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

Professor P. Dietze, Head, Alcohol and Other Drug Research, Centre for Research Excellence in Injecting Drug Use, Burnet Institute.

The CHAIR — I formally open this afternoon's inquiry proceedings and welcome Professor Paul Dietze, who is the head of alcohol and other drug research at the Centre for Research Excellence in Injecting Drug Use, CREIDU. You will appreciate that we have media in the room as well as Hansard. I will just go through the terms of engagement in relation to this hearing. 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 of other Australian 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 at parliamentary committees?

Prof. DIETZE — Yes.

The CHAIR — We are recording the evidence and will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. Today is our first public hearing of the inquiry into the supply and use of methamphetamines in Victoria, particularly ice. We thank you for your time in presenting to the committee.

Overheads shown.

Prof. DIETZE — Thank you for the opportunity to present. This is obviously something that we do a lot of work in, as you will see shortly. It is probably worth me just introducing the Burnet Institute so that you get a sense of who we are and what we do. We are one of the largest medical research institutes in the country and also one of its leading ones. We are unique in many respects. We are a non government organisation, which sets us apart from other medical research institutes. We have about 400 staff. About 50 of them work in the Centre for Population Health, which is where I am from. Our work focuses on patterns of alcohol and other drug use and related harms in the community and ways in which we can develop better responses to them. That gives you a sense of the background.

I think we are uniquely positioned in relation to the terms of reference of this inquiry because I do not think anyone else in the state is doing the kind of research that I will be outlining today. While there is stuff on, say, ambulance attendances and things like that, I do not think anyone is actually talking to people who use these drugs in the kinds of ways we do.

I will outline how we do that in two slides, which detail our studies. We have a series of cross sectional studies. 'Cross sectional' means that you are just taking a snapshot of people at any one particular time. We have surveillance systems, which are known as the ecstasy and related drug reporting system and the illicit drug reporting system.

They are two key platforms from which we can start to look at what actually happens in drug markets. The things that they focus on are: user perceptions of price, purity and availability; indicators, so things like the ambulance attendances you have been privy to this morning; and also interviews with key experts, so people who have contact with people who use different drugs. The ecstasy and related drug reporting system focuses on the nightclub style drug use, whereas the illicit drug reporting system focuses on injecting drug use. Each year we interview 100 people through the ecstasy and related drug reporting system and 150 people who inject drugs through the illicit drug reporting system.

Mr SCHEFFER — Are they the same people?

Prof. DIETZE — Different people. Basically they are very similar studies: one is with people who inject and one is with people who are basically party drug users as opposed to people who are at the hard end of injecting and so forth.

Mr SCHEFFER — So each time you do a slice for each of those samples it is with 100 different people?

Prof. DIETZE — Generally. We do record whether or not they have done the study before — some of them have but most of them have not. We also do another cross sectional survey

at the Big Day Out, which is a music festival. We recruit as people are coming in. We ask them a whole series of questions about their health and wellbeing, some of which relate to drugs.

Our flagship studies are our prospective cohort studies. A prospective cohort is where you do a cross section of people but then you start following them up. The Melbourne injecting drug user cohort study, or MIX, is the largest study of its type ever conducted in Australia. We have about 700 people in the cohort, all of whom are injectors, and we follow them up every year. We specifically recruited young people when we established the study in 2009, and we are following them up over time. Something which has an obvious relationship to the committee's inquiry is another of our studies called UnMet, which specifically looks at service utilisation, so mostly the treatment services of another cohort of 255 psychostimulant users. These are basically the methamphetamine users. We followed them up once, and we are planning to follow them up again through another NHMRC funding application. These two studies are funded by the NHMRC through a competitive grant processes.

You will have seen the data on ambulance attendances from the database that Turning Point maintains, which I established in the 1990s. You will see that there have obviously been some increases, mostly driven by methamphetamines. I will not run through these. The interesting thing is that the inclusion of regional data shows a relatively flat curve in comparison to the metropolitan area of Melbourne, which has shown an increase in ambulance attendances. This is in relation to crystal methamphetamine. The important thing to note is that these increases are still dwarfed by other drugs like alcohol, benzodiazepines and opiates. In terms of perspective, we need to realise that these numbers are still relatively small.

The CHAIR — Is there an expectation that that graph would go up in the following year?

Prof. DIETZE — I will look at my expectations around this in relation to some of the other data that we have. Certainly I would be very surprised if that trend line were to continue up, but I could be proven wrong.

The CHAIR — I was thinking that the regional blue line finishes in June 2012.

Prof. DIETZE — I am honestly not sure. Ambulance Victoria would have more current data than this; they might have shown that this morning. I am not sure.

The CHAIR — Okay.

Prof. DIETZE — One thing that I do not think has been spoken about much at all is what is happening in the methamphetamine market. If you have a look at this figure — the brown line is Victoria — you can see that the medium purity of samples seized by Victoria police, which are a reasonable measure of what is happening in the market, skyrocketed from 2009 onwards. In 2009, medium purity was around 10 per cent. By the time you get to 2011–12 median purity was up around 60 per cent. I think that is what is actually driving the harms that you are seeing at the moment and that people are reporting on. I do not think there is much evidence to suggest that there has been this explosion in new people coming in and using these drugs; my thinking is the people who were already using the drugs are getting themselves into more trouble because basically they are getting a whole lot more bang for their buck when they go to buy the drug and they end up using a lot more, thinking that they might not be using a lot more. I think that is what is driving some of the things like the ambulance attendance data that you just saw.

I will not run through this particular slide. The only thing to note is that it is pretty difficult to get people who use methamphetamines to engage with drug treatment. They only account for 12 per cent of presentations. We also know that retention rates are low. Most of them do not stay in treatment once they get in. But we really do not know much about what is going on in Melbourne or Victoria more broadly, apart from the indicator data like the ambulance attendance data and also the work we do at the Burnet.

In terms of what my program can do in this area, we have some key aims, and these are the capacities that come with the studies that we do. We conduct surveillance and epidemiology of methamphetamine use and associated harms, and you will see some of this data specifically. We

are particularly interested, as I said, in service utilisation. What are the barriers to getting into professional support? We also want to know what happens to people over time. Once you start using the drug are you really just hooked into it forever? There are people who argue that it is so addictive that you cannot get away from it et cetera. We also want to know: what are the things that predict going into treatment and starting to deal with the issues for those people who have them.

Let us have a quick look at the epidemiology. I am sure someone will have mentioned that the household survey for Australia shows that around 1 per cent of the Australian population reported using methamphetamine in 2010. That is one of the highest in the world, if not the highest. We are interested to see what happens in the 2013 survey, which is going to field later in the year — in fact it is probably going to field about now. Realistically we are up there, but this is still relatively fringe.

Who are the sorts of people who use? If we have a look at the UnMet study that I have mentioned, which will feature a lot in what I will be covering, basically most people are male. There are a lot of unemployed people who we have recruited into the study. Two thirds of people in the study were injectors. They are the sorts of people who we were able to access when we were trying to sample. Most of them do not have particularly high levels of education or anything like that. These people are typical of who one finds when one tries to recruit samples of people who are using methamphetamines.

The CHAIR — Sorry to butt in. You talk about a report. Is that a fair indication of use? Why would you voluntarily report to using methamphetamines?

Prof. DIETZE — Certainly with the particular studies that I am talking about we are recruiting people because they have told us that they are using methamphetamines. When they are reporting to us there is no real incentive to lie or anything like that. We have a really good rapport with our participants because they know how we work. With the population surveys there might be underreporting; that is absolutely the case. But I think the bigger issue for the big population surveys is that the people who do not want to report will not participate in the study and you have a lot of studies with really poor response rates, so the household survey response rate is very low.

There was one study that I think really needs replication, and that is the Victorian Youth, Alcohol and Drug Survey which was done most recently in 2009. That was a Victorian specific survey; I am not sure whether the committee is aware of it. It showed high levels of methamphetamine use. It would be really interesting to follow up what has happened with that since 2009. I am not aware of that being done again.

The CHAIR — Okay.

Prof. DIETZE — A key thing at baseline — this is when people are recruited in — is that there has been a lot of injection. Most were using speed powder at that time, and I will come back to that in a minute. Around 60 per cent, so the bottom line there, were methamphetamine dependent. That gives you an indication of what the sample looks like. This is a purposive sample; it is not a general population sample. In the general population methamphetamine dependence would be very low. If we are talking about 1 per cent of the general population maybe using methamphetamine, then it would be a very small fraction of that 1 per cent who would qualify as dependent. Obviously we are recruiting these people because of their methamphetamine use and we are interested in the services. I will not go into that.

Let us have a look at the stuff around market characteristics. These are the numbers that people report spending on methamphetamine. If you look at the top line, you can see the amount of money per gram of speed powder is basically stable across all of those measures. 'BL' is 'baseline'. 'FU' is 'follow up'. You can see it is basically $200 per gram right across there. Instead for crystal meth you can see the numbers have increased, so from baseline to follow up the amount spent per gram went from $400 to $600, and in the illicit drug reporting system we had a very similar finding. The price has gone up and the purity has gone up. Keep that in mind.

This is with our big cohort. Our big cohort is people who inject drugs, so they have to be injectors. This is methamphetamine price per gram. We are really in the process of just pulling this data together. Price per gram for methamphetamine has basically stayed absolutely flat in that big cohort. If you look at the right hand side of that figure, you will see that the dots represent each purchase of methamphetamine. The dots on the right hand side are much more sparse, so people are not purchasing normal methamphetamine in the same quantities as what they were.

If we turn to crystal methamphetamine, you can see the dots on the right hand side have started to get more frequent and the price per gram has gone up, so the price has gone up and the purity has gone up. What we really need to know — and we are in the process of analysing this — is whether or not the price per pure gram has gone up. Purity fluctuates. If the purity and the price have gone up, it might still be the case that people are paying less for more methamphetamine. That is what I suspect is happening. As I said, we are in the process of analysing that. We have data from Victoria Police which I cannot release yet. If you have a look at the steepness of that curve that I showed you before on that brown line, I think you will find pretty clearly that the price per pure gram has actually declined, so things have gotten cheaper. In contrast, heroin has stayed absolutely flat and the purity of heroin has stayed absolutely flat. It is fair to say that more of our big cohort is starting to use crystal than they used to. I want to remind you again of that purity line. When that brown line goes up in 2009–10 is basically when things start to happen in our cohort and right across the scene.

What does that translate to in relation to overall patterns? This is the illicit drug reporting system, for which we are interviewing 150 people who inject drugs every year. Speed use has basically declined since 2009. Ice or crystal meth use increased dramatically from 2009 to 2012 but has started to tail off. If we turn to look at the sample of people who are party drug users, you get more or less the same pattern. Speed powder use has started to climb, whereas ice use increased and then basically stabilised. I think what has been happening is that there has been a relatively large increase in use among people who were using drugs that has basically reached its peak and may well be starting to decline.

Some of the harms you have seen from the harm indicators will have been because people have starting using the drug more and then there is a lag before they start experiencing problems. The lag is probably where people are starting to see these increases in ambulance attendances and so forth around that time. That is what I think is actually happening in the market at the moment, but we really do need to wait and see. We cannot necessarily anticipate exactly where things are going, because it is obviously a hidden behaviour and a hidden population we are accessing.

In terms of professional support, let us have a quick look at what the barriers are. I guess the most common reason we were able to identify in our study of treatment service use was that most people basically felt they did not have a problem. You can see a couple of quotes from some of our sample. The sorts of things that predicted them not being in contact with services and thinking they were okay were things like being employed and using the drug less frequently. Not surprisingly, if you are able to manage your use and so forth, then people are going to think that they really do not have a problem, but half of those people were methamphetamine dependent according to the measures we were using. A lot of them were injecting, which is a big risk for a whole variety of other things like blood borne viruses such as hepatitis C and HIV, and quite a few of them were experiencing the financial problems that go with use of the drug and so forth. We need to follow up these people more now. We have only interviewed them twice, so we have had baseline and first follow up, and we are trying to interview them further.

Other barriers are things like people thinking they should be able to manage these things themselves. There is a certain amount of pride and so forth. A lot of people felt that services were not able to address their needs adequately. A lot of them could not find any methamphetamine specific services and services where staff were knowledgeable about methamphetamine. I did a simple search, and this is instructive. If you look at the website for methamphetamine treatment, there are errors throughout it. If you follow it through to the national one that has been set up, there is no mention of the Victorian telephone service direct line. It takes you to ADIS, which is in New South Wales and the rest of the country.

There are other errors, such as when you go to access Access Point. Turning Point used to have a specific methamphetamine service; it may well still exist, but when you go to that you do not get Access Point but rather something called Psycheck, which has got something to do with methamphetamine but not much. It is not actually a methamphetamine specific service. Some of the resources that are out there are out of date and not particularly user friendly. Basically some people regard their use as functional, like it is helping them to deal with various issues they might have.

Let us have a look at what happened to the sample over time, and I think this is really interesting as well. These are the characteristics of the sample at baseline and the sample at follow up, because we cannot always follow up these people. We followed up about 80 per cent of them, which is pretty good, but we did lose some — we were unable to follow up 54 or so. The one thing that changed — this is between 2010 and 2011 — is the increase in the number of people reporting that they were using crystal methamphetamine rather than speed, and that is consistent with the market indicators we are seeing.

Thirty two per cent of them had stopped using methamphetamine by the time we got to follow up, which is interesting. As for the idea that this is some sort of addictive thing that you cannot get out of, 32 per cent of them had just stopped using. The frequency of use had dropped off, so people were not using as frequently, and as for people who were classified as methamphetamine dependent on the scale that we had, there was a drop in that as well.

There were no changes in the route of administration or anything like that. There was not much progression to dependence amongst those who were not dependent at baseline, so people were not really skyrocketing in their use in spite of these market changes. It was not just that people were switching to using a whole series of other drugs; in actual fact in this cohort drug use generally went down right across the different substances that are listed up there.

In many respects it is a good news story for this particular cohort. Importantly, around one third of those who were dependent at baseline were no longer dependent at follow up. The things that were predictive of that were being younger, getting a job — not surprisingly; the more integrated you are, the better social supports you have. Those sorts of things lead to a decrease in the use of these kinds of drugs.

Importantly, though, we were not able to see any effect of accessing services like drug treatment, so these people were largely managing this transition on their own. We did not find there was any effective drug treatment in the cohort. That needs to be further followed up; we need to get more years of data collection.

Let us just have a quick look at the sorts of services people were accessing. You can see that about 36 per cent reported accessing one on one drug counselling and 44 per cent were talking to their GPs. Quite a few of them — 24 per cent — ended up going to a generalist psychiatric service and so on. You can see that people were contacting these services during follow up, but the point is that they are accessing a range of services, and so there are some potential points. I will not go into that because of time. The sorts of things that predicted accessing drug treatment services were accessing services for mental health, so people are obviously being referred in if they are going into health services for mental health; if people were methamphetamine dependent, not surprisingly, if you have got more of a problem; and people who were injecting were more likely to access services.

One of the things I mentioned before is that we asked a range of people who have contact with people who inject drugs or with party drug users, or key experts who have real knowledge of what is going on, a series of questions about their perceptions of what is going on. These are the sorts of things that they were reporting in the most recent interviews we have done with them, which was just a few weeks ago. Basically they were reporting that ice is a big problem and that it was leading people to display behaviours and aggression that was out of character. There were issues around the timing of the treatment programs. Particular services were saying that because of the nature of the system they were having to push people through the system more quickly than what the person actually needed. They needed more time in treatment. It was specifically identified that there were

some issues around Indigenous people who were running into trouble with these drugs. There were full case loads for Indigenous services.

Younger age of initiation is a key thing that people were reporting, so people are starting to use the drug at a younger age. Alcohol is still the major problem. The idea that it is methamphetamine alone is very prevalent, but some people just use methamphetamine so they can drink more alcohol and so on, so the motivation for the use of these drugs needs to be taken into account.

One thing I need to point out is that the key experts are not immune to media reports, and so they might hear media reports and they might be reporting things that are just feeding into the groundswell of expectations around this.

This slide shows some ideas about what I think is needed. I think that better services are needed. The services need to be more responsive, and they need to allow for adequate length of stays. We know, for example, from wider surveys and wider studies that length of stay — long term residential rehabilitation services — works for methamphetamine. We do not have an adequate replacement drug like we do for, say, heroin dependence. It is really lots of talking therapies and things like that that are needed.

We need better integration between research and policy development. We rarely get a chance to properly use the research that is around, and the processes for the way in which research is commissioned need some revision at the moment. In that regard, I think there needs to be some regional research done, because that is obviously where a lot of reports are coming from, and the qualifications and expertise of the people who are doing that research really need to be focused on.

In the end, in many respects what I have been saying is that I believe there is not a big increase in the number of people who are out there using these drugs. But, irrespective, when someone has been on a big binge and they are experiencing some kind of acute psychotic episode, the impact that they have on mental health services in particular really needs to be taken into account and the resourcing of those mental health services needs to be thought through. If someone is having an acute psychotic episode and it takes them a full two weeks to recover from that, they may well recover and be absolutely fine afterwards. If they are spending the whole two weeks in an acute psychiatric ward, that is a huge burden on the ward and it also requires specialist training to manage, because the people can often be quite aggressive in those circumstances.

In light of what I think has changed in the market, we really do need a lot of targeted information and education. I am not sure that some big mass media campaign is required here at all. As I said, it is only a very small number of people in the community who are using these drugs, and I think that there need to be well thought through, targeted campaigns, maybe peer based delivery of some of these things. There is peer based delivery of, say, drug overdose education. Why would we not be doing education around methamphetamine use and the harm that is done for peer networks?

I would just like to acknowledge all my colleagues at the institute and various chief investigators on studies and so forth. That is it for me.

The CHAIR — Thank you. I will open it up to the committee now and invite questions, starting with Mr Scheffer, the deputy chair.

Mr SCHEFFER — Could you just go back two slides? That one there. There is a lot of information preceding this, which I have not had time to absorb properly. Without taking up too much time going through a single thing, overall what does that evidence tell you about what these experts are saying?

Prof. DIETZE — I think they are experiencing what I was sort of getting at with what I was talking about in relation to, say, the mental health services, so what they are experiencing at the sharp end of heavy methamphetamine use. One of the characteristics of course of heavy methamphetamine use is that people can keep going for ages and ages, and when they are starting to come down from these binges, they are experiencing all sorts of really quite severe problems. So when you talk to people who are at the front line of managing that, that is where you get these sorts of things coming out. I think it is the pointy end that is driving these perceptions.

Mr SCHEFFER — Are they the people who we as a committee are probably more likely to talk to?

Prof. DIETZE — Yes.

Mr SCHEFFER — Does that mean we need to be running a test over those perceptions that rely more on the kind of data that you are presenting us with?

Prof. DIETZE — Yes, I think so.

Mr SCHEFFER — You do, do you?

Prof. DIETZE — Yes, of course.

Mr SCHEFFER — We are in agreement.

Prof. DIETZE — Again I want to point out that, while the data that we have potentially suggests that there is not a big increase in the number of users out there, it still does not mean that the way people are presenting is not challenging, and a lot of them are really challenging. I think it is hard for the front line services that have to deal with people who are coming off really big intense binges.

Mr SCHEFFER — Absolutely. Thank you.

Mr SOUTHWICK — Thanks for your presentation. I would like to pick up on the point about the number of users and your suggestion that it is more about potency and not necessarily about getting into trouble and us seeing the prevalence. What would you say about the number of drug labs that we have been able to uncover in the last period? In the last 12 months of the financial year we found 99 drug labs, and in the last 3 months there have been something like 90. We are seeing more of these. Would you then suggest that maybe it is more of a local market of, say, methamphetamine coming into play as opposed to what we were getting before from overseas?

Prof. DIETZE — I think all these things are pointing to improvements by the chemists who are making it, improvements in escaping detection and so forth. The numbers are increasing, and I suspect that is because people are responding to this market. The increase in purity is astonishing really when you think about it, because if you are marketing a product, one of the competitive advantages that you derive is from a better product, so what people are doing is producing better and better product. Excuse my marketing speak here. The product is getting better and better, and I think that is partly due to this big market response that is driving these changes in people's experiences of using the drug. As I suggested, the price per pure gram is probably dropping as these labs are getting better at doing what they do, whether or not that is a good thing. Of course it is not a good thing, but I think that is what it is actually driving it. I think it is these fundamental changes that really are important.

Mr SOUTHWICK — Did your participants suggest that there is more availability of a local product as opposed to an overseas product? Is there differentiation in the product between what might be produced locally versus offshore?

Prof. DIETZE — No, there is not. They are basically just buying from local dealers all the time. I should point out that these guys are not buying it over the internet yet or anything like that, as far as we know. Most of them are still getting it locally through normal dealers. They are not differentiating that.

Mr CARROLL — Thanks, Paul. I am also going to pick up on your point about purity. Our terms of reference are looking at supply — local manufacture versus importation. In terms of purity, over the weekend or last week a big drug haul was made of the ingredients to make ice that came from India. Is the highest purity level coming from imported ingredients, do you know, or are the locals and possibly bikie gangs so well equipped that they can produce it at the highest grade?

Prof. DIETZE — My understanding is that local chemists are improving their capacity to produce high quality product, but these are really questions for VicPol. They will have much better intelligence on these kinds of things than me. I suggest you speak to Cate Quinn or someone like that around those issues.

Mr CARROLL — How big a skill is it?

Prof. DIETZE — I am not sure, to be honest. I am not a chemist.

Mr McCURDY — We could become a state of choice for purchasers if we have the highest purity.

Prof. DIETZE — Sure, yes. I am sure that any clandestine laboratory would be looking to expand its market too, so that is quite possible.

Mr SOUTHWICK — I am not sure we are seeking that sort of reputation.

Mr McCURDY — No, I am not sure we are seeking it either. Could you elaborate on your point that you think the seven day program is inadequate in terms of treatment? You briefly touched on that before.

Prof. DIETZE — That is just my understanding from talking to people in the sector, that the withdrawal services and some of the programs that are out there just do not have enough time to deal with the sorts of issues that come up in relation to methamphetamine. In many respects it is a one size fits all the different drugs, and what is needed is something that is specific to different drugs in terms of the way the service is actually funded. That is what I mean. I think ReGen run the Catalyst program, for example. My understanding is that they need extra time to allow people to sleep and things like that, because trying to push people through means they are getting woken up, and that is contrary to what they need, if that makes sense. Their residential rehabilitation is something that requires a lot of resources; it is time intensive, all those kinds of things, and that is something that we still need to be emphasising in methamphetamine in particular.

The CHAIR — I have a quick question, Paul. As we go through this inquiry, I guess your view of the world might well be tested as well in relation to impact because, as you said, front line services tend to have a different view about what is happening out there. I am interested to hear — and we will probably test that ourselves through the reporting process — that there is no significant acceleration of new users to the drug; it has been traditional users who have moved from heroin and others to methamphetamine. That is contrary to what we are hearing out in the bush, because there is a more regional focus in the use of this drug, or in fact it has been there all the time but it just has not been given a media spotlight, if you like. I guess my question is just to confirm, from your point of view, that you believe there has been no significant spike in the use of drugs per se by traditional drug users but that they have just transitioned from one drug to another because of its purity and its price. I pose to you, if that is the case, would not the fact that it has been traded with a significantly greater profit margin accelerate the quantity out there in mainstream drug land? In fact, that does encourage non users to take the drug up because it provides a whole range of things for them.

Prof. DIETZE — Absolutely. While I am saying that the market parameter is key, and one of the ways in which they can improve profitability is presumably to increase the size of the market, I am not at all saying that it is going to be the case that things are going to peter out completely and it is going to stay the same stable number of people who use the drug and so forth. I am only hypothesising that there has not been this big increase in the number of users, so I take your point, absolutely. It will be fundamental to keep monitoring those things. We need to keep systems going and systems in place to actually be able to monitor these things, understand them and try to put them into perspective. The purchase data we have in our cohort study, for example, is revealing amazing new insights that we are only just properly analysing now. We need to keep doing that kind of stuff to properly monitor what is going on in the market.

The CHAIR — I would like to see your data for 2012–13, because that seems to be more about the greater awareness of use.

Prof. DIETZE — In terms of the purchase data that I showed you, and I apologise for the graphs — —

The CHAIR — I thought it was the usage data. It went through to June 2012. Remember I posed that to you, and you said that they are still collecting the 2013 data?

Prof. DIETZE — This data here through to August 2013?

The CHAIR — No, it was not that graph; it was another one. Don't worry about it.

Prof. DIETZE — I guess the point is that this is very current data. This is August 2013, which is literally hot off the press in relation to our big cohort, and the IDRS data that I showed you here is the 2013 data that is going to be presented at next week's drug trends conference, which is being held at the state library here.

Mr SOUTHWICK — I am just wondering if you could elaborate a little bit further about your studies of the Big Day Out cohort of individuals and whether that is giving you any information specifically about first time users and what you are seeing with that type of user.

Prof. DIETZE — In relation to our Big Day Out study, I did not present a graph of that here because our computer network died this morning. Basically, reported use of methamphetamine or crystal at the Big Day Out has declined since 2010, and it has shown a relatively steady decline, but then the only problem there is we do not have very detailed data, so we do not actually ask about things like when they first started using and so forth. I think in many respects what will be really interesting will be the household survey. The next one, as I said, in 2013, is in the field at the moment, and I really do think there is a strong case for a repeat of the Victorian youth alcohol and drug survey, which was last done in 2009, because I think there is enough of a sample size there to be able to look specifically at methamphetamine, and there is some really useful data in there.

The CHAIR — If there are no other burning questions, time is against us, so thank you very much for your contribution this afternoon.

Prof. DIETZE — Thank you for the opportunity.

Witness withdrew.