective, the explosion of meth users is largely socially driven, and the means of administration is predominantly smoking. Yes, there is some uptake of injecting, clearly, and some smokers will inevitably transition to injecting at some stage, possibly as they develop tolerance to methamphetamine. It is harder to say just why it has increased — certainly access and availability are always part of the equation, and all reports confirm that ice is readily and easily available in Melbourne and Victoria. Our reports suggest that much of it is locally made. It is local product — often inferior product — but again it is hard to confirm this sort of information.

I am actually surprised that the cost of methamphetamine is not more of a deterrent, especially for younger users. It is bought and sold at exorbitant prices. I do not know if anyone has gone into the cost of methamphetamine, but the current price is $100 for a point. That is a 10th of a gram. Opiates have never reached that kind of price.

The CHAIR — Can I just interrupt? The advice we have been given is that in fact it has higher purity. Yes, it is more accessible, but it is also cheaper than the alternatives.

Ms KELSALL — You see, the argument against the cost is that you are getting good value for money.

The CHAIR — That is right; it is more pure.

Ms KELSALL — Because that one point, even though it is a tiny amount of the drug, is enough for four people to have a good night out. So, yes, there is quality for money, if you like, but that is a large outlay for a small amount of a drug, particularly by comparison with opiates. It is excessive, particularly when you realise that it is not actually the cost of the drug — most of this is profit. It is not an expensive drug to manufacture or produce. Methamphetamine is nothing new, as we all know; it is simply a stronger version of amphetamine, and amphetamines have been with us for a very long time.

The CHAIR — Do you think that is why the outlaw bikie clubs and organised crime are so active — because there are such profit margins in the distribution tree?

Ms KELSALL — Absolutely.

The CHAIR — Other than heroin and ecstasy and others?

Ms KELSALL — Yes, and because it can be made locally. With heroin there are all sorts of issues and restrictors of importation and growing a crop and weather. Yes, I think it is that it is easily made; it is easily produced despite all the clampdowns on various ingredients. It seems that it can lead to an even more toxic cocktail of ingredients.

How have we tended to deal with amphetamine to date? This is a compilation of images from the Montana meth campaign in America from some years ago. I do not know how clearly you can see the individual images, but you can probably get the idea. These are grotesque images, and the impulse — certainly my impulse — is to look the other way. This is one of the ads. We have tended to follow suit in Australia. This is another ad; it was from the federal government funded anti ice campaign from 2008. There was a series of television commercials which you may remember.

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 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.

What do we think would be a more appropriate response? 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. Peer education is Harm Reduction Victoria's stock in trade, and I guess we are in a position to see it work and to see how and why it works.

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 are in the process of rolling out a comprehensive training program for health professionals to challenge stigma and discrimination, and these are also major barriers to open and honest dialogue and access to appropriate care and support.

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. I think that is where we need to begin and where we need to focus a lot more attention.

We have never had a dedicated meth health promotion staff member, and we simply do not have the capacity to roll out this sort of education on the scale required, but I think this sort of education and mobilising young people to educate each other is the key to the door. Thank you.

The CHAIR — Thank you.

Mr SCHEFFER — You talked about the kinds of things you are doing in your program. You said it was based on evidence and talked about evidence for increased use, and I think you said a lot of young women were more exposed or using amphetamine?

Ms KELSALL — That was in relation to alcohol.

Mr SCHEFFER — When you talk about the cluster of things, do you derive that information from the people who are part of your organisation —

Ms KELSALL — Yes.

Mr SCHEFFER — or do you rely on external studies that have been done? Could you step us through how you draw those conclusions?

Ms KELSALL — Sure. On a regular basis the information is being imparted by staff members who come back from those events and provide a report about each event. That report includes this kind of information, but we also do external evaluation. We talk to the patrons who utilise the DanceWize program. DanceWize also operates what they call a chill out space. They work very closely with the first aiders, so if somebody is in distress but no longer requires medical attention, the first aiders refer them to the DanceWize area so that there is someone to monitor them and make sure that they are okay, but they are still not able to get up and join the party or to look after themselves. Our external evaluation does speak to the first aiders, and they are some of our most vocal and avid supporters.

The information is coming from a number of different sources. You are right; we need external evaluation to make sure that what we are doing is effective and that the information that we are capturing is reliable information.

Mr SCHEFFER — Okay. Thank you.

Mr SOUTHWICK — Jenny, you mentioned before some of the shock campaigns that you showed can have an adverse effect on taking methamphetamine. Were the people you spoke to

about that users as opposed to people who have not experienced the drug before? I wonder whether you would be able to at least suggest that maybe those who feel bulletproof and are users but are not at that point in their lives would see that but that somebody who has not experienced it at all would see 'Don't go there', as I did. For somebody who has not been exposed to the drug, I think it could be effective for that one group. Maybe there are different campaigns for different clientele.

Ms KELSALL — Absolutely. There was the response we got when we showed some of these ads. Yes, you are right; these are people who have some experience of ice. The big problem is that these ads simply do not fit with their experience of the drug. A lot of these ads are claiming that you will become addicted and you will present in that kind of dilapidated way after your first use. A lot of the Montana meth ads were, 'I'm just going to use once', and the thrust of the whole campaign was that. Yes, the first time leads to the second time and to subsequent times, but the thrust of the message was that one time is enough to do untold damage.

I think that is the danger in exaggerating the picture, because if it does not sit with your experience of the drug, then you just tend to discount all of it as lies and misinformation. I am not saying for a moment that there is not some truth in that, but I think the way it is presented and because the point of it is to scare and shock and repulse — and yes it certainly does that to me — I just think people quickly discount all of that because it really has no bearing on what they are experiencing, which is a great night out and having the best time of your life. This is a very sociable drug — and mostly it is — with really harmonious and happy situations. It is just light years from these really ugly, grotesque images. It is almost like we are talking about a different drug when we show these images, and it just has no bearing.

These are the people I think we need to get to. We know it is part and parcel of youth and adolescence to experiment and push the boundaries. Those are the people I like to think we can reach — the people who can go either way. They are experimenting and they are curious. If we can arm them with the right information, we can keep them safe. If we provide them with this sort of information that they just discount totally, then — —

Mr SOUTHWICK — But it would be interesting to know how many of those sorts of ads have stopped people from taking the first lot of ice.

Ms KELSALL — That is true, and I have not seen any research that actually focus tests it completely with people who have never tried it or experienced it on any level, but overall the research indicates that it does not work. 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. You are right; I am talking about a different group. 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.

The CHAIR — I do not know if you have tested that here against the Grim Reaper ads in relation to the AIDS unprotected sex theory of marketing. I think you would probably have a different view of the world.

Mr CARROLL — With all those ads — like sunscreen or seatbelts — it is about being contemporary. It is about being very realistic, and probably that particular ad was maybe a bit too over the top. Some people do present quite comfortably who have an addiction and can treat themselves and carry on their lives.

I just had a look at your website, Jenny. Congratulations. It is very good, very contemporary.

Ms KELSALL — Thank you.

Mr CARROLL — And a lot of young people are writing in. Harm Reduction Victoria is not a treatment agency as such.

Ms KELSALL — No.

Mr CARROLL — But you help people with managing their addiction. With the drug ice people inject it, so there are risks of HIV and hepatitis C. What are you seeing in that area? People come along; they are users; they do not inhale it, they inject it. What do you do when they come along?

Ms KELSALL — We run regular workshops around safer drug use. The term 'safer drug use' has been coined because there is no such thing as safe drug use. There are risks inherent in the very act of putting a needle in your arm. You are taking a risk. But we do like to equip people with best practice when it comes to injecting to make sure that they do not expose themselves to a blood borne virus like HIV and hepatitis C. These are chronic infections that will be with them possibly for the rest of their lives.

Mr CARROLL — The drugs to treat HIV are quite good and people live a long time, and we have almost seen a spike in drug use, unsafe sex and things like that. Are you seeing that even with ice and people injecting it, that they are bit more casual?

Ms KELSALL — That is a very good question, because definitely that is the information we are getting from the gay community. We have actually established recent partnerships with some of the gay organisations, like the Victorian AIDS Council and Living Positive. They have brought us in to work with a group that has been termed 'sexually adventurous young men', the SAMs. They are seeing exactly that nexus of methamphetamine that has resulted in very, very unsafe sexual practices. I think part of the problem with getting to methamphetamine users with education or anything else, including treatment — and I did not have time to go into it in my presentation — is that a lot of ice users do not identify as drug users. They do not identify with our organisation. They do not want to be labelled as a drug user. That is not their identity, and that is the problem within the gay community. The people who are using ice and even injecting it do not identify as drug injectors, and so we have to design very nuanced information and education to work with this particular group.

I think you are right; it is always about being very targeted in our information and education. That is why we really encourage consumer participation and input. We bring the people on board that we are creating this information and education for. They are the best way of testing whether we are on the right track or not. I think it is particularly problematic when it comes to treatment, because the treatment sector has very little to offer methamphetamine users. We know that the search continues for a pharmacotherapy the equivalent of a methadone or a buprenorphine for amphetamine users, but it remains elusive.

I would love to see simple respite care for methamphetamine users, just time out — a warm bed and a hot meal and some time out. That is what I think would benefit some of the users we see who are running into problems. It is no longer something they do on a Saturday night; it has encroached into their working week and it is starting to interfere with an integrated life. I would love to be able to take those people home, just to give them some TLC for a week or two. I think that is the kind of treatment they need.

Mr SCHEFFER — That is a very different characterisation of withdrawal than would apply to other drugs. Do you see that there is something different about people who have a high usage and feel they are losing a little bit of control over the use of amphetamines?

Ms KELSALL — I think that is a very difficult one. It is the chicken and the egg argument. Is ice producing these behaviours and these mental health issues or is there a predisposition, as we argue with marijuana? Does somebody have that predisposition in terms of mental health problems?

Mr SCHEFFER — No, it is not that. What I am getting at is that you are saying that for a person who has some issues with methamphetamines, a hot meal and a warm bed and a bit of security and a bit of time out would see them out the other side, whereas that would not be said for

some other drugs where you would need some quite sophisticated and professional interventions. You are saying a quite interesting thing there.

Ms KELSALL — I do believe that the addiction is predominantly psychological. It is not a physical addiction in the way that an opiate dependency manifests physically. It is largely about putting some distance between you and that drug. No, I do think that it is a different kettle of fish — very much so. I think that is a really good point.

The CHAIR — Thank you very much, Jenny, for your time this afternoon. We appreciate that, and congratulations on the work you are doing through your agency.

Ms KELSALL — Thank you. Can I leave a couple of these magazines? This is just some information about our organisation, if you are interested.

The CHAIR — Thank you.

Ms KELSALL — Thank you for your time.

Committee adjourned.