ACT Council of Social Service Inc

Submission to the ACT Legislative Assembly Standing Committee on Health and Disability Inquiry into

THE USE OF CRYSTALLINE METHAMPHETAMINE IN THE ACT

April 2007

About ACTCOSS

ACTCOSS acknowledges that Canberra has been built on the traditional lands of the Ngunnawal people. We pay our respects to their elders and recognise the displacement and disadvantage traditional owners have suffered since European settlement. ACTCOSS celebrates the Ngunnawal's living culture and valuable contribution to the ACT community.

The ACT Council of Social Service Inc. (ACTCOSS) is the peak representative body for not-for-profit community organisations, people living with disadvantage and low-income citizens of the Territory. ACTCOSS is a member of the nationwide COSS network, made up of each of the state and territory Councils and the national body, the Australian Council of Social Service (ACOSS).

ACTCOSS' objectives are representation of people living with disadvantage, the promotion of equitable social policy, and the development of a professional, cohesive and effective community sector.

The membership of the Council includes the majority of community based service providers in the social welfare area, a range of community associations and networks, self-help and consumer groups and interested individuals.

ACTCOSS receives funding from the Community Services Program (CSP) which is funded by the ACT Government.

ACTCOSS advises that this document may be publicly distributed, including by placing a copy on our website.

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Table of Contents

Abbreviations

ACT	Australian Capital Territory
ACTCOSS	ACT Council of Social Service Inc.
ADHD	Attention Deficit Hyperactivity Disorder
AOD	Alcohol and Other Drugs
AOSD	Amphetamines and Other Synthetic Drugs
ATS	Amphetamine Type Substances
Committee	ACT Legislative Assembly Standing Committee on Health and Disability
CSP	Community Services Program
CAHMA	Canberra Alliance for Harm Minimisation and Advcocacy
DHCS	Department of Disability, Housing and Community Services
GHB	gamma-hydroxybutyrate
HIV/AIDS	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
IDRS	Illicit Drug Reporting System
LSD	lysergic acid diethylamide
MDMA	3,4-methylenedioxymethamphetamine
NDARC	National Drug and Alcohol Research Centre
NSW	New South Wales
OCYFS	Office of Children, Youth and Family Support
PDI	Party Drugs Initative
YCACT	Youth Coalition of the ACT

Introduction

The current attention on the use of crystalline methamphetamine in Australia gives us an opportunity to examine the current and past arrangements for reducing problem drug and alcohol use. Australia has been leading world practice in many respects in this area for some time, particularly through our efforts at minimising harm to drug users, for instance through the widespread adoption of needle exchange programs and user support and rehabilitation services. While this submission focuses upon the current situation and possible improvements, it is important to recognise and build upon the many successes we have had in this area, and use this experience to give the service system greater capacity to change and respond to the rise in crystalline methamphetamine use.

ACTCOSS has produced this submission in close consultation with the Youth Coalition of the ACT (YCACT). We understand that YCACT will be producing an additional submission that will build upon and extend the information in this submission, particularly by utilising the insights they have gained from consulting directly with young people.

Just Crystalline Methamphetamine?

ACTCOSS recognises that the Legislative Assembly Standing Committee on Health and Disability (the Committee) has chosen to focus on the particular drug of methamphetamine in its crystalline form in its deliberations. However, we would encourage the Committee to examine the broader context of problem drug use in the ACT, particularly as the underlying reasons for drug use are often common across a wide variety of substances.

While we acknowledge that this particular form of a particular drug has attracted considerable media attention of late, it is often unhelpful to point to an individual drug and try to formulate public policy around that substance. This approach to drug policy has been adopted in the past and often not been particularly successful. There has been a long list of drug-focused strategies for: cannabis, LSD, cocaine, heroin or ecstasy. Often, these have rapidly been made obsolete by some new change in the drug-use environment, and the policy prescriptions have been slow to adapt. More recently, Governments have attempted to produce more holistic policy frameworks that look at a large range of substance use in their social and cultural environments and have the capacity to more easily respond to a change in drug use patterns. ACTCOSS commends this approach, although the policy intention does not always translate to government practice.

This is not to say that psycho-stimulants in general, and methamphetamine in its crystalline form in particular, do not have specific issues that have been identified with their use. However, it is more useful to incorporate particular solutions into existing institutions, policy and practices rather than trying to create a new 'ice' strategy or policy direction.

Many of the harms and concerns that may be associated with crystalline methamphetamine are also salient in the context of broader drug use, and indeed other social problems such as mental health or criminogenic behaviours. It is difficult to separate out these concerns, and more useful to adopt a broader consideration of the issues. In this light, we will attempt to address the terms of reference of the inquiry, but draw upon broader issues in our analysis.

Social Determinants of Health

It is well recognised in a large and growing amount of international literature that social disadvantage and social inequality have a substantial impact on differential health outcomes for people across the social spectrum. Presentation of illness and early death in Australia is concentrated in low socio-economic population groups, with one study finding that people in the lowest socio-economic status group had 50% more 'lost years of life' than those in the highest.[1] Qualitative research undertaken by ACTCOSS found that the health outcomes for disadvantages people could be improved by addressing:

- Adequate diet;
- Stable housing;
- Flexible transport options;
- Resilient support systems of family and friends;
- Being valued by the broader community;
- Being recognised as a contributor to the community; and
- Knowledge of health service options.[2]

The social determinants of health are also implicated in drug use. Associations have been found between unemployment, homelessness, poverty, family disadvantage, crime and the presentation of health-damaging behaviours, including drug use.[3] The social determinants of health and drug use are a web of complex and interactive social effects, meaning that while the overall health outcomes for these groups are lower, the interaction of individual risk and protective factors will mean some individuals will do well, while others will not.

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[1] Loxley *et al.* (2004) *The Prevention of Substance Use, Risk and Harm in Australia: A review of the evidence*, National Drug Research Institute, p.63
[2] ACTCOSS (2004) *Sustaining the Social Determinants of Health in the ACT*, p.5
[3] Loxley *et al.* (2004) *The Prevention of Substance Use, Risk and Harm in Australia: A review of the evidence*, National Drug Research Institute, p.65

Any meaningful strategy seeking to address problem drug use, including methamphetamine, must contemplate the broader social determinants of health and drug use, and seek to reduce social inequality and lack of opportunity. Focussing on drug use behaviours alone cannot hope to provide any cohesive or comprehensive solution. It is acknowledged that the ACT Alcohol, Tobacco and other Drug Strategy recognises these factors[4], however, it is less evident that they have been incorporated into program planning, collaboration and resources.

A Short History of Drug Use and Methamphetamines

Since the dawn of civilisation, human beings have used substances for both medical and cultural purposes. Documented alcohol use dates back 8000 years, and opium, tobacco and cannabis has been used for millennia.[5] In the middle ages the introduction of coffee into Europe and the Middle East sparked political responses to the social changes they wrought. English monarch Charles II attempted to ban coffee, and some Arab countries executed sellers of coffee beans.[6]

Methamphetamine is reported to have been first manufactured in the late 19th century in Japan[7]. Its first widespread use was in World War II by soldiers and factory workers in Japan, the United States and Germany to improve alertness and fight fatigue.[8] After the war, surplus supplies were widely available in Japan, leading to relatively widespread use, and in America it became commercially available and was used by truck drivers and university students to stay awake. In 1970, the United States criminalised methamphetamine use.[9]

The last century has seen prohibition more actively pursued as a response to concerns about drug use and dependency, lead particularly by the United States in the "war on drugs" it has waged unsuccessfully for a century. During the late 20th century, Australia has seen successive sensationalised episodes of "new" drugs becoming prominent in illicit usage, from cannabis, LSD, heroin and cocaine to a whole range of manufactured "designer drugs", including powder amphetamines ('speed'), 3,4-methylenedioxymethamphetamine (MDMA or 'ecstasy'), gamma-hydroxybutyrate (GHB or 'fantasy'), and ketamine.

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[4] ACT Health (2004) *ACT Alcohol, Tobacco and other Drug Strategy*, p.9
[5] Rickwood *et al.* (2005) *Perspectives in Psychology: Substance Use,* Australian Psychological Society Ltd, p.2
[6] *Ibid.*, pp.2-3
[7] Meredith *et al.* (2005) *Implications of Chronic Methamphetamine Use*, Harvard Review of Psychiatry, Vol. 13, p.142
[8] *Ibid.*
[9] Gettig *et al.* (2006) *Methamphetamine: Putting the Brakes on Speed*, Journal of School Nursing, Vol. 22, No.2, p.67

The advent of these substances attracting higher usage has often attracted media attention, with each labelled as a new ‘epidemic’ and presenting an often distorted picture of the drug’s properties, usage and effects. ‘Ice’ is the latest in a long line of drugs to receive this attention.

Methamphetamine Use

Crystalline methamphetamine is just one form in which methamphetamine is commonly available, and is commonly known as 'ice' (or 'crystal meth', 'crystal', 'pure', 'p' or 'shabu')[10]. However, the most common form of methamphetamine is in powder form ('speed'), and it is also available as a sticky or oily paste or damp powder ('base')[11]. While there has been a dramatic rise in the availability of 'ice' over the past decade[12], methamphetamine has been available as 'speed' for a longer period. In a sense, 'ice' is simply a new take on an old drug – albeit with purity of over 80%[13] and with potentially greater effects.

Methamphetamines are one form of a larger group of chemically similar drugs often referred to as "amphetamine-type substances" (ATS) which include amphetamine, dexamphetamine and sometimes 'ecstasy'. These, in turn, are part of a broader group of drugs commonly referred to as stimulants, grouped according to their action in "speeding up the activity of the central nervous system and are associated with increased feelings of energy, confidence and well-being"[14]. These include illicit substances of amphetamine and cocaine as well as licit drugs such as nicotine and caffeine.

Care needs to be taken when referring to data and statistics on 'ice', as many data sources agglomerate all forms of methamphetamine, or into broader categories of ATS or psycho-stimulants. These are often misreported as being solely due to "methamphetamine" or "ice", often giving a mistaken impression of the extent of usage.

'Ice' can be administered in a variety of ways. It can be taken orally, 'snorted' nasally, smoked in a glass pipe, 'chased' on aluminium foil, mixed with marijuana and smoked in a bong, or injected intravenously[15]. It is this variety of means of delivery that gives a clue to the use of the drug by a wide variety of population groups.

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[10] Dore & Sweeting (2006) *Drug-induced psychosis associated with crystalline methamphetamine*, Australian Psychiatry, Vol.14, No.1, p.86
[11] Ibid.
[12] McKetin *et al.* (2006) *The relationship between methamphetamine use and violent behaviour*, Crime and Justice Bulletin, NSW Bureau of Crime Statistics and Research, p.1
[13] Maxwell (2005) *Emerging Research on Methamphetamine*, Current Opinion in Psychiatry, Vol.18, p.235
[14] Rickwood *et al.* (2005) *Perspectives in Psychology: Substance Use,* Australian Psychological Society Ltd, p.4
[15] Maxwell (2005) *Emerging Research on Methamphetamine*, Current Opinion in Psychiatry, Vol.18, p.235

Poly-drug Use

Despite the perception often generated by research and statistics which seeks to isolate the particular use of a single substance, or a user's 'drug of choice', it is more usual that drug users will use a variety of substances, either in combination or at different times. There remains a paucity of research on this poly-drug use, despite it being a common occurrence.

The community organisations we consulted confirm a rise in poly-drug use, based on their perception that a greater proportion of services users had used multiple substances. One notable instance, in the context of 'ice' usage, are reports of switching behaviour in injecting drug users, where even though the preferred 'drug of choice' may be heroin, for example, users will inject 'ice' due to its greater availability and lower cost.

The available data confirms a high prevalence of poly-drug use. Findings from the ACT Illicit Drug Reporting System found that a sample of 125 injecting drug users had used a median of 12 different classes of drugs in their lifetime, and in the last six months had used a median of 7 drug classes, including injecting a median of 3 different drug classes.[16] Similarly, the National Drug Strategy Household Survey indicated that 87.2% of meth/amphetamine users had used the drug concurrently with alcohol, 67.6% had used it with cannabis, and 49.4% had used it with MDMA.[17] The Australian Crime Commission also reports that:

> "ATS users are known to use the drug in conjunction with alcohol, cannabis, heroin, MDMA, anti-depressants and tranquilisers. The increasing prevalence of ketamine use in the 'party drug' scene has resulted in this drug being commonly used in conjunction with ATS either knowingly or in drug mixture tablets, sold as MDMA."[18]

In this context, the difficulties of attempting to deal with methamphetamine use in isolation become obvious, as it is clear that people using 'ice' and other forms of methamphetamine are doing so in a broader context of drug use. Designing interventions to combat problem drug use and minimising their associated harm must be able to address a wide variety of substances and the reasons for use that underlie these behaviours.

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[16] Buckingham *et al.* (2006) *ACT Drug Trends 2005: Findings from the Illicit Drugs Reporting System (IDRS)*, NDARC Technical Report No. 257, p.11
[17] Australian Institute of Health and Welfare (2005) *2004 National Drug Strategy Household Survey: Detailed Findings*, p.62
[18] Australian Crime Commission (2006) *Illicit Drug Data Report 2004-05*, p.16

Effects on Users

The effects of using methamphetamine depend on the quantity, purity and route of administration of the drug. The physiological changes accompanying methamphetamine use are similar to the "flight or fight" response of the autonomic nervous system, including increased blood pressure, body temperature, heart rate, and breathing rate.[19] The psychological effects include greater confidence and energy levels, an increased libido, feelings of strength, and users are likely to be talkative and restless.[20] The more efficient routes of administration, such as smoking or injection, are reported to result in intense euphoria for several minutes. The "high" is less intense and less immediate if administered by means involving slower absorption, and lasts for some 8-12 hours due to the long half-life of the drug.[21]

According to one researcher, "crystalline methamphetamine users state that one of the reasons they prefer taking crystalline methamphetamine is because it provides a stronger 'high' than other forms of methamphetamine".[22] This short burst of extreme euphoria, along with tolerance to the drug, is thought to facilitate repeated dosing of the drug in a single usage episode, and providing one path to dependence.[23]

Extent of Methamphetamine Use

Getting data specifically on 'ice' usage is difficult, as many drug surveys do not separately distinguish methamphetamine in crystalline form, instead focussing on larger categories such as ATS.

The National Drug Strategy Household Survey reports that an estimated 9.1% of Australians aged over 14 had used meth/amphetamines in their lifetime.[24] This places the proportion of people who had ever used meth/amphetamines second to cannabis (33.6%) for illicit drug use, although lifetime use of alcohol (90.7%) and tobacco (47.1%) remain much higher.[25]

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[19] Rawson *et al.* (2002) *Treatment of methamphetamine use disorders: an update*, Journal of Substance Abuse Treatment, Vol. 23 p.146
[20] Drabsh (2006) *Crystal Methamphetamine Use in New South Wales*, NSW Parliamentary Library Briefing Paper No. 19/06, p.4
[21] Meredith *et al.* (2005) *Implications of Chronic Methamphetamine Use*, Harvard Review of Psychiatry, Vol. 13, p.143
[22] McKetin *et al.* (2006) *The relationship between crystalline methamphetamine use and methamphetamine dependence*, Drug and Alcohol Dependence Vol.85, p.202
[23] *Ibid.*, p.203
[24] Australian Institute of Health and Welfare (2005) *2004 National Drug Strategy Household Survey: Detailed Findings*, p.59
[25] *Ibid.*

For ACT school students, The ACT Secondary Student Drug and Health Risk Survey shows an estimated 5.8% of school students had used amphetamines in their lifetime, lower than reported levels of lifetime use of alcohol (89.6%), tobacco (32.0%), inhalants (17.6%), cannabis (16.9%) and tranquilisers (14.7%).[26]

Information from ACT alcohol and other drug treatment services shows that 8.2% of clients presenting for treatment had amphetamines as their principal drug of concern, behind alcohol (42.7%), heroin (27.4%) and cannabis (18.6%).[27]

Among specific user populations, in 2005 97% of injecting drug users reported having used methamphetamine, with 82% reporting using 'ice' specifically.[28] Sixty-two percent reported having injected 'ice' in the last six months[29], and preliminary data suggests this has risen to 88% in the 2006 survey.[30] Among party drug users, 49% reported having ever used 'ice', behind alcohol (98%), cannabis (94%), speed (90%), tobacco (88%) and cocaine (68%).[31]

Availability, Purity and Price of 'Ice'

The Illicit Drugs Reporting System (IDRS) and Party Drug Initiative (PDI) report that 'ice' is considered relatively easy to obtain in the ACT – 89% of injecting drugs users who responded say that ice is easy or very easy to obtain[32], as did 76% of party drug users who responded.[33]

Both these data sources generally agree that the price of a 'point' (0.1g) of ice is stable at around $50. Similarly, the purity of ice continues to be perceived as high and stable.

These perceptions were confirmed by our consultations with community agencies, who agree that part of the attraction for using 'ice' is its price and availability, particularly for injecting drug users who would otherwise prefer heroin. One interviewee described the situation as "easier than going to the bottle-o".

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[26] ACT Health (2007) *The Results of the 2005 ACT Secondary Student Drug and Health Risk Survey*, Health Series No.39, Population Health Research Centre, p.16
[27] Australian Institute of Health and Welfare (2006) *Alcohol and other drug treatment services in the Australian Capital Territory 2004-05*, p.4
[28] Buckingham *et al.* (2006) *ACT Drug Trends 2005: Findings from the Illicit Drugs Reporting System (IDRS)*, NDARC Technical Report No. 257, p.13
[29] *Ibid.*
[30] National Drug and Alcohol Research Centre (2006) *Media Release: Methamphetamine – The Current State of Play: New National Research*, p.3
[31] Proudfoot *et al.* (2006) *ACT Trends in Ecstasy and related Drug Markets 2005: Findings from the Party Drugs Initiative (PDI)*, NDARC Technical Report no. 247, p.7-8
[32] Buckingham *et al.* (2006) *ACT Drug Trends 2005: Findings from the Illicit Drugs Reporting System (IDRS)*, NDARC Technical Report No. 257, p.37
[33] Proudfoot *et al.* (2006) *ACT Trends in Ecstasy and related Drug Markets 2005: Findings from the Party Drugs Initiative* (PDI), NDARC Technical Report no. 247, p.40

Who Uses 'Ice'?

One concern generally raised about methamphetamine usage is its ability to appeal to a wide range of user groups. Our consultations raised the issue that methamphetamines were used by a wide variety of people, including penetrating a variety of youth subcultures, as well as injecting drug users. While it is known that most injecting drugs users begin their 'drug career' with occasional use[34], it is unclear whether low-level use of methamphetamines will make users any more likely to progress to 'heavy' use. As with most drug use, most methamphetamine users engage in occasional 'experimental' or 'recreational' use, with only a small minority progressing to frequent use or dependence.

A general observation is that young people are more likely to use drugs, at a time in their lives when they are 'experimenting' and less averse to risk. As an indication, the respondents to the Party Drugs Initiative had a median age of 22.[35] In the particular case of amphetamines, Australia-wide, people aged 20-29 were the most likely age group to have used meth/amphetamines, and the average age of first use was 20.8 years.[36] In addition, evidence from treatment data suggests that these figures flow onto requests for treatment, while people under the age of 30 make up less than 50% of all people seeking treatment, they account for more than 60% of people seeking assistance with problem amphetamine use.[37]

As with most drug use, men are more likely to use methamphetamines than women[38], although a number of studies have found that this appears to be a largely cultural influence and the often higher concentration of other risk factors in men.[39]

A notable proportion of the methamphetamine literature, particularly from the United States, has focussed on methamphetamine use among gay men. The most recent ACT data from the Canberra Gay Community Periodic Survey found that 14.5% of men surveyed had used 'speed' in the last six months, and 4.7% had used 'crystal meth'.[40]

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[34] McKetin *et al.* (2006) *The relationship between crystalline methamphetamine use and methamphetamine dependence*, Drug and Alcohol Dependence Vol.85, pp.198-9
[35] Proudfoot *et al.* (2006) *ACT Trends in Ecstasy and related Drug Markets 2005: Findings from the Party Drugs Initiative* (PDI), NDARC Technical Report no. 247, p.5
[36] Australian Institute of Health and Welfare (2005) *2004 National Drug Strategy Household Survey: Detailed Findings*, p.59
[37] Australian Institute of Health and Welfare (2006) *Alcohol and other drug treatment services in the Australian Capital Territory 2004-05*, p.4
[38] Australian Institute of Health and Welfare (2005) *2004 National Drug Strategy Household Survey: Detailed Findings*, p.59
[39] Loxley *et al.* (2004) *The Prevention of Substance Use, Risk and Harm in Australia: A review of the evidence,* National Drug Research Institute, p.76
[40] Hull *et al.* (2004) *Gay Community Periodic Survey: Canberra 2003*, National Centre for HIV Social Research, p.20

Another group which generally has higher levels of drug use are indigenous people, although most data sources do not separately report indigenous status. Treatment data shows that at least 7% of clients to ACT alcohol and other drug services identified as indigenous, which is highly disproportionate to their representation in the population. However, the report also states that "these figures need to be interpreted with caution due to the high number of 'not stated' responses for Indigenous status and the fact that the majority of Australian Government-funded Indigenous substance use services or Aboriginal primary health care services are not included in the [data] collection."[41]

Trends in Usage

A number of specific changes in methamphetamine usage and availability have occurred over the past decade or so.

The first was the introduction of methamphetamine into wide circulation in the illicit drugs market, usually in powder form (speed), in the mid-1990's, gradually replacing the less potent and harder to manufacture amphetamine, which is now increasingly uncommon.[42]

A second change in the methamphetamine market was the introduction of more potent forms of the drug, including 'base' and 'ice', from around the turn of the 21st century. These rapidly increased in availability in the first few years of the century.[43]

Occurring at the same time was the advent of the 'heroin drought'. The relatively sudden shortage of heroin in the illicit drugs market meant there was an opportunity for alternative drugs to substitute for heroin among injecting drug users, and 'ice' in particular has become a frequent substitute for heroin users. This substitution behaviour also allowed the use of existing supply networks and aided the development of wide availability. However, one researcher suggests that heroin users only represent a small percentage of users, but their high contact with health services may have inflated indicators of methamphetamine-related harm.[44]

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[41] Australian Institute of Health and Welfare (2006) *Alcohol and other drug treatment services in the Australian Capital Territory 2004-05,* p.2
[42] McKetin *et al.* (2006) *The relationship between methamphetamine use and violent behaviour*, NSW Bureau of Crime Statistics and Research, Crime and Justice Bulletin No.97, p.3
[43] *Ibid.*
[44] *Ibid.*

In the past few years, since about 2003 or so, most indicators of methamphetamine use have remained relatively stable.[45] However, it is unclear whether this is the case locally, particularly among injecting drug users. Data from the IDRS show that the ACT had the highest use of 'ice' among injecting drug users in Australia in 2006, at 88% compared with the national average of 57%[46].

However, treatment agencies have reported to us that the last couple of years have seen an influx of 'ice' users into drug and alcohol treatment agencies. As it frequently takes some time after a rise in usage of a "new" drug for dependence to develop and treatment sought, the impact on treatment services has been slower to develop.

Why Do People Use Methamphetamine?

The diversity of methamphetamine user populations also underlines the myriad reasons for alcohol and drug use in general. As an overarching perspective, we would urge the Committee to examine the reasons that underlie problem drug use, because without such an understanding effective interventions are unlikely to be found.

People use methamphetamine (in its various forms) for a variety of reasons, including:

- Weight loss;
- Improved concentration and fighting fatigue, particularly for studying or completing long, repetitive work;
- Enhanced sporting performance;
- Additional energy and stamina to continue celebrating for extended periods;
- That they find the subjective experience 'fun';
- Increased social interaction and 'bonding' through shared experimentation with drugs;
- Enhanced confidence that the drug induces;
- An escape from the 'boredom' of everyday living into an altered reality;
- Feelings of empowerment that they do not generally experience;
- Enhanced libido and sexual performance;
- A cheap alternative 'high', substituting for their usual 'drug of choice'; and,
- Blocking out past experiences, including sexual and physical abuse and trauma.

In turn, these indicate a number of psychological states and experiences that may be a factor in the development of problem methamphetamine use, including:

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[45] *Ibid.*, p.4

[46] National Drug and Alcohol Research Centre (2006) Media *Release: Methamphetamine – The Current State of Play: New National Research*, p.3

- Poor body image or self-esteem;
- Fear of failure in education or employment;
- Feelings of failure to live up to unrealistic expectations from family, peer or social images of success;
- Feelings of inadequacy or dissatisfaction with their family life, relationships or employment;
- Feelings of being powerless or being excluded from community life and decision-making;
- An existing drug dependency causing financial stress;
- An intergenerational culture of usage; or
- A past history of abuse or mistreatment.

A large number of individual risk factors have been identified for drug use more generally throughout the life span in various studies. These are summarised in the following table:[47]

Prior to birth	Infancy/ Pre-school	Primary School (5-11 years)	Secondary School (12-17 years)	Adulthood (18-64 years)	Retirement/ old age (65+ years)
RISK FACTORS					
Social disadvantage Family breakdown Genetic Influences Maternal smoking and alcohol use	Parental neglect & abuse	Early school failure Conduct disorder Aggression	Low involvement in activities with adults Perceived high level of community drug use Community disadvantage & disorganisation Availability of drugs Positive media portrayal of drug use Parent-adolescent conflict Favourable parental attitudes to drug use Parental AOD problems Parental rules permitting drug use Not completing secondary school Peers who use drugs Delinquency Sensation seeking & adventurous personality Favourable attitude towards drug use	Frequent drug use in late adolescence Unemployment in early adulthood Mental health problems	Losing a spouse Loneliness & reduced social support
PROTECTIVE FACTORS					
Birth outside Australia	Easy temperament	Social and emotional competence Shy & cautious temperament	Attachment to family Low parental conflict Parental communication and monitoring Religious involvement	Well-managed environment for alcohol use Marriage in early adulthood	

[47] Reproduced from Rickwood et al. (2005) *Perspectives in Psychology: Substance Use*, Australian Psychological Society Ltd, p.24

Many of these risk and protective factors are interlinked and cannot be addressed in isolation. ACTCOSS would particularly note that many of these risk factors tend to be concentrated in disadvantaged households, and are frequently the result of broader social exclusion in access to resources and basic human needs, such as housing, education, employment, healthcare, family cohesion, and participation in community life. That being said, it is also noted that social disadvantage is not necessarily present in all users, particularly large groups of young, relatively advantaged, occasional 'recreational' users, although we understand that these cohorts are far less likely to progress to heavy problem use and dependency.

While there are a number of specific initiatives that can reduce problem drug use, assist people recover from dependency and minimise the health and social harms that are associated with problem drug use, these can never be a total solution. When we see the myriad influences associated with drug use, it become clear that addressing social disadvantage before people become involved with problem drug use must be part of any holistic and effective government strategy.

Health Impact

Burden of Disease and Injury

In 1999, illicit drug use was estimated to account for 1.8% of the total attributable burden of disease and injury in Australia, with about half of this attributable to heroin use. This is far outweighed by licit drug use, with tobacco use accounting for 9.7%, and alcohol use accounting for 2.2%.[48] While the rising use of methamphetamine may have changed these results slightly, it is still the case that, from a public health perspective, legal drugs cause far greater health impacts and costs to the public health system than illicit drugs.

Physical Health Effects

Methamphetamine use has a number of negative effects on the body. During usage, methamphetamine stimulates the respiratory and circulatory systems, increasing the heart rate, blood pressure and rate of breathing, and constricts the blood vessels, leading to increased risk of disorders of the circulatory system.

Prolonged use of methamphetamine may expose users to cardiac arrhythmia (heart murmurs), stroke, cardiac valve sclerosis (hardening of the heart valves), decreases in lung function, pulmonary hypertension (high blood pressure in the arteries that supply the lungs), hyperthermia (heat stroke) myocardial infarction (heart attack), pulmonary oedema (fluid in the lungs) and aortic dissection (tearing of the aorta).[49] Teeth grinding and jaw clenching may damage the teeth and mouth, snorting of methamphetamine may cause nasal irritation and damage, and injection of the drug may cause related problems such as abscesses.[50] Because there is limited data on the long-term outcomes of users, there may be further physical effects that have not been adequately documented.

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[48] Mathers *et al.* (1999) *The burden of disease and injury in Australia*, Australian Institute of Health and Welfare, Cat. No. PHE 17

[49] Maxwell (2005) *Emerging Research on Methamphetamine*, Current Opinion in Psychiatry, Vol.18, pp.237-8

[50] Drabsh (2006) *Crystal Methamphetamine Use in New South Wales*, NSW Parliamentary Library Briefing Paper No. 19/06, p.22

Mental Health Effects

Like all categories of drug and alcohol usage, there is a significant relationship between mental health conditions and methamphetamine use. While numerous studies have documented the relationship between mental health and methamphetamine use, it needs to be remembered that these are not always a causal relationship. In some instances, people with mental health difficulties will be more likely to use drugs, be they legal or otherwise, and methamphetamine is no exception. Untangling the relationship between mental health and substance use is difficult, and this needs to be kept in mind when examining the data.

Methamphetamine users are more likely to develop a number of mental health difficulties, and they are generally more likely to have poorer cognitive functioning and poorer mental health. Under the influence of methamphetamine intoxication, there are associations with irritability, physical aggression, hyperawareness, hypervigilence, psychomotor agitation and compulsive behaviour.[51] More generally, methamphetamine use is associated with disturbed sleep, fatigue, poor appetite, decreased concentration and memory, decreased motivation and inability to maintain usual activities,[52] as well as higher levels of psychiatric symptoms, including depression, anxiety and suicide.[53] One study found that methamphetamine users had higher rates of alcohol dependence, depressive disorder and anti-social personality disorders.[54]

At a cognitive level, one study found an association with a 40% prevalence of global neuropsychological impairment, and more generally, methamphetamine use has associations with specific impairments in memory, attention and executive functioning, which includes abstract reasoning, planning and behavioural flexibility.[55]

While there is a tendency, both in the academic literature and the media, to focus on the more conspicuous issue of psychosis, the less obvious mental health concerns listed above are actually more prevalent among methamphetamine users, and require the appropriate emphasis in policy development.

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[51] Maxwell (2005) *Emerging Research on Methamphetamine*, Current Opinion in Psychiatry, Vol.18, p.237
[52] Drabsh (2006) *Crystal Methamphetamine Use in New South Wales*, NSW Parliamentary Library Briefing Paper No. 19/06, p.22
[53] Maxwell (2005) *Emerging Research on Methamphetamine*, Current Opinion in Psychiatry, Vol.18, p.237
[54] *Ibid.*, p.238
[55] Barr *et al.* (2006) *The Need for Speed: An Update on Methamphetamine Addiction*, Journal of Psychiatry and Neuroscience Vol. 31, No. 5, p.306

Psychosis and Violence

A large amount of research has focussed on the increased likelihood of methamphetamine users to develop psychosis. It has been estimated that 26% of regular users of methamphetamine will experience some psychotic symptoms from the drug in a year,[56] or about 5% of people who use the drug in any given year. People who are dependent on the drug, have a pre-existing psychotic disorder or who have a family history of psychosis are particularly at risk of developing methamphetamine-induced psychosis.

Psychotic symptoms include delusions, paranoid thinking, auditory and visual hallucinations, strange or unusual beliefs such as the belief that one's thoughts are being read, aggression, delirium, disorientation, confusion, fear and anxiety.[57] It may also be accompanied by euphoric disinihibition, extremely impaired judgement, grandiosity, extreme psychomotor agitation, stereotyped behaviour, and trigger or resemble manic or hypomanic episodes or ADHD.[58] Methamphetamine-induced psychosis typically last for 2 or more hours, although in rare severe cases it can extend for several days.[59] While in some cases, the onset of psychosis may be the first of many episodes, others will not experience the condition again, particularly if they are able to sustain more controlled use or abstinence in the future.

While a variety of sources document and acknowledge the link between methamphetamine and psychosis, the link has been overstated in some cases. Much media attention has been focussed on the connection, to the extent where some people could be forgiven for believing that ice use automatically induces psychosis. The reality is that psychosis will rarely occur after methamphetamine use, and 95% of users will not experience any psychotic symptoms at all. We are particularly concerned that the current attention on the issue is leading to a false impression of ice users, and creating a stereotype that may reduce the likelihood of users seeking health or social assistance, or creating unfounded fears among people who work with them.

A similar connection has been made been methamphetamine use and violent and aggressive behaviour. This is confirmed by our community consultations; although some care need to be taken with establishing a causal link between the two. One review examining the link found that:

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[56] Australian National Council on Drugs (2007) *Position Paper: Methamphetamine*, p.4
[57] Maxwell (2005) *Emerging Research on Methamphetamine*, Current Opinion in Psychiatry, Vol.18, p.238
[58] Meredith *et al.* (2005) *Implications of Chronic Methamphetamine Use*, Harvard Review of Psychiatry, Vol. 13, p.145-6
[59] National Drug and Alcohol Research Centre (2006) *On Thin Ice: A Users' Guide*, p.12

> "Experimental evidence shows that acute intoxication with methamphetamine is not sufficient to induce violent behaviour, but it may exacerbate hostility in individuals who are otherwise predisposed to violence, or exacerbate violence associated with other conditions (e.g. alcohol intoxication, opioid withdrawal).[60]

The same paper notes that, in particular, the aggression inducing effects of alcohol are extensively documented, and combined with the high level of dual use of alcohol and methamphetamine, this may give greater explanatory power to the incidence of methamphetamine-related violence. It also provides a reminder that poly-drug use needs to be kept in mind when considering the effects of drug use.

Sexual Health and Blood-Borne Viruses

A further concern associated with use of ice is the possibility of increased transmission of blood-borne viruses through either increased sexual transmission or injecting behaviours, particularly in high risk populations such as men who have sex with men and injecting drug users. A further concern for people living with HIV/AIDS is that methamphetamine use can disrupt stringent treatment regimes.

Our consultations revealed that health promotion organisations involved at targeting these groups are aware of the concerns raised by methamphetamine use. They stressed the importance of using messages targeted specifically at these populations, using messages that matched user's actual experiences and providing information on practices that reduced the risk of transmission.

Precipitation of Crisis

A feature of problem alcohol and drug use is that while people can continue to manage their use for extended periods, at some point they will usually reach a 'crisis point', where they find themselves in a situation that they can no longer control. Examples include contact with the police or hospital emergency services, a financial crisis or homelessness. The experience of crisis will often spur people to seek assistance, or in the case of the criminal justice system, force them to do so.

[60] McKetin *et al.* (2006) *The relationship between methamphetamine use and violent behaviour*, NSW Bureau of Crime Statistics and Research, Crime and Justice Bulletin No.97, p.10

Evidence from our consultations suggests that it is widely believed that problem 'ice' use results in a more rapid deterioration into crisis than is commonly seen with other drugs. This includes a rapid deterioration in both physical and mental health, and one agency reported that ice users were disproportionately in contact with the criminal justice system. This evidence suggests that the period of heavy usage is shorter before reaching crisis, and potentially treatment, than for other drugs commonly seen in the service system, and consequently users tend to be younger and have a shorter drug history than other clients.

Dependence and Withdrawal

It has been estimated that in 2005 around 70%, or 72,700, of Australia's regular methamphetamine users are dependent upon the drug.[61] If this rate of 7.3 per 1000 people aged 15 to 49 was true for the ACT, it would translate to about 1280 dependent users in Canberra.[62]

Dependence on the drug is associated with many of the social and health consequences of methamphetamine, and these are likely to be concentrated in dependent users rather than occasional users of the drug. One study has documented that crystalline methamphetamine use is associated with methamphetamine dependence, and more regular usage patterns. It also suggests that use of crystalline methamphetamine may be related to a migration to more potent forms of the drug as people progress to heavier usage.[63]

While ACTCOSS has not discovered any data on the particular 'addictiveness' of methamphetamines or crystal methamphetamine in particular, we note that stimulants in general tend to have lower levels of 'addictiveness' than other drug classes such as tobacco, heroin and alcohol.[64] However, the particular properties of 'ice' may make it more addictive than other stimulants.

[61] McKetin *et al.* (2005) *Estimating the Number of Regular and Dependent Methamphetamine Users in Australia: Executive Summary*, NDARC Technical Report No. 230, p.2
[62] Calculated using 2005 population estimates from Australian Bureau of Statistics (2005) *Australian Demographic Statistics*: June Quarter 2005, Cat. No. 3101.0, p.18
[63] McKetin *et al.* (2006) *The Relationship Between Crystalline Methamphetamine use and Methamphetamine Dependence*, Drug and Alcohol Dependence, Vol. 85, p.201
[64] Rickwood *et al.* (2005) *Perspectives in Psychology: Substance Use*, Australian Psychological Society Ltd, p.10

The withdrawal effects of methamphetamine include severe depression and social withdrawal, and extreme cravings for the drug.[65] These may last for several days or weeks. The cognitive impairment associated with heavy methamphetamine use continues after abstinence, and may initially worsen. One study showed some improvement after 9 months of abstinence.[66] However, it remains unclear whether some impairment may be permanent, with some evidence that neurological changes persist for many years of abstinence.[67]

[65] Rawson *et al.* (2002) *Treatment of methamphetamine use disorders: an update*, Journal of Substance Abuse Treatment Vol.23 p.147
[66] Maxwell (2005) *Emerging Research on Methamphetamine*, Current Opinion in Psychiatry, Vol.18, p.238
[67] Meredith *et al.* (2005) *Implications of Chronic Methamphetamine Use*, Harvard Review of Psychiatry, Vol. 13, p.147

Social and Community Impact

Social Impacts

Problem drug use does not only affect individuals: problems reverberate through the greater community. Beyond health concerns, individuals may find themselves in financial difficulty through the high cost of maintaining their drug use, resulting in financial debt, both formal and informal, or may even turn to criminal activities to finance their dependency, including drug dealing itself.

Problem drug use may cause deterioration of relationships and social connections with friends and family, leading to relationship breakdown and social isolation, including estranging parents from their children. Partners, parents, children and/or carers may be similarly distressed and anxious about a persons drug use, and are often left to deal with the problems it causes, such as the emotional and financial consequences. In some cases, they may have to confront aggression or domestic or family violence, and face the difficult decision of whether to dissolve the relationship and/or contact the police, particularly when the person refuses to seek assistance for their problem.

The issue of drug-related crime also has wider effects on the community. Not only are there impacts on the victims of crime and their families, but it also impacts on wider community perceptions of public safety, and economic factors such as insurance premiums.

Impact on Emergency Services and Police

The impact of crystal methamphetamine is highly visible in the increased presentation of people to police services and the emergency departments of hospitals experiencing methamphetamine intoxication. Hospital admission data shows a threefold increase in people presenting with a principal diagnosis of mental and behavioural disorders due to use of stimulants other than cocaine, from 938 in 1998-99 to 2,852 in 2004-05.[68] Similarly, ambulance officers would be likely to report difficulties with people experiencing methamphetamine intoxication, who may be difficult to manage and in some cases may exhibit aggression or psychotic symptoms.

[68] Australian Institute of Health and Welfare (2006) *National Hospital Morbidity Database: Principal Diagnosis Data Cube*.

There are current guidelines for emergency department workers and police to assist in immediate control of people with stimulant toxicity. ACTCOSS notes that, as with all guidelines on dealing with people experiencing mental disturbance, verbal de-escalation techniques are the first strategy to be employed.[69]

The increased presentation of methamphetamine intoxication on emergency departments and police services has likely drawn resources away from other areas of activity. While it remains incumbent on Government to ensure that police and emergency departments are adequately resourced, we would note that additional resources into crisis response do little to reduce the extent of the problem. It is important to note that if "upstream" strategies are not resourced by Government, the public purse will ultimately be required to resource services such as police and emergency departments to deal with people in crisis.

Impact on Community Sector Organisations

Generally, problem alcohol and drug use has been a concern for community sector organisations throughout their history. Problem drug and alcohol use is a common barrier many services providers face in dealing with a range of social difficulties and services, including mental health, homelessness, youth services, family support, domestic violence, employment services, community health services, and interaction with the justice system. Drug and alcohol services play a central role in the community sector in addressing this issue, particularly through education, referral, support and treatment programs, but it needs to be kept in mind that people with problem alcohol and drug use may contact the service system through other organisations, and may not identify as having an alcohol or drug use problem. A commonly raised complication is difficulty in assisting people with a dual diagnosis (co-morbid mental health difficulties and problem drug use), which many organisations in the mental health and drug and alcohol fields, among others, are not sufficiently equipped to handle.

Again, the effect of methamphetamine is most visible on services that deal with people in crisis, such as drug and alcohol drop-in services or homelessness organisations. Some of these services have reported that they have had to significantly alter their method of service delivery because they simply did not have the capacity to deal with a person, or several people, who were intoxicated with methamphetamine and also be able to ensure sufficient levels of safety and support for the individual, other clients and their staff.

[69] Jenner et al. (2006) *Management of patients with psycho-stimulant toxicity: Guidelines for emergency departments*. Canberra: Australian Government Department of Health and Ageing

Problem drug and alcohol use, including methamphetamine use, is an issue that will often be observed as a complicating factor in other areas of service provision, and services that are not specific to drug and alcohol use are encountering its effects as well. Two-thirds of ACT community organisations surveyed last year reported that their clients have more complex needs than in the previous year,[70] and this would include complexity resulting from problem drug and alcohol use. This increasing complexity in need is generally making human service delivery more difficult and resource intensive, and means that consumers often require more time and energy to improve their circumstances than they may have in the past.

According to official statistics, the ACT has 9 funded alcohol and other drugs agencies, which provided 4,213 'closed treatment episodes' in 2004-05.[71] These services range from counselling, case management and support, education and assessment services, to more intensive detoxification and rehabilitation programs.

Drug and alcohol treatment agencies report that while their service models have not, in most cases, changed drastically, they note that clients presenting with 'ice' usage can pose particular challenges. It has been reported to us that clients presenting with problem 'ice' use (including secondary use of 'ice') often require additional attention, particularly in the early stages of treatment. These clients often have more difficult behaviours, including some aggression, and greater difficulties in understanding concepts and engaging in therapeutic and educational activities. This may be due to the cognitive effects associated with heavy 'ice' usage previously described.

It has been reported to us that methamphetamine users are less inclined to seek support or treatment than other problem alcohol and drug users, and are more likely to deny evidence of problem drug use. We note that people seeking assistance for amphetamine problems are more likely than other drug and alcohol users to receive detoxification and rehabilitation services rather than lower level interventions such as education or counselling.[72] This means that methamphetamine clients may wait until a more extreme crisis before they seek treatment, and therefore these clients may have more complicated issues to address and take more time and resources to rehabilitate. Some organisations have reported that as a result, their resources are more stretched and their services are under greater pressure.

We also note that the lack of adequate treatment facilities and resources has hindered drug and alcohol services in the ACT, and contributed to levels of unmet demand. The Territory has been aware for some time of the lack of treatment facilities, although attempts to increase the size of facilities have been set back through planning considerations and community objections.

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[70] ACOSS (2007) *Australian Community Sector Survey*, p.88
[71] Australian Institute of Health and Welfare (2006) *Alcohol and other drug treatment services in the Australian Capital Territory 2004-05*, p.1
[72] Ibid, p.6

Impact on Public Perceptions

As previously mentioned, methamphetamine is not a new substance, and warnings of the possibility of increased usage in Australia have been around since at least the early 1990's, particularly through observation of the earlier rise of methamphetamine use in South-East Asia and the United States, and the slow conversion of 'speed' from amphetamine to methamphetamine. There has been criticism of government, including both law-enforcement and health authorities, for not recognising these warnings, and failing to take preventative action to reduce the supply and take-up of methamphetamine when there was still an opportunity to do so. When this predicted rise in methamphetamine use translated into fact, the issue was quickly noticed by frontline workers and soon attracted the attention of the media.

While the media rightly drew this to public attention, the 'hype' that has surrounded 'ice' has not always been reported in proportion to its impact. As one review commented, some people have been lead to believe "that all users become hostile and aggressive when 'high' and that a person is addicted from the moment the drug is sampled."[73] The sensationalist way that 'ice' usage has often been reported has drawn necessary public and Government attention to the issue, but also given false impressions of the usual effects of the drug by focussing on the worst possible outcomes in a minority of cases. These individuals, of course, need access to support and treatment, but popular misunderstanding of the effects is ultimately unhelpful in addressing the issue.

This is particularly the case of people who may come into contact with 'ice' users, such as police, health professionals and community workers. It has been reported to us that some people in these groups misunderstand the more usual nature of 'ice' use, and are reluctant – even frightened – to deal with 'ice' users. This reaction not only presents a barrier to effective support for 'ice' users, but also reduces the propensity for 'ice' users to seek assistance, not only for problem 'ice' usage but other social services including healthcare and social support.

Similarly, while media attention has also spurred political reactions to the issue, it is debatable whether these have, as yet, translated into a useful response. The level of political debate has appeared to focus on relatively trivial side-issues such as the banning of "ice-pipes", rather than any comprehensive examination of drug and alcohol policy to ensure that it is responsive to a changing drug use environment.

[73] Drabsh (2006) *Crystal Methamphetamine Use in New South Wales*, NSW Parliamentary Library Briefing Paper No. 19/06, p.42

Strategies for Intervention

A Systemic Response

Tackling problem drug and alcohol use, including problem methamphetamine use, is no simple task and needs to be addressed systemically and utilise a variety of interventions that are based on solid evidence.

The National Drug Strategy identifies 3 main strategies, often referred to as the "Three pillars" approach. These are:

- Demand reduction;
- Supply reduction; and
- Harm minimisation.

In the ACT, one study estimated that the ACT Government spends some $85 million on problem alcohol and drug use each year across the health, justice, police and emergency services portfolios. However, this is strongly skewed towards police and criminal justice spending, which accounts for $65 million per annum, or 77% of the total.[74] While this does not include services funded by DHCS, many of which also regularly assist people with problem alcohol and drug use by providing a range of human services, it is nonetheless clear that the ACT Government's expenditure on the 'three pillars' is significantly lopsided, with criminal justice responses being the primary recipient of resources. ACTCOSS advocates a more balanced approach to drug policy, with a greater proportion of resources being directed at demand reduction and harm minimisation, much of which would reduce the need for interventions by the police and justice systems.

In addition, it is becoming increasingly evident that the ability of government and community agencies to respond to a changing drug use environment requires greater dynamism to respond quickly and effectively. As previously mentioned, ACTCOSS does not advocate building an 'ice'-specific service or program to respond to the recent rise in 'ice'-use, rather we would encourage the development of a service system that has the capacity to understand, analyse and respond to changes in the drug use environment as they occur, rather than have to wait for high-level government attention and policy development to proceed before the issue receives a meaningful reaction. Our response to a changing drug use environment needs to come from the bottom up as well as the top down.

[74] McDonald (2006) *Australian Capital Territory Government Expenditure on Preventing and Responding to Drug Abuse 2004-05*, p.iv

Addressing the Social Determinants of Health and Drug Use

While not specific to the issue of problem drug use, no holistic approach to addressing social issues can be conducted in isolation. At a population level, there are clear associations between problem drug use and poverty, disadvantage and social marginalisation, which extend into health and social outcomes. The *Canberra Social Plan* and the *Health Action Plan* are both useful strategic documents in tackling these issues, although the extent of their implementation in the current fiscal environment remains of concern.

It should be emphasised that addressing the social determinants of health and drug use have both preventative and treatment properties. Reducing social disadvantage not only has the potential to reduce the propensity for people to develop problem drug use, but by ensuring that problem drug users have access to basic social needs they are likely to be more successful in treatment programs. Essential elements of the social determinants of health include:

- Housing security and affordability;
- Affordable and flexible transport options to access health and social services;
- Knowledge of and ability to pay for a range of health services;
- Knowledge of and access to nutritious food and development of healthy eating behaviours;
- Access to employment and stable income sources;
- Development of strong family and community relationships and support networks; and
- A sense of being respected and included in community life.

Reducing Risk Factors and Engaging in Early Intervention

There are risk factors for problem drug and alcohol use throughout the life-course, but they are particularly evident in childhood, adolescence and young adulthood. If the ACT Government wishes to adopt a holistic and long-term strategy for reducing problem drug use in the ACT, it needs to build upon strategies that intervene much earlier in the process, long before exposure to the drug environment or dependence develops.

Promoting resilience and addressing disadvantage in children and young people is a key factor in reducing the long-term propensity for people to become drug-dependent. There are a number of points where the ACT Government has a significant ability to promote well-being in children and young people, and build their resilience to minimise the risk of problem drug use.

The ACT youth sector are important service providers in this regard. Youth organisations provide many of the early intervention services with children and young people experiencing disadvantage that assist in building resilience and helping to reduce the incidence of youth disadvantage that can lead to problem drug and alcohol usage. A well resourced youth sector that has the capacity to respond effectively and over a sustain period of time is essential to ensure that early interventions strategies are effective.

The ACT Government has already established two Child and Family Centres to assist the development of cohesive and supportive family environments, being a 'flagship' commitment of the *Canberra Social Plan*[75]. These have been tangible step forward in developing a public response to issues of childhood development, but are still limited in their reach and scope.

Likewise, the ACT Government has resourced the Office for Child, Youth and Family Support (OFYCS) to respond to the findings of the Vardon Report.[76] However, this review mainly addresses internal issues with the management of the child protection system, and does little to give guidance about the development of less intrusive forms of support that would improve family functioning. The ACT Children's Plan includes many impressive sounding actions, such as:

- Provide joint training to support service providers in the delivery of early intervention and collaborative services;
- Reorient service and operational policies and guidelines to support early intervention and co-ordinated service delivery to support children with behavioural concerns and children with complex health and social needs; and
- Provide early intervention social skills programs that develop positive relationships.[77]

However, the plan does not specify the resources for these commitments, nor does it have any identifiable targets, either at a population or service delivery level, although it at least lists 'progress indicators' which provide some basis for analysis. The plan commits to an evaluation every two years[78], although after 32 months of operation, none have been publicly released.

[75] ACT Government (2004) *Building our Community: The Canberra Social Plan*, p.8
[76] Vardon (2004) *The Territory as Parent*: Review of the Safety of Children in Care and of ACT Child Protection Management.
[77] ACT Government (2004) *The ACT Children's Plan 2004-14*, p.6
[78] Ibid, p.9

Schools that Improve Student Resilience

The school environment remains an important site for ensuring children and young people are equipped to respond to the social environment they encounter now and in the future. In earlier years of schooling, the focus for student resilience would generally not be on drug-use per se, but instead would facilitate the development of self-esteem, good health and body-image, and building strong interpersonal relationships.

As children approach secondary school, however, they will begin to reach an age where exposure to drug-use becomes more likely, and the propensity for risk-taking and experimentation increases. At this point, it is recommended that drug education is more explicit, and in particular gives adolescents the information they require to understand the realities of drug use and the possible risks associated with them. We particularly emphasise the capacity of partnerships between schools and community organisations to assist in the development and delivery of drug education programs.

Peer and Targeted Education and Health Promotion

School-based education alone, while a useful strategy to raise awareness and provide a space for adolescents to discuss the social and ethical issues surrounding drug use, will generally be unable to effectively target information to those most at risk of problem drug use, or give the extent of information required for effective harm minimisation methods associated with drug use in some circumstances. It is also likely that schools in a mixed public/private school system will give different emphasis or information in their programs. Similarly, mass media “awareness” campaigns are also restricted in the detail they can give and message they can advocate, and are often discounted by people as government propaganda (‘scare-campaigns’) and as not reflecting the reality of drug use.

Thus, it is important that other means of informing people of the risks involved in drug use and methods of reducing them are used. The health promotion workers we consulted emphasised that information is most useful and utilised if it is:

- Targeted at the point of experimentation and use;
- Targeted at the specific user population, with an understanding of the context and reasons for drug use;
- Provides information that aligns with the user’s experience of drug use, in language that they understand;
- Provides clear ‘warning signs’ about when usage is becoming dependent or a problem;
- Contains ‘safer-usage’ strategies that reduce the potential for drug-related harms; and
- Comes from a trusted and credible source.

Peer education is a valuable tool in this context. Peer education involves training people who are part of the target population who are interested in providing information to their peers, and can relate to people from a position of trust, understanding and empathy. As previously discussed, there are a range of groups and sub-cultures that use methamphetamine and a peer-education strategy would require that a range of different peer educators were recruited to target different populations. We note that this strategy has also been used in promoting sexual health.

ACTCOSS would particularly point out the current lack of a funded consumer organisation for drug users in the ACT. Recently, funding arrangement have changed for the existing consumer group, the Canberra Alliance for Harm Minimisation and Advocacy (CAMHA), and as a result there is no resourced organisation with this function in the ACT. While we understand that there is a continuing commitment from ACT Health to support this role, evidence of progress to reinstating resourced is not forthcoming.

Similarly, a number of organisations provide drug information as part of their work, either as a central function or alongside other health promotion and support activities. These organisations are often well placed to understand the particular context and experience of drug use in these groups, and act as a conduit for information, both through consumer contact as well as targeted health promotion campaigns that reach a broader section of actual or potential drug users. There is potential for these organisations to be given additional resources to ensure that methamphetamine use is appropriately addressed in their activities.

Our consultations revealed a high level of concern that user populations had little knowledge of the effects and risks of ice, and expressed the concern that this ignorance was contributing to the levels of ice usage and particularly dangerous and problem use of the drug.

Minimising Harm

Harm minimisation is one of the 'three pillars' of the National Drug Strategy[79], with the key focus of implementing interventions that reduce the risks of health and community impacts from drug use. This includes interventions that recognise the reality of drug use and seek to change drug-use behaviour towards practices that are less risky, as well as programs that encourage and support drug-users to reduce and abstain from drug-use.

[79] Commonwealth of Australia (2004) *The National Drug Strategy: Australia's Integrated Framework 2004-2009*, p.2

As mentioned previously, educative practices targeted at using populations are one such strategy. The information useful for methamphetamine users should be based on information supported by evidence, and should be produced in consultation with research and treatment organisations. An example of the type of information provided is the booklet produced by the National Drug and Alcohol Research Centre (NDARC): *On Thin Ice: A User's Guide*.[80]

Useful information might include:

- General health information, including encouraging users to get enough sleep and nutrition, given these factors can be disturbed by stimulant usage;
- Dosage information, including that fact that low-level users generally need less of the drug, and that repeated dosing, particularly through smoking or injection to try to re-induce euphoria is unnecessary and dangerous;
- Safer-usage information, including social supervision, hydration, and encouraging safe sexual practices during intoxication;
- Safe injecting information, including clean needle use and the fact that methamphetamine should dissolve easily – if it does not it is likely to be contaminated with other substances and is dangerous to inject;
- Warning signs of problem usage, particularly psychotic symptoms and indicators of dependency;
- Information on managing 'come-down' and withdrawal symptoms safely; and
- Referral information to confidential counselling and treatment agencies.

Another proposal to minimise harm is to introduce pill-testing facilities at venues that 'party-drug' users may frequent. It is frequently noted that pills sold as ecstasy tablets are often actually methamphetamine or a mixture of substances. The availability of pill-testing facilities would allow people considering using pills to ascertain what substances they were actually using, and then make an informed decision about whether to use the drug or not, with the ability to ensure that they have access to appropriate precautions depending on the substance they possessed.

[80] Available at http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/Ice+Resource/$file/ICE+RESOURCE.pdf

Availability of Appropriate Treatment

While educational and preventative strategies need attention from government, there will remain a need to improve the availability and diversity of treatment options for alcohol and drug dependence in the ACT. Agencies continue to report that detoxification and rehabilitation facilities in the ACT remain full and have significant waiting lists. This shortfall means that at the times when alcohol or drug-dependent individuals feel ready to enter treatment, they often find they cannot enter immediately, and may have to wait several weeks before a place becomes available. During this time, their resolve may deteriorate and they will continue engaging in problem alcohol and drug use, and may ultimately fail to enter treatment as a result. Greater availability of treatment is required if any serious reduction in dependence is to occur for those people already dependant on alcohol or other drugs, including methamphetamine. We note that expansion of treatment facilities is current ACT Government policy[81], although there is little evidence of progress to date.

In the case of methamphetamine, we note that while most ACT Alcohol and Drug programs are designed primarily for alcohol or heroin, they remain the best treatment models that we currently have for methamphetamine. In particular, psychosocial rehabilitation programs target addiction and the psychological dependence that occurs with it, and this is applicable regardless of the particular substance being involved. We understand that there is ongoing research into the development of improved treatment options for methamphetamine dependence, and these efforts should be supported and adopted where possible, but this should not be used as an excuse to delay investment into treatment.

Ensure a Diversity of Treatment Options

While the ACT has a relatively small number of treatment services, these organisations provide a range of treatment options underpinned by different service philosophies. We note that there are currently no treatments that guarantee a successful outcome, so maintaining a diversity of options for treatment remains essential to combating drug and alcohol dependence in the ACT, along with the ability to try to match consumers with the options that are likely to be most effective considering their individual circumstances.

[81] ACT Health (2004) ACT *Alcohol, Tobacco and Other Drug Strategy 2004-2008*, p.35, Item 17

In the case of methamphetamine, there remain limited studies that systematically document the effectiveness of treatment alternatives for this user groups. The available evidence suggests that Cognitive Behavioural Therapy is an effective psychosocial treatment, along with some evidence that Contingency Management (i.e. rewards for abstinence) may also be effective.[82] It should be noted however that the bulk of research is based on studies from the United States, which has a considerably different substance use environment and social security system which may impact on the applicability of their research.

Most reviews of methamphetamine treatment note the possibility of developing pharmacotherapies to assist in withdrawing from the drug, but we understand that no effective therapy has yet been developed. While additional research on pharmacotherapies is supported by drug and alcohol agencies, they should not be considered a panacea for treatment, and practitioners warn against viewing pharmacotherapies as a 'cheap' alternative for health authorities, particularly when they are not combined with psychosocial support to address the underlying psychological issues that are implicated in dependence.

One agency noted that there was currently no option for volume reduction therapy in the ACT, and that this should be considered in expanding the diversity of treatment programs in Canberra.

There is potential to improve the capacity of treatment organisations by improving resources for the purpose of modifying treatment models and trialling new initiatives. Our investigations have suggested that this occurs to limited extent within ACT agencies, but their capacity to innovate and respond to new research outcomes and changes in client drug-use and profiles remains restricted by resources.

Suitable Treatment for Different Population Groups

In treatment for drug and alcohol dependence, it is important to ensure that there is capacity within the service system for different population groups. For instance, a number of interviewees noted the efforts in the ACT to ensure that women with children had access to treatment programs. The literature also points to other population groups that may need specific programs.

[82] Baker *et al.* (2004) *Models of Intervention and Care for Psycho-stimulant Users*, Monograph Series No.51, 2nd Edition, Australian Government Department of Health and Ageing, p.63

For instance, it needs to be remembered that "young people in drug treatment programs are not just younger versions of adults in drug treatment: their issues and needs differ qualitatively and quantitatively, and youth-specific services are best able to meet those needs".[83] Similarly, "the use of methamphetamine in gay and bisexual men frequently becomes inextricably intertwined with the sexual and social behaviours"[84], and this means that it is inappropriate to deal with these issues in mixed client groups. Finally, we would note that the cultural needs of Indigenous people are often very different from the non-Indigenous population, and services need to ensure that they have the capacity to address these concerns.

Addressing Dual Diagnosis (co-morbidity)

A continuing area of concern in addressing problem alcohol and other drug use remains appropriate treatment for people with a dual diagnosis, meaning the presence of concurrent mental health difficulties with problem drug or alcohol use. Anecdotal feedback suggests this is a particular issue for methamphetamine users, due to the association between heavy methamphetamine use and the presentation of psychotic symptoms.
We note that progress with specific reference to methamphetamine is hampered by the fact there is virtually no research on treatment for dual diagnosis clients dependent on methamphetamines, or psycho-stimulants in general.

Despite the issue being repeatedly drawn to the attention of government by agencies and consumers – and a previous government project dedicated to the issue[85] – we are advised that dual diagnosis clients continue to fall through the gaps in the service system. Both mental health and AOD agencies continue to report to us that they are not resourced and do not have the expertise to treat dual diagnosis clients, particularly where one or both disorders are relatively acute.

A number of organisations suggest that there is a need for a specific dual diagnosis residential (step-up/step-down) facility, where service users could have short- to medium-term accommodation during the early stages of a mental health episode, or after leaving hospital. This would give them greater support in preventing a mental health crisis and assisting them to return to wellness.

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[83] Rickwood *et al.* (2005) *Perspectives in Psychology: Substance Use,* Australian Psychological Society Ltd, p.24
[84] Rawson et al. (2002) *Treatment of methamphetamine use disorders: an update*, Journal of Substance Abuse Treatment Vol.23 p.149
[85] Cupitt *et al.* (1999) *Dual Diagnosis: Stopping the Merry-Go-Round*, ACT Health

Building Community Capacity and Workforce Development

Training for Key Workers

Due to continuing concerns with the lack of knowledge of methamphetamine use and how to respond to users and intoxicated individuals, numerous stakeholders have suggested that there is a role for training of key workers. This is not limited to workers in the alcohol and other drug and mental health sectors, although they would be an essential component, but would also include other workers who were likely to come into contact with intoxicated or dependent individuals, such as police and ambulance officers, hospital emergency staff, homelessness workers, youth workers, bus drivers, and general practitioners, amongst others.

Specifically, these workers would benefit from receiving training in:

- The range of problem alcohol and other drug use and reasons for use and the changing drug use environment;
- Skills in managing difficult behaviours, particularly verbal de-escalation techniques and non-confrontational methods of dealing with aggression;
- Mental health "first aid", and materials and referral pathways that give options for advice, counselling and treatment.

It is essential that service providers across the health and human services are equipped to deal with the presentation of 'ice' users, not only for services designed to respond to problem drug use, but other services that assist people with managing their everyday lives. By ensuring that other needs can continue to be catered for, it is more likely that problem 'ice' users will be able to reach a point where they can confront problem drug use, while the health and social impacts continue to be minimised.

Workforce Development and Capacity Building

Community sector organisations in the ACT continue to experience difficulties maintaining their viability, and this only makes responding to the increased use of methamphetamine more difficult. Issues include:

- The lack of suitable accommodation for community sector organisations in general, and suitable sites to deliver residential and other drug and alcohol services in particular;
- An increase in the complexity of client need experienced by all service delivery organisations, with increased presentation of methamphetamine-intoxicated individuals;
- Increased demand for services, including AOD treatment services, which is unmatched by increases in resources for organisations;

- Increased specificity in funding outputs in community service contracts and micro-management by public funding managers, which constrains organisations' capacity to innovate and respond to a changing drug use environment;
- Paucity of independent policy development, co-ordination and development services for organisations to improve organisational functioning and linkages within the community sector; and
- High staff turnover and difficulties recruiting and retaining an adequately skilled workforce.

This last point deserves some expansion. While the staff turnover in ACT community sector has recently been estimated at 26% across the sector[86], anecdotal evidence suggests the figure is likely to be even higher in the AOD sector due to the reported high incidence of stress and 'burn-out' in this area. Drug and alcohol work often involves dealing with people who suffer multiple forms of disadvantage, and can exhibit challenging behaviours. More generally, community sector organisations face workforce challenges through:

- the comparatively low wages in the sector, which can be up $20,000 less than comparable positions in the public sector;[87]
- fewer leave and other entitlements, including lack of portable long-service leave, paid maternity leave and lower levels of superannuation contributions;
- higher levels of short-term and casual positions;
- workforce ageing, in a sector that already has above average ages for workers;
- Difficulty accessing appropriate training, and a system of training that remains of variable quality and coverage; and
- Resource constraints in improving workplace safety and employee support systems.

These issues were, in part, discussed in the ACT Governments' Report of the Community Sector Taskforce. However, a year after receiving the report, the Government has yet to issue a response.

We understand that the ACT government is in the process of developing new requirements for staff qualifications in the AOD sector, which is broadly supported in the sector. However, while additional training opportunities are to be provided for this transition, we understand this is only to be provided in the short-term, and this generates concerns for the availability of training opportunities for workers in the longer term.

[86] Australian Council of Social Service (2007) *Australian Community Sector Survey*, p.90
[87] ACT Government (2006) *Towards a Sustainable Community Sector in the ACT: The Report of the Community Sector Taskforce*, p.29

Further, there are currently limited opportunities for workers assisting clients with problem drug and alcohol use to network and develop improved personal and organisational linkages between agencies, as well a providing a site for peer support for workers. We understand that ACT Health has recently released a tender for the provision of such services, but raise the concern that this appears to also be a short-term initiative at this stage.

Supporting Collaboration

Addressing problem alcohol and drug use, including methamphetamine use, will never be wholly effective without the effective co-operation and interaction between the range of workers and agencies that are in contact with problem drug and alcohol users, and those that work to educate and prevent these difficulties occurring. This includes a broad range of participants, including both community and government organisations who work across the treatment, education, health, human service, law enforcement and justice areas.

Collaboration does not occur by itself, nor can it simply be mandated. Ultimately, long-term relationships and partnerships must be built up slowly over an extended period of time, allowing trust, respect and understanding to develop before extensive co-operation is possible. It is also not a costless process, and many organisations report that they are often asked to contribute to time-intensive collaboration processes without the additional resources required in an environment of already stretched capacity. If collaboration is to succeed, it must be resourced and supported.

With that caveat, the potential for greater collaboration to address problem drug use is considerable. There are a number of individuals and organisations, particularly in the fields of mental health, health promotion, youth services, homelessness, prisoner support, policing and the justice system that would be interested in working with AOD agencies to find better solutions to problem drug use, and working together to locate and reduce the ‘gaps’ in the service system and beyond that contribute to these difficulties.

For example, we understand that problem drug users are unlikely to seek assistance directly from a drug treatment agency in the first instance, and more likely be referred from another source, such as a mental health organisation, youth worker, homelessness worker or general practitioner. Developing understanding of the services offered throughout the health and human services system and improving referral pathways for agencies is a useful first step. More integrated service co-operation, such as joint case-management and collaborative service development may also deliver fruitful outcomes.

Similarly, there is scope to examine how different areas of government interact in supporting recovery from dependency. For instance, we understand that despite frequently drawing the issue to Housing ACT's attention, people exiting drug and alcohol rehabilitation programs continue to be placed in Housing ACT properties situated in areas with high drug use. Obviously, it is not conducive to recovery to live an environment with constant exposure to drug use, and greater care can be taken to place people exiting rehabilitation services in areas where they are less likely to encounter drug users or an easily available drug supply. Another area for useful co-ordination, although primarily directed by the Commonwealth, is employment services, where improvements may be achieved in securing employment opportunities for people in recovery.

Research and Evidence-based Interventions

While increasing the capacity of agencies and promoting collaboration between them is an appropriate response to reducing the extent of problem drug and alcohol use in the ACT, ultimately this will be limited by the extent of available data and research on the drug use environment and effective intervention and treatment strategies. While it is important to remember that service delivery organisations themselves can be important sites for treatment innovations, ultimately involvement from research institutions and medical researchers is required to ensure full coverage of the myriad of social, biological and psychological issues involved.

We recognise that the ACT Government has limited responsibility for research funding, however, it is clear that Australian research capacity on these issues are limited, and both own-source funding for research as well as clear and aggressive advocacy at the Commonwealth level for additional resources for research is required to make a significant difference in this area.

Legal and Law Enforcement Responses

Combining Law Enforcement with Harm Minimisation

As previously discussed, police and the courts appear to have been impacted by problem methamphetamine use, particularly in instances where they are confronted by methamphetamine-induced psychosis, although we would emphasise these are small minority of users. The response of the justice system to problem drug use remains fraught, and framing drug use as a "law and order" problem misses crucial information about drug dependence, poverty and health concerns that are essential to understanding and addressing the problem. While the rhetoric around law enforcement frames it as a 'supply reduction' strategy, one ACT Health review found that 85% of people arrested for a drug offence or issued with a simple cannabis offence notice could be classified as 'consumers' rather than 'suppliers' of illicit drugs.[88]

It is all too easy for legal perspectives on problem drug use to descend into an unhelpful slanging match over the criminalisation of drug use and sentencing. ACTCOSS notes many of our member organisations would take different positions on these issues, and that some have been ardent advocates for decriminalisation.

Yet in any case, this is not to argue that there is no role for police or the courts in addressing problem drug use. We point out that police can, on occasion, be an important referral pathway for problem drug users, and the judicial system has begun to examine alternate methods for managing people convicted of drug-related crimes, such as the NSW Drug Court. We are concerned that there continue to be problems with current police and judicial practice, and the associated legislative response to drug use, but this demonstrates the potential to improve the co-ordination of police and judicial responses with harm minimisation and treatment principals. We certainly advocate a strengthening of relationships and referral pathways for problem drug users who come into contact with the criminal justice system, with the aim of diverting people from corrective facilities into management and treatment programs.

Reducing Supply

There is, of course, a role for police in genuine supply reduction strategies. The ACT is a land-locked jurisdiction and requires a co-ordinated approach for any meaningful impact, particularly with the NSW and the Australian Governments. A unilateral injection of resources into ACT Policing seems unlikely to produce any significant outcomes.

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[88] McDonald (2004) *Background Paper for the ACT Alcohol, Tobacco and Other Drug Strategy Implementation and Evaluation Group*, ACT Health, p.iii

According to the Australian Crime Commission:

> "Australian ATS production is dominated by domestic clandestine production, primarily methylamphetamine manufacture which is underpinned by importation of chemical precursors".[89]

In regards to the ACT, the ACT Chief Police Officer reports that:

> "Intelligence within the ACT suggests there are a number of groups involved in the distribution of large quantities of AOSDs [Amphetamines and Other Synthetic Drugs] within the region. While these groups may not be connected with traditional organised crime groups, there is no doubt they are well established within the local community. They operate within defined 'networks' of suppliers, trusted associates and sub-dealers, and are also actively involved in (various) other types of criminal behaviours."[90]

Of particular concern is the presence in the ACT of clandestine drug laboratories, which not only supplement interstate supply, but themselves present considerable health risks to manufacturers and the surrounding community, including risks of chemical exposure and explosions.[91] Three such laboratories were discovered in the ACT in 2004-05, as many as in the preceding 5 years.[92] Discovery and dismantling of such facilities should be the major focus of police activity given the clear and present danger they pose.

In contrast, we would question the efficacy of targeting drug users in any supply reduction strategy. Criminal prosecution of drug users has doubtful effects on reducing supply, and few identifiable social benefits for either the community or the individual involved. Where possible, alternatives to imprisonment should be pursued, including diversionary programs or treatment orders.

The Sale of 'Ice-pipes'

In addition to the general issues discussed above, we remain unconvinced about the proposal to ban the sale of 'ice' pipes. Recent media commentary, particularly by Commonwealth representatives, has drawn public attention to this option. An 'ice-pipe' is simply a small tube, usually made of glass or other heat resistant material, with a bulb or 'cone' suitable for heating the drug and inhaling it once vaporised. We understand that 'ice-pipes' are currently available for sale in the ACT.

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[89] Australian Crime Commission (2006) Illicit Drug Data Report 2004-05, p.11
[90] Fagan (2006) *Submission to the Parliamentary Joint Committee on the Australian Crime Commission Inquiry into Amphetamines and Other Synthetic Drugs*, p.2
[91] Caldicott *et al.* (2005) *Clandestine Drug Laboratories in Australia and the potential for harm*, Australian and New Zealand Journal of Public Health, Vol.29, No.2, p.155
[92] Australian Crime Commission (2006) Illicit Drug Data Report 2004-05, p.18

The suggestion that prohibiting the sale of 'ice-pipes' would reduce the use of 'ice' is based upon the association between smoking the drug and dependence[93]. Smoking 'ice' is a more efficient route of administration than ingestion, resulting in a stronger 'high' and does not have the stigma and 'yuck factor' associated with injecting drug use. However, it remains unknown to what extent smoking 'ice' causes dependence, or is simply a result of dependent methamphetamine users choosing a more efficient route of administration to combat their growing tolerance to the effects of the drug.

Further, it is unclear whether prohibiting the commercial sale of 'ice-pipes' will do anything to reduce 'ice' smoking. Any number of makeshift 'ice-pipes' can be readily obtained, including using equipment from a chemistry set. 'Ice' can also be smoked with tobacco or marijuana in a 'bong', or 'chased' on aluminium foil. 'Ice-pipes' are also available for purchase on the internet. There is also an issue as to whether makeshift 'ice-pipes' may be more dangerous than those commercially available, and more susceptible to breakage and causing other harms.

Finally, it has been noted that even if the lack of commercially available 'ice-pipes' did lead to a reduction in smoking the drug, there has been concern expressed that dependent users may simply move to injecting the drug, which has even worse associations with health problems and dependency.

On balance, it seems unlikely that prohibiting the sale of 'ice-pipes' is an effective intervention to reduce the use of 'ice' or dependency upon it. We are concerned that the public debate on this issue has been raised to a level of hysteria that is not backed by any strong evidence. It is all too easy to accuse governments of being "soft on drugs", but ultimately good policy should be determined by the available evidence and its effectiveness in practice, rather than by a relatively silly debate involving political point-scoring and one-upmanship.

[93] McKetin *et al.* (2006) *The Relationship Between Crystalline Methamphetamine use and Methamphetamine Dependence*, Drug and Alcohol Dependence, Vol. 85, p.201

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